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Assessing and treating PTSD within the perinatal loss community: An evidenced-based approach using Cognitive Processing Therapy

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CONFLICTS OF INTEREST

Gen Judayna Elmarhdi, LCSW, PMH-C does not have any personal, professional, legal, financial, or other interest that could reasonably be expected to impair her objectivity, competence, or effectiveness.


Dr. Kiley Hanish, OTD, OTR/L, PMH-C does not have any personal, professional, legal, financial, or other interest that could reasonably be expected to impair her objectivity, competence, or effectiveness.

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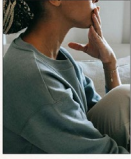
WHAT IS PERINATAL LOSS?

Types of Loss

- Failed IVF, embryo transfers
- Miscarriage (<20 weeks)
- Ectopic or molar pregnancies, blighted ovum
- Termination for medical reasons
- Stillbirth (>20 weeks)
- Neonatal death
- Infant death
- Failed adoption
- Surrogate experiences loss



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TRAUMATIC LOSS IN THE PERINATAL COMMUNITY

WHAT IS TRAUMATIC LOSS?

- Encompasses any loss that results in significant emotional distress and disrupts one's sense of safety and well-being.
- Subjective and varies for the individual.

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THE IMPACT OF LOSS TRIAD

BIRTHING PERSON

- Physical and emotional trauma (4)

PARTNER

- Feelings of helplessness, inadequacy, and grief (27)

LOWID ONES

- Feelings of grief, sadness, and powerlessness

HOW IS THE IMPACT THE SAME/DIFFERENT?


- Shared experiences of grief and trauma can foster empathy, understanding, and support within the family unit (16)
- **LOSS/TRAUMA** + clients higher PTSD pre-treatment symptomatology make more significant gains than counterparts during treatment with CPT with similar post-treatment outcomes (1)




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RISK FACTORS FOR DEVELOPMENT PTSD IN THE PERINATAL LOSS COMMUNITY

- Personal or family history (18)
- History of hormonal mood disorders (32)
- Endocrine dysfunction (39)
- Traumatic or disappointing childbirth experience (26)
- History of abuse (5)
- Recent stresses (5)
- Social Factors (10)
- Societal Factors



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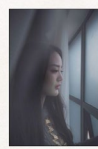


IS PTSD IN THE PERINATAL LOSS COMMUNITY PREVENTABLE?

- Trauma-informed approach
- Diversity cultural/racial/ethnic/LGBTQIA+/neurodiversity factors (40)
- Marginalization issues (39)
- Decolonization of support (39)
- Creating a safe space (39)
- Inclusivity "Parents/individuals who have experienced Loss/On Their Traumatic Growth Process" (40)

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WHEN PERINATAL LOSS RESULTS IN PTSD



- 10% TO 39% OF INDIVIDUALS EXPERIENCE PTSD FOLLOWING LATE FETAL DEMISE (1)
- HIGHER PREVALENCE OF PTSD SYMPTOMS WITH A TRAUMATIC LOSS (24)
- BEREAVED WOMEN HAD 4X POSITIVE SCREEN FOR DEPRESSION AND 7X POSITIVE SCREEN FOR PTSD (22)
- LATE FETAL DEMISE IS A SIGNIFICANT RISK FACTOR FOR PTSD
- LOSS CAN IMPACT NOT ONLY THE BIRTHING PERSON, BUT THE PARTNER AND/OR FAMILY
- 26% OF THE FATHERS AND BIRTHING PARTNERS REPORTED SYMPTOMS CONSISTENT WITH DIAGNOSABLE PTSD (52)

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FACTORS THAT MAY INFLUENCE THE PREVALENCE OF PTSD AMONG INDIVIDUALS EXPERIENCING PERINATAL LOSS



- Gestational age
- Previous mental health history
- Severity of the loss
- Level of social support
- Cultural and individual differences

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MORE IN-DEPTH QUESTIONS TO EXPLORE (CONTINUED)

Relationship Dynamics

- How has the loss(es) impacted your relationship with your partner, if applicable?
- Have you and your partner been able to talk openly about your feelings and experiences related to the loss(es)?
- Are there any challenges or conflicts that have arisen in your relationship as a result of the loss(es)?

Future Pregnancy Concerns


- How do you feel about the prospect of future pregnancies or expanding your family after experiencing the loss(es)?
- Are there any fears or concerns you have about the possibility of another loss or complications in a future pregnancy?
- Have you taken any steps to prepare for or address these concerns, such as seeking medical advice or counseling?




