**Recognising the differences between Post Traumatic Stress Disorder-Post Childbirth (PTSD-PC) and Post Natal Depression (PND): a guide for midwives**

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**Abstract**

Post Traumatic Stress Disorder-Post Childbirth (PTSD-PC) is a powerful pathophysiological reaction that occurs in response to experiencing a traumatic birth and affects between1-6% of women. Regardless of its trigger, PTSD-PC causes significant impairment to women’s social interactions, capacity to work, and daily life. A key symptom of PTSD-PC is re-experiencing the birth in the form of nightmares, flashbacks, continual replay, intrusive thoughts, and images. When these symptoms persist beyond ‘one month’ (DSM-V definition), a diagnosis of PTSD-PC should be considered. In full awareness that there are additional mental health problems that a childbearing woman could encounter, we have elected to focus on two of the more commonly experienced diagnoses; specifically PTSD and Post Natal Depression (PND). It is important for midwives to be able to differentiate between PTSD-PC and Post Natal Depression (PND), because diagnoses and treatments differ. Generally PND is treated with antidepressants and Cognitive Behavioural Therapy (CBT), whilst PTSD is treated with Eye Movement Desensitisation and Reprocessing (EMDR) therapy or Emotional Freedom Technique (EFT). Also, there is potential for a women to develop a dual diagnosis, with partner and family affected also. Clarity surrounding the differences between PND and PTSD are key to accessing appropriate diagnosis, referral, and treatment.

**Key words**: Childbirth, Mental health, Midwives, Post Natal Depression (PND,

Post Traumatic Stress Disorder (PTSD)

**Keypoints**

(1) Midwives knowing more about mental health problems is an essential area of their educational development. Being aware that there are several mental health conditions that a childbearing woman could encounter, this article focuses on two of the more commonly experienced diagnoses of Post Traumatic Stress Disorder-Post Childbirth (PTSD-PC) and Postnatal Depression (PND).

(2) Knowing the differences between PTSD-PC and PND is essential knowledge for a midwife to have for appropriate recognition and referral.

(3) Symptoms of PTSD-PC include flashbacks, nightmares and repetitive mental tape recordings of a traumatic birth, whereas PND presents with symptoms of a more generalised depression.

(4) Post recognising symptoms of PTSD-PC, the City Birth Trauma Scale (City BiTS) can be completed by the woman for initial diagnosis and referral.

(5)Treatment for PTSD-PC involves Eye Movement Desensitisation and Reprocessing (EMDR) therapy.

(6)Continuity of care models are beneficial for recognising mental health problems, because relationship forming with woman, partner and family permits the midwife to distinguish between usual behaviour and emerging mental health symptoms.

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**Introduction**

The transition to motherhood is multifaceted, with many biological, physiological, social and psychological changes occurring simultaneously. Although the majority of women make the transition to motherhood successfully, some experience Perinatal Mental Health Problems (PMHP), as they attempt to psychologically adjust to the radical changes that childbirth and parenting brings. In their primary role, midwives hold responsibility for recognising, assessing, and referring PMHP whilst delivering maternity care to women. Completely missing or providing an incorrect diagnosis of a mental health problem can have vast implications for the woman, infant, and wider family. PMHP is a major cause of maternal morbidity and in some instances mortality, with 17% of recorded maternal deaths of UK childbearing women dying directly or indirectly from mental health problems between 2012 and 2014 (Knight et al., 2016).Consequently, the midwife’s role is crucial in relation to initial recognition, referral for diagnosis, and treatment of PMHP. In full awareness that there are other mental health problems that childbearing women can experience, in this article we have elected to focus upon the more commonly experienced conditions of PTSD and PND.

Midwives knowledge surrounding Post Natal Depression (PND) is reported to be high. However, there is a dearth of similar understanding of allied mental health conditions, such as Post Traumatic Stress Disorder-Post Childbirth (PTSD-PC). The consequences are that many midwives are unsure of how to recognise and differentiate between different types of PMHP, and upon recognition know the appropriate referral pathway (Noonan et al., 2017; McGlone et al., 2017). In response, recognising variance in diagnoses between PTSD-PC, PND and other PMHP can result in unsuitable referral and treatment (NICE 2014), with an incorrect diagnosis augmenting distress for the woman and family (White et al., 2015). Zauderer (2014) provides a long list of negative sequelae for woman experiencing PMHP, which include failing to bond with the baby, substance misuse, panic disorder, phobia, marital breakdown, and suicide.

