Early Intervention and Identification of People at Risk for Post-Traumatic Stress Disorder Secondary to Birth and Pregnancy Related Trauma – A Case Report

Aneline Amalathas MD MS, Kaitlyn Catanzarite PsyD, Sarah E Stuart DO, Brian L McGee MD

Louisiana State University Health Sciences Center, New Orleans, Department of Psychiatry

BACKGROUND

- Even though PTSD during the perinatal period has well-documented consequences for maternal and child outcomes, there is limited research on trauma-informed care as primary prevention for PTSD in pregnant women.[1,3]
- Risk factors for developing post-traumatic stress (PTS) or PTSD after reproductive loss include but are not limited to a history of previous traumas, mental health problems, and advanced pregnancy.[2]
- We present a case of psychological intervention for a 24yo G1P0 with high risk for developing trauma-related symptoms due to pregnancy with fetal abnormality that ultimately resulted in neonatal demise.

PRESENTATION

- KL is a 24yo G1P0 who at 20 weeks gestation, following neonatal diagnosis of lumbosacral myelomeningocele and other abnormalities, was referred to psychology services embedded within the UMC/LSU OBGYN clinic.

- KL's risk factors for pregnancy-related mood and anxiety disorders and PTS/PTSD:
  - History of Generalized Anxiety Disorder (GAD)
  - Childhood trauma history
  - Unplanned pregnancy
  - Fetal abnormalities

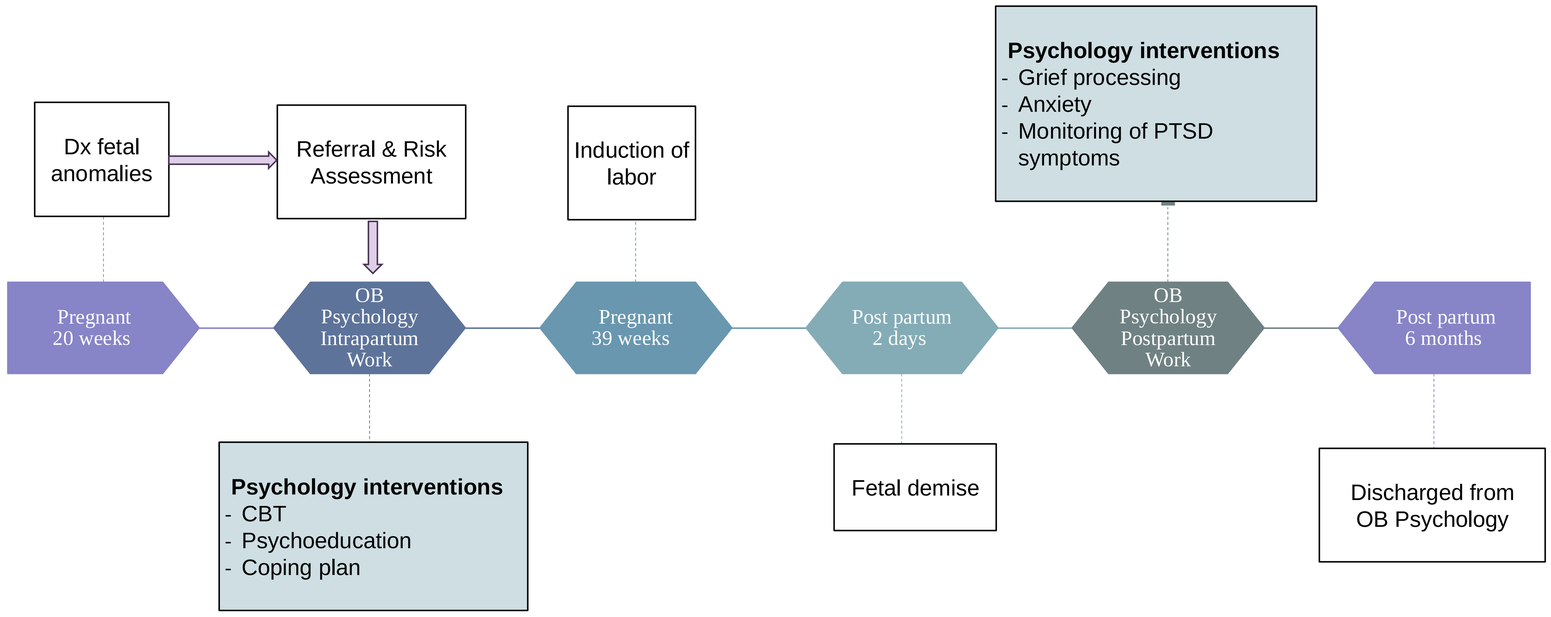
METHODS

- KL treated with 21 therapy sessions over one year
  - Biweekly appointments on average - frequency varied in response to symptom severity and taper at the end of treatment

