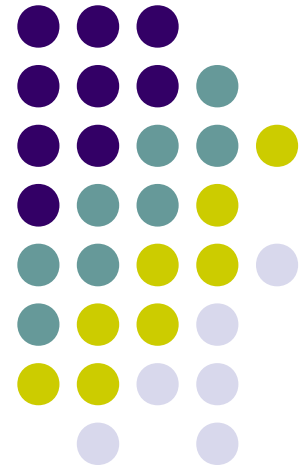
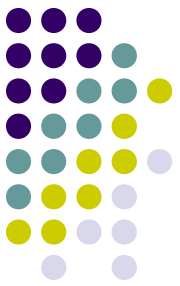


# Treatment of perinatal PTSD

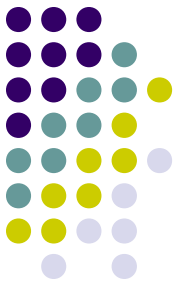
resulting from birth trauma





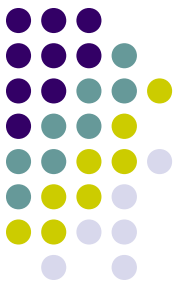
# Context

- Between 1-3% of all births meet ‘caseness’
  - UK: approx 6,000 - 18,000 women per year
  - Sweden: approx 1,100 – 3,300 women per year
- Up to 33% have some symptoms
  - UK: 198,000 women per year
  - Sweden: 38,000 women per year
- Unclear course of the illness, including severity, duration and resolution



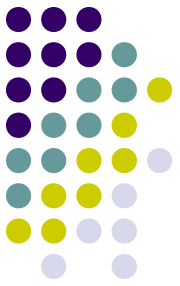
# Treatment Guidance

- National Institute for Clinical Excellence (NICE): Antenatal and Postnatal Mental Health Guideline
- Do NOT offer ‘single session formal debriefing focused on the birth’ to women following a traumatic birth
  - Structured debriefing aimed at eliciting feelings



# Treatment Guidance

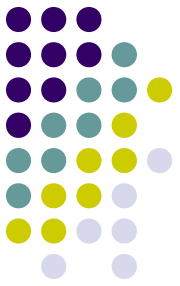
- NICE: Post-Traumatic Stress Disorder Guideline (not specific to perinatal time)
- ‘Watchful waiting’ in first 4 weeks if symptoms are mild
- Trauma-focused CBT for those with severe PTSD or symptoms within 1 month (8-12)
- Trauma-focused CBT or EMDR for those more than 3 months post-trauma



# CBT / EMDR

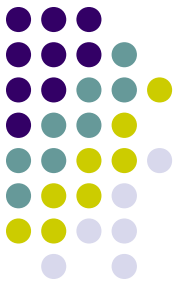
- Cognitive Behavioural Therapy: a psychological approach which aims to influence cognitions, behaviours and feelings linked to the trauma
- Eye Movement Desensitisation and Reprocessing: bilateral stimulation of the brain together with cognitive reprocessing of the trauma

# Published Perinatal Research



- At the level of case studies
  - EMDR: Midwifery 2008; 24(1): 62-73 4 women
  - CBT: JPOG 2007; 28(3): 177-184 2 women
- Otherwise, general PTSD literature can be utilised; many differences in the population
  - ‘positive event’ two individuals involved
  - Expectations of care sexual implications
  - Constant trigger ‘prospective trauma’

