Childbirth-related PTSD: How it differs and who's at risk

Reid Mergler, MD, and Amanda Koire, MD, PhD

Childbirth-related posttraumatic stress disorder (CB-PTSD) is a form of PTSD that can develop related to trauma surrounding the events of giving birth. It affects approximately 5% of women after any birth, which is similar to the rate of PTSD after experiencing a natural disaster.[1] Up to 17% of women may have posttraumatic symptoms in the postpartum period.[1] Despite the high prevalence of CB-PTSD, many psychiatric clinicians have not incorporated screening for and management of CB-PTSD into their practice.

This is partly because childbirth has been conceptualized as a "stressful but positive life event."[2] Historically, childbirth was not recognized as a traumatic event; for example, in DSM-III-R, the criteria for trauma in PTSD required an event outside the range of usual human experience, and childbirth was implicitly excluded as being too common to be traumatic. In the past decade, this clinical phenomenon has been more formally recognized and studied.[2]

CB-PTSD presents with symptoms similar to those of other forms of PTSD, with some nuances, as outlined in ***Table 1***.[3] Avoidance can be the predominant symptom; this can affect mothers' engagement in postnatal care and is a major risk factor for postpartum depression.[3]

Many risk factors in the peripartum period can impact the development of CB-PTSD (***Table 2***,[3] ***page 56***). The most significant risk factor is whether the patient views the delivery of their baby as a subjectively negative experience, regardless of the presence or lack of peripartum complications.[1] However, parents of infants who require treatment in a neonatal intensive care unit and women who require emergency medical treatment following delivery are at higher risk.

Screening and treatment

Ideally, every woman should be screened for CB-PTSD by their psychiatrist or obstetrician during a postpartum visit at least 1 month after delivery. In particular, high-risk populations and women with subjectively negative birth experiences should be screened, as well as women with post-

Table 1

Symptoms of childbirth-related posttraumatic stress disorder

Symptom	Notes
Hyperarousal	Irritable behavior, excessive vigilance about baby
Intrusive symptoms	Re-experiencing the delivery with negative images and nightmares
Negative cognitions	Themes of guilt and shame regarding motherhood or the manner of delivery, an inability to care for their baby, fears of sickness and death in their baby
Avoidance	Limiting postnatal care engagement; isolating from other women with babies, which may lead to postpartum depression; challenges bonding with their baby; feeling deeply anxious or conflicted about future pregnancy or determined to prevent it; sexual dysfunction/impaired relationship with partner

Source: Reference 3

Dr. Mergler is Assistant Professor of Clinical Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania. Dr. Koire is a PGY-4 Research Track Psychiatry Resident, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts.

Disclosures
The authors report no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

doi: 10.12788/cp.0422

Table 2

Risk factors associated with childbirth-related posttraumatic stress disorder

Category	Obstetric factors	Social factors	Psychological factors
Pregnancy	Complicated course, preterm birth, preeclampsia	Psychosocial vulnerability, unwanted/unplanned pregnancy, relationship difficulties, financial stress	Previous trauma (rape, sexual abuse), fear of childbirth, depression during pregnancy
Delivery	Emergency cesarean delivery, hemorrhage, use of forceps, lack of privacy, 3rd- and 4th-degree tears, negative delivery experience	Lack of practical and emotional support	Feelings of loss of control, dissociation
Postpartum	NICU admission, resuscitation, stillbirth, poor postnatal care, infant with a disability	Stress, poor coping skills	Poor sleep, lack of support

NICU: neonatal intensive care unit

Source: Reference 3

Every postpartum woman should be screened for CB-PTSD during a visit at least 1 month after delivery

partum depression that may have been precipitated or perpetuated by a traumatic experience. The City Birth Trauma Scale is a free 31-item self-report scale that can be used for such screening. It addresses both general and birth-related symptoms and is validated in multiple languages.[4]

Selective serotonin reuptake inhibitors and prazosin may be helpful for symptomatic treatment of CB-PTSD. Ongoing research studying the efficacy of cognitive-behavioral therapy and eye movement desensitization and reprocessing for CB-PTSD has yielded promising results but is limited in its generalizability.

Many women who develop CB-PTSD choose to get pregnant again. Psychiatrists can apply the principles of trauma-informed care and collaborate with obstetric and pediatric physicians to reduce the risk of retraumatization. It is critical to identify at-risk women and educate and prepare them for their next delivery experience. By focusing on communication, informed consent, and emotional support, we can do our best to prevent the recurrence of CB-PTSD.

References

1. Dekel S, Stuebe C, Dishy G. Childbirth induced posttraumatic stress syndrome: a systematic review of prevalence and risk factors. Front Psych. 2017;8:560. doi:10.3389/fpsyg.2017.00560
2. Horesh D, Garthus-Niegel S, Horsch A. Childbirth-related PTSD: is it a unique post-traumatic disorder? J Reprod Infant Psych. 2021;39(3):221-224. doi:10.1080/02646838.2021.1930739
3. Kranenburg L, Lambregtse-van den Berg M, Stramrood C. Traumatic childbirth experience and childbirth-related post-traumatic stress disorder (PTSD): a contemporary overview. Int J Environ Res Public Health. 2023;20(4):2775. doi:10.3390/ijerph20042775
4. Ayers S, Wright DB, Thornton A. Development of a measure of postpartum PTSD: The City Birth Trauma Scale. Front Psychiatry. 2018;9:409. doi:10.3389/fpsyt.2018.00409