- To address GAD and pregnancy-related concerns:
  - CBT interventions for anxiety
  - Increase interpersonal/communication skills to strengthen use of social supports
  - Create a "cope ahead plan" to navigate possible challenges in delivery and NICU stay

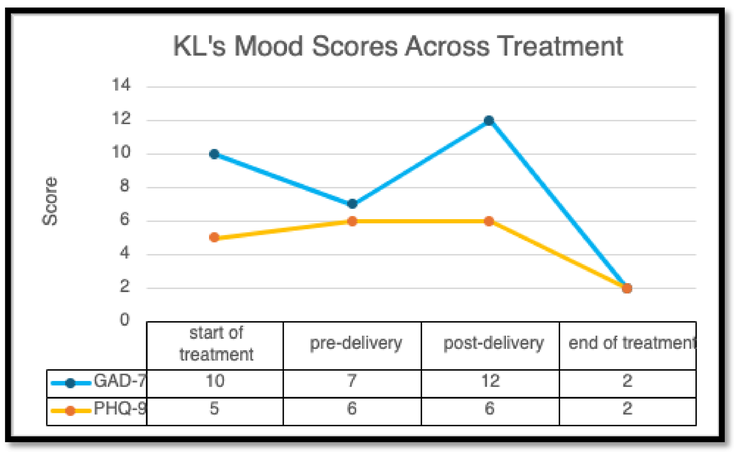
- To address neonatal demise:
  - Processing grief and addressing anxiety related to communicating loss to others
    - Grief based interventions to support commemorating loss
    - Role plays to practice communicating loss with coworkers
  - Distress tolerance skills to address feeling overwhelmed at work
  - Monitoring for symptoms of PTSD

COURSE



RESULTS

- Symptoms of anxiety and depression were monitored over KL's treatment with GAD-7 and PHQ-9 (graph). GAD-7 scores increased briefly after delivery. At the end of treatment, PHQ-9 and GAD-7 were lower than at initiation of treatment and clinically insignificant.
- KL returned to work at the end of her maternity leave without unexpected absences, started a graduate program as planned, and memorialized her loss with her partner.
- KL reached treatment goals without requiring initiation of psychiatric medications.



	start of treatment	pre-delivery	post-delivery	end of treatment
GAD-7	10	7	12	2
PHQ-9	5	6	6	2

DISCUSSION

- Literature supports primary prevention of PTSD through trauma history and trauma symptom screening of all pregnant patients as well as identifying patients at increased risk for PTSD based on specific events during pregnancy and birth trauma.
- Between 9-50% of individuals experience birth-related trauma,[1] with 3-19% of pregnant individuals meeting criteria for PTSD.[4]
- For KL, trauma-informed care and behavioral health services integrated into the UMC/LSU OBGYN clinic allowed for prompt coordination of care and increased accessibility to treatment.

CONCLUSION/IMPLICATIONS

- Integration of psychological and psychiatric care into perinatal clinics supports prevention of PTSD symptoms.
- With increasing restrictions limiting access to abortion care, it is anticipated that mental health needs for perinatal women are expected to rise,[4] as unwanted pregnancies have been found to correlate with increased psychological distress, and treatment non-adherence.[5]

REFERENCES

1. Horsch, A., et al. (2024). "Childbirth-related posttraumatic stress disorder: definition, risk factors, pathophysiology, diagnosis, prevention, and treatment." Am J Obstet Gynecol 230(3s): S1116-s1127.
2. Daugirdaitė, V., et al. (2015). "Posttraumatic stress and posttraumatic stress disorder after termination of pregnancy and reproductive loss: a systematic review." J Pregnancy 2015: 646345.
3. Yildiz, P. D., et al. (2017). "The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis." J Affect Disord 208: 634-645.
4. Londoño Tobón, A., McNicholas, E., Clare, C. A., Ireland, L. D., Payne, J. L., Moore Simas, T. A., ... & Byatt, N. (2023). The end of Roe v. Wade: implications for Women's mental health and care. *Frontiers in Psychiatry*, *14*, 1087045.
5. Poleschuck, E. L., & Woods, J. (2014). Psychologists partnering with obstetricians and gynecologists: Meeting the need for patient-centered models of women's health care delivery. *American Psychologist*, *69*(4), 344.

Corresponding Author: AAmala@LSUHSC.edu

Disclosure Statement: All presenting authors and co-authors have no relevant conflicts of interest to disclose.