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QUESTIONS FOR CLINICIANS TO CONSIDER

- How do we as clinicians feel about discussing this topic?
- Do we feel safe/ready to ask?
- Are we prepared to hear the answers?
- Do we know about resources available?
- Do we understand how to assess for PTSD, and other trauma-related conditions?
- Are we assessing?
- Are we assessing the birthing person/partner/loved ones?
- Are we considering only current losses or previous losses?




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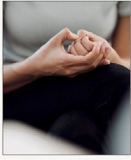
CPT V, CPT+A

- Allow the client to choose.
- If there have been missing 'pieces' of the event, CPT+A could allow the client to 'put things together' and understand why things unfolded as they did.
- Clients with high levels of dissociation may benefit from CPT+A.

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<p>FACTORS FOR SUCCESS</p> <ul style="list-style-type: none">• Prioritizing assimilation before overaccommodation• Focus on Socratic questioning• Attending to practice assignments• Adhering to protocol• Emphasis on natural affect expression <p>Contraindications for CPT</p> <ul style="list-style-type: none">• Mania• Psychosis• Imminent suicidality/homicidality• SUD detoxification	
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	<p>COMORBID CONDITIONS-AXIS I</p> <p>DEPRESSIVE DISORDERS</p> <ul style="list-style-type: none">• Commonly co-occure with PTSD following perinatal loss• Exacerbates symptoms and impairs functioning <p>ANXIETY DISORDERS</p> <ul style="list-style-type: none">• Prevalent among individuals with PTSD (42)• Examples include anxiety disorder and panic disorder <p>BI-POLAR DISORDERS</p> <ul style="list-style-type: none">• Bipolar disorder may complicate the presentation and treatment of PTSD• Requires careful monitoring and coordination of care
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<p>USE CAUTION WITH POSTPARTUM DEPRESSION MEASURES</p> <ul style="list-style-type: none">• Postpartum Depression Screening Scale (PPDS)• Edinburgh Postnatal Depression Scale (EPDS) <p>EPDS ASSESSMENT STARTS WITH THE FOLLOWING STATEMENT: "Since you are either pregnant or have recently had a baby, we want to know how you feel?"</p> <p>*THIS COULD BE VERY TRIGGERING FOLLOWING LOSS*</p>	
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COGNITIVE PROCESSING THERAPY (CPT) FOR PTSD WITHIN THE PERINATAL COMMUNITY


- Front-line treatments for PTSD: Trauma-focused therapies
- Gold standard for treatment: Manualized trauma therapy (43)
- Clinical practice: Combine Perinatal-PTSD research with current guidelines for PTSD (3)
- Case study Childbirth Related-PTSD (2)
 - Initial support for CPT as a "strong psychotherapeutic intervention" for targeting CB-PTSD
 - Adapted to an 8-session length



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CPT FOR PERINATAL LOSS-RELATED PTSD


- Research on perinatal loss-related PTSD and Cognitive Processing Therapy (CPT) is needed.
- CPT has shown efficacy in treating PTSD related to various traumatic experiences. It is reasonable to consider its potential utility in treating PTSD following perinatal loss.
- Some studies using CPT in broader populations of individuals experiencing traumatic grief or complicated grief (including perinatal loss) show reduced PTSD symptoms, depression, and overall distress associated with traumatic grief.



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CLINICAL PRACTICE GUIDELINES FOR THE TREATMENT OF PTSD (3)


- Strongly recommends that clinicians offer cognitive processing therapy compared to no intervention (adult patients with PTSD).
- Panel makes "strong recommendations" for use of trauma-focused psychological treatments including CPT.
- Moderate strength of evidence benefit for the critical outcome of PTSD symptom reduction.
- Moderate strength of evidence benefit for 2 additional important outcomes: loss of PTSD diagnosis and prevention/reduction of comorbid depression.
 - Insufficient/very low strength of evidence for the critical outcome of serious harms. Benefits clearly outweigh harms/burdens.
 - No evidence that raises concern about applicability.