# Cognitive Model of PTSD



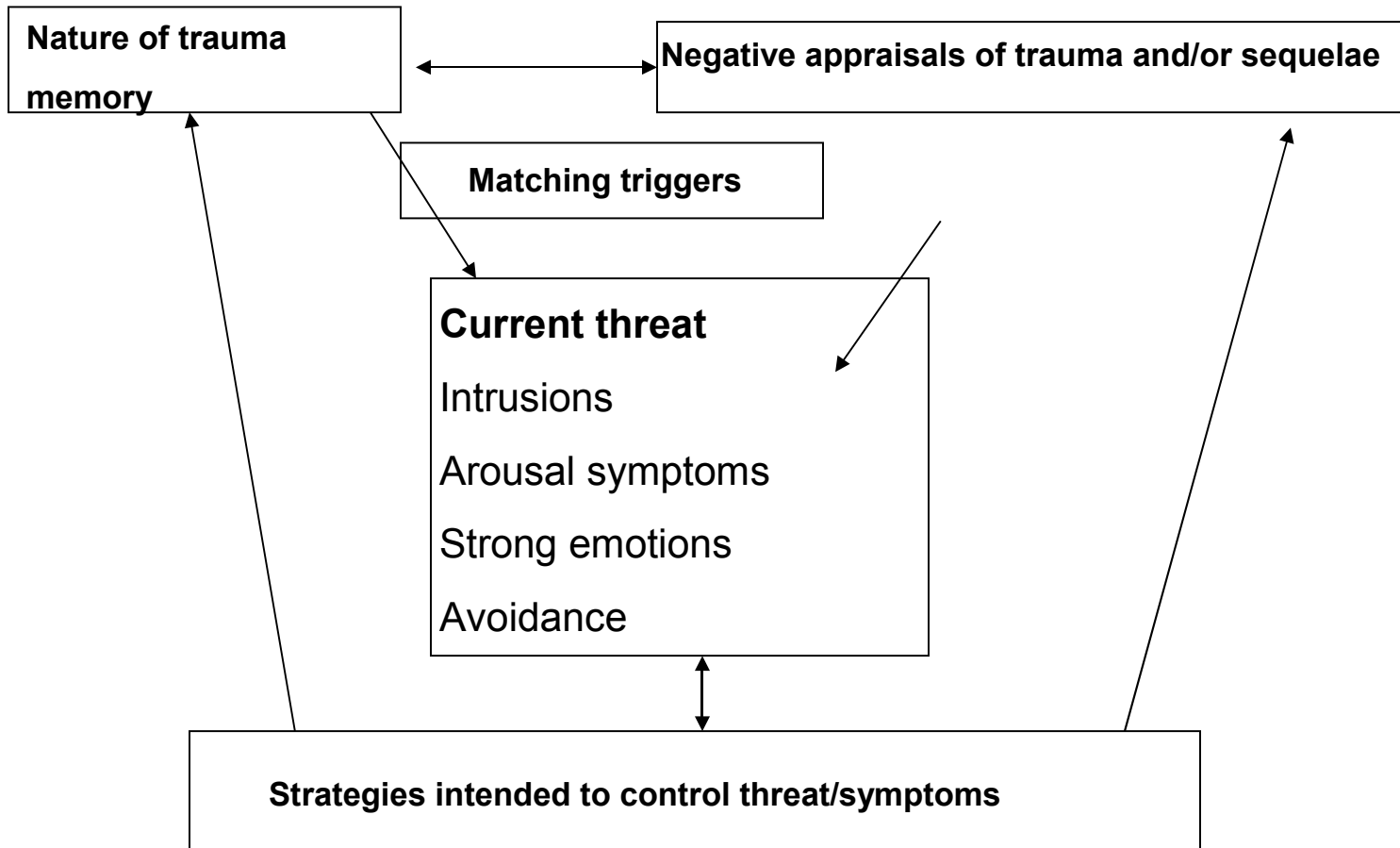
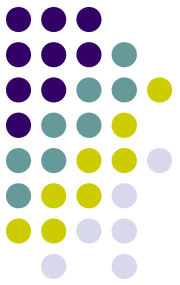
- **The Puzzle**

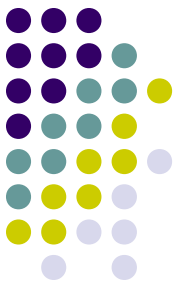
Anxiety is about future threat. PTSD is to do with memory for past event.

- **The Solution**

Individuals are processing the trauma and/or its sequelae in a way which poses a current threat to self.

# Cognitive Model of PTSD



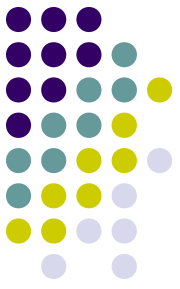


# Cognitive Model of PTSD

## 1. Nature of Trauma Memory

- Fragmented memory of the traumatic event
- Poor integration with other personal memories
- Unintentional triggering of memory fragments

# Cognitive Model of PTSD



## 2. Negative Thoughts

These produce a sense of current threat that lead to and maintain PTSD.

- ***The traumatic event*** , e.g. “The next disaster will strike soon”
- ***Emotions during the trauma*** , e.g. “I’m out of control; I’m failing”
- ***The trauma sequelae*** , e.g. “My reactions since the event mean that I am going crazy”

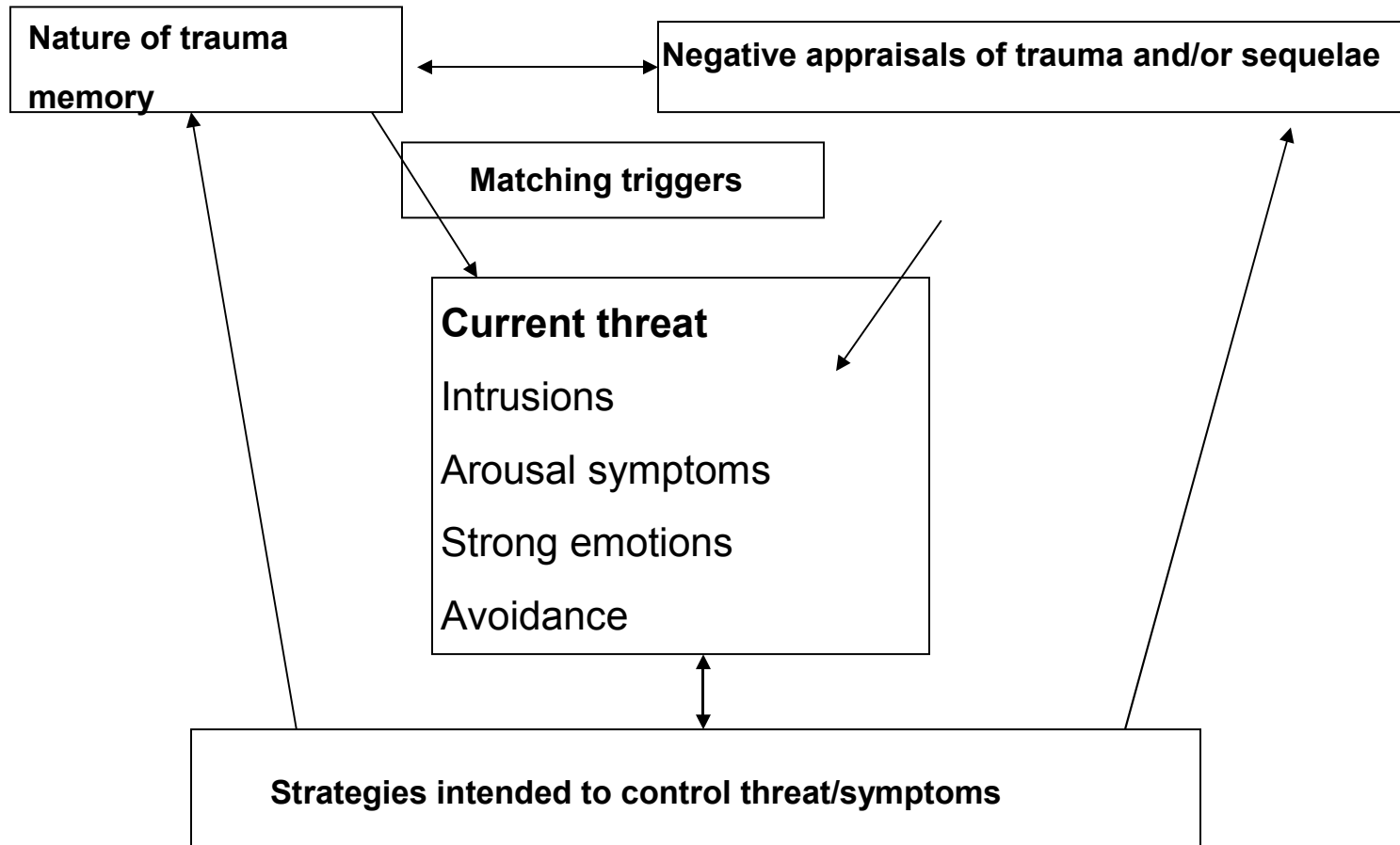
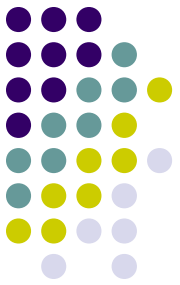
# Cognitive Model of PTSD