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UNTREATED PTSD IN THE PERINATAL LOSS COMMUNITY


- PTSD has been observed in up to 25% of women in the immediate aftermath of a pregnancy loss (46)
- As many as 1 in 3 experience PTSD (46)
- Approximately 62% of women who miscarry become pregnant again within 12 months of the loss (24)
 - Prior pregnancy loss is a risk factor for developing anxiety and depression during subsequent pregnancies.
 - The risk is greater if the pregnancy occurs within one year of loss.
- 21% of women with a prior pregnancy loss experience PTSD in subsequent pregnancies. (52)
- Subsequent pregnancies may serve to reactivate symptoms of distress (29)



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UNTREATED PTSD IN THE PERINATAL LOSS COMMUNITY

- Avoidance symptoms may impact bonding and attachment during future pregnancies (18)
- Physiologic symptoms and neuroendocrine consequences of anxiety, hyperarousal, and dysphoria create a suboptimal milieu for the developing fetus (18)
- Pregnancy-related anxiety increases risk of pre-term delivery, low-birth-weight, and stillbirth (18)
- Women with PTSD in pregnancy are at higher risk for several obstetric complications including ectopic pregnancy, miscarriage, hypertension and preeclampsia (18)
- Undiagnosed birthing persons may be prescribed medication unnecessarily (18)




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BASIC ASSESSMENT RECOMMENDATIONS

The CPT for PTSD Therapist's Manual recommends:


- CAPS-5: Clinician Administered Interview
- PCL-5 (Cutoff Score >31-33): Self-Report




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<p>GRIEF V. PTSD</p> <p>The brain's response to grief and post-traumatic stress disorder (PTSD) can differ in several ways, reflecting the distinct nature of these two conditions:</p> <ol style="list-style-type: none">1. Neural Circuitry2. Triggers and Memories3. Nature of Loss4. Duration and Course	
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<p>GRIEF V. PTSD CONT.</p> <ul style="list-style-type: none">• INTRUSIONS (5)• MOOD CHANGES (18)• PREOCCUPATION WITH LOSS (7)• AVOIDANCE (41)• AROUSAL (8, 41)• LASTS 2 MO), (37)• INABILITY TO INTEGRATE LOSS (36)	
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<p>WHEN BOTH PRESENT: INTERVENTION CONSIDERATIONS</p> <p>Evidence-based treatment: Grief Counseling v. PTSD</p> <ul style="list-style-type: none">• Practice addressing PTSD symptoms to facilitate grief processing and resolution. (36) <p>Proceeding with PTSD treatment can forge a way forward to move sadness toward grief.</p> <ul style="list-style-type: none">• Integrated treatment approaches that target both PTSD and complicated grief can promote adaptive coping and facilitate psychological healing. (2)• CPT for PTSD can and should facilitate grief and grieving following loss. <p>Pretreatment Considerations</p> <ul style="list-style-type: none">• Most clients do not need coping skills before starting PTSD.• Causes a delay in treatment.• Increases dropout.	
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WHEN CLIENT DOESN'T FULLY MEET CRITERIA FOR PTSD

- PCL-5 cutoff for PTSD is usually 31-33.
- Full criteria necessary for research, not in practice.
- Clients with subthreshold PTSD have been shown to do as well as those who meet full criteria.
- Subthreshold PTSD symptoms were double that of full PTSD but had clinically impactful functional impairment. (2)
- Must have at least 1 intrusive symptom.
- Must have a trauma-related avoidance symptom.
- If client is subthreshold and meets criteria for another diagnosis, do not offer CPT.

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IDENTIFYING THE INDEX TRAUMA (42)

- LIFE EVENTS CHECKLIST (40)
- TIMELINE OF EVENTS (3)
- CHOOSING THE APPROPRIATE TARGET FOR THE MEASURE (3)
- THE LOSS ITSELF (48)
- WHAT HAPPENED AFTER
- THE MEANING OF THE LOSS (3)

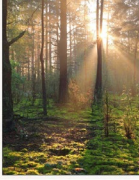
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IDENTIFYING THE INDEX TRAUMA (43)

ATTEND TO:

- The most bothersome event
- Content of intrusions/nightmares
- Content of negative cognitions
- People, places, and events that are avoided
- What they LEAST want to talk about


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WHAT IS HELPFUL

- Education and awareness
- Support groups (bereaved parents)
- Social Support (family and friends)
- Professional support (therapy)
- Ongoing bonds with the deceased child
- Movement
- Nature
- Creating meaning

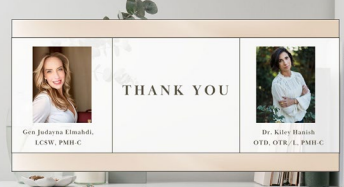
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RESOURCES
www.rtzhope.org


- [Pregnancy and Infant Loss Directory](#)
- [Virtual Support Groups & Workshops \(RTZ\)](#)
- [Perinatal Bereavement Brochures \(RTZ\)](#)
- [Pregnancy After Loss \(website\)](#)
- [Providers Resource page \(website\)](#)

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THANK YOU


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