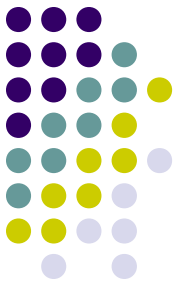


## 1. Unhelpful Strategies

- Have short-term aim of reducing distress but long-term problem of maintaining symptoms
- Problematic as they directly produce symptoms, prevent change in negative appraisals and contribute to the nature of the trauma memory.
- **Cognitive strategies**, e.g. thought suppression, cognitive avoidance, physical avoidance
- **Behavioural strategies**, e.g. use of alcohol and medication, giving up or avoiding activities, rumination

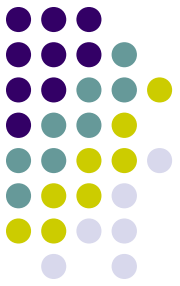
# Cognitive Model of PTSD





# In labour

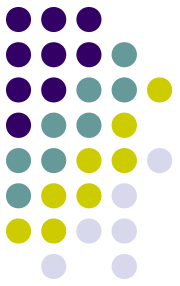
- Good communication and explanation
- Empathic attitude
- Giving opportunities to express concerns
- Be responsive to needs



# Antenatally

- Be aware of possibility of PTSD
- Early referral / treatment is best
- Education / myths
- Informal discussion re birth
- Differential diagnosis from PPD
- Be aware of risk factors
- Give opportunities to volunteer issues

# CBT Treatment

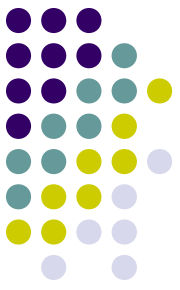


- Each symptom cluster may utilise a specific treatment approach
  - Reliving: guided reliving/visualisation; follow-up reliving with simultaneous cognitive reprocessing; subsequent guided reliving with ‘updated meanings’ of traumatic events
  - Avoidance: (overt and covert) – visit labour ward; exploration of meaning; tackle avoided triggers
  - Arousal: sleep tips; relaxation; distraction; anger management; anxiety management etc.



# Clinical Experience

- Women present with symptoms in 1-3 clusters (avoidance; arousal; reliving)
- Often present in a subsequent pregnancy
- Women can be traumatised within a range of situations (three case studies):
  - ‘objectively traumatic’ birth
  - perceived hostility/lack of support from staff
  - revival of previous trauma symptoms



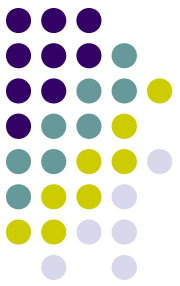
# Case Study 1

- Long labour resulting in 4<sup>th</sup> degree tear, emergency caesarean section and ano-vaginal fistulae
- Two corrective operations failed
- One (last) attempt to be made
- Daily problems with faecal continence persisting at 8 months postnatal
- Full caseness for PTSD and postnatal depression (secondary to PTSD)

# Treatment



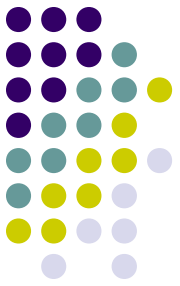
- Review of medical notes
- Case meeting with uro-gynaecologist and women's physio
- Avoidance
  - Visit to the labour ward
  - Joint attendance at a mother's group
- Reliving
  - Reliving of traumatic experience with cognitive reprocessing
  - Negative appraisals – 'I must have done something wrong'; 'I'll never get better'; 'I can't care for my son properly'
- Arousal
  - Anger and anxiety management techniques; sleep hygiene; relaxation; visualisation; distraction
- Depression (treated subsequently)
  - Exercise and CBT



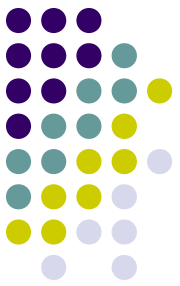
## Case Study 2

- Uneventful pregnancy
- Normal labour and delivery
- Sense of loss of control
- Midwife said 'pull yourself together'
- High levels of arousal (intrusive thoughts) and reliving; no avoidance
- Now pregnant again

# Appraisals

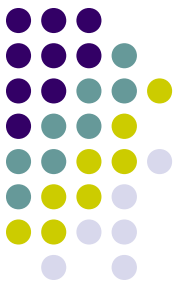


- Pre-traumatic:
  - harsh, critical childhood upbringing
  - high expectations of self; 'I will get it right'
- Peri-traumatic:
  - 'I can't do this'
  - 'I've lost control'
- Post-traumatic:
  - 'I'm a failure'
  - 'I'm a bad mother'
  - 'I can't do this again'



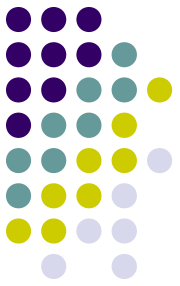
# Treatment

- Pre-traumatic:
  - Exploration of meaning of loss of control
  - Exploration of meaning of feeling judged
  - Exploration of need to achieve perfection all the time
- Peri-traumatic:
  - Meeting with midwife who attended birth
  - Review of delivery notes
- Post-traumatic:
  - Visit to labour ward
  - Plan for subsequent birth
  - Utilise hypnobirthing techniques
  - Exploration of current parenting and child development



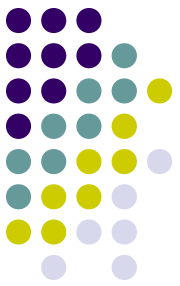
# Case Study 3

- Twin pregnancy
- One baby diagnosed with Down's – decision to terminate that baby
- TOP conducted with audible heartbeat
- Subsequent pregnancy resulted in shoulder dystocia
- Referred for traumatic response to second delivery
- Actual trauma related to termination, symptoms revived by traumatic second delivery
- Flashbacks to moment of TOP occurring during *second* labour and postnatally



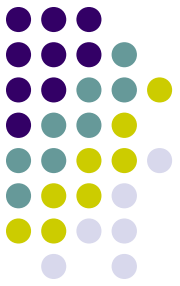
# Appraisals

- Pre-traumatic:
  - Strong Catholic faith; belief in wrongness of TOP
- Peri-traumatic:
  - ‘I’m murdering my baby’
- Post-traumatic:
  - ‘This is my punishment’ (2<sup>nd</sup> delivery)
  - ‘I don’t deserve to be a mother’
  - ‘I’m a bad person’



# Treatment

- Reliving
  - Address moment of fetal death
  - Cognitive reprocessing around guilt and shame
- Contact the delivering hospital to establish standard practice; psycho-education
- Involve hospital priest; memorial service arranged
- No avoidance or arousal (other than normal levels for newly postnatal woman)



# Ways Forward

- Reducing factors in the environment likely to result in trauma
- Training for staff
- Specialist training for trainee psychologists
  
- A work area of great positivity
- A chance to make some real change

**Thank You!**