Hence, the rationale behind this paper is to provide midwives with important information to improve their confidence in recognising, referring and supporting treatment of PTSD-PC. First we address the confusion in diagnostic and treatment differences between PND and PTSD-PC, with it noted that midwives are not expected to formally diagnose and treat women. Instead what is important, is for midwives to be aware of the differences in clinical features, which are clearly defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).Having this knowledge could make the difference between a correct or incorrect diagnosis and a successful or unsuccessful recovery for the woman.

**PTSD-PC: symptoms, diagnosis and treatment**

*PTSD-PC: Symptoms*

PTSD-PC is characterised by a reaction to a stressful event, which causes a pathophysiological alteration in the hypothalamic-pituitary-adrenal axis (Zauderer, 2014). Resultant clinical features of PTSD-PC are similar to those experienced in non-childbirth PTSD, and can affect between 1-6% of women following childbirth (O’Donovan et al., 2014). The DSM-V (2013) places symptoms of PTSD into 4 categories:

1. *Intrusive thoughts*: flashbacks, disturbing memories or nightmares of the birth, describing a repetitive ‘mental tape recording’ of the experience.
2. *Avoiding reminders*: evading people, place or activities that trigger memories of the traumatic birth experience, with the baby a ‘constant reminder’ and possibly causing detachment and avoidance of breastfeeding.
3. *Negative thoughts and feelings*: disbelief in ability to mother, guilt or shame surrounding behaviour towards baby, lack of interest in everyday and previously enjoyed activities or people, reduced sexual activity and a detached relationship from partner, and fear of future pregnancy.
4. *Arousal and reactive symptoms*: irritability and outbursts of anger, problems sleeping or concentrating, and being easily startled.

A woman with PTSD-PC will display many of the symptoms in these categories with varying severity. Symptoms need to be present for over one month after the event for a diagnosis of PTSD-PC to be given. When clinical features have only been present for between 3 days and less than one month, a diagnosis of Acute Traumatic Stress Disorder becomes appropriate (DSM-V). Epidemiological research on PTSD suggests that it may be acute or chronic, onset immediately or be delayed, remit and re-occur (Blank, 1993). Symptoms may persist for 5, 10 or even 40 years post the traumatic event (White et al., 2006).To view the associated signs and symptoms of PTSD (see *Table 1*).

TABLE 1 HERE

*PTSD-PC: Diagnosis*

Many symptoms of PTSD-PC are difficult to recognise in a new mother. For instance, it is usual for new parents to experience lack of sleep, and therefore midwives require to use considered clinical judgement and the DSM-V as a guide. In addition, the recently developed City Birth Trauma Scale (City BiTS) (Ayers et al., in press) is a new psychometrically robust self-reporting instrument consisting of 31 questions that relate to four categories of symptoms. It is anticipated that the City BiTS may in the future be added to the schedule for diagnosing PTSD-PC, but as yet is a fairly new development. When the woman answers positively to the following questions, the midwife should consider screening for PTSD-PC using the City Birth Trauma Scale (City BiTS) (Ayers et al., in press).

1. [Do you] try to avoid thinking about your birth experience?
2. [Do you] get upset when reminded of your birth experience?
3. [Are you] not sleeping well because of things that are not related to your baby’s sleep pattern?

What follows is a detailed comparison of symptoms, diagnosis, and treatment differences between PTSD-PC and PND. When using the City BiTS:

* The total PTSD-PC symptom score range is 0-60.
* Each symptom question has a score range of 0-3.
* A rising score correlates with increased severity of PTSD-PC.
* To be referred and treated a woman must score as follows on the City BiTS:
  + Answer yes to question 1 or 2
  + Answer positive (with a score of at least one point) to one question in both subsections 1 and 2 (re-experiencing symptoms& avoidance symptoms)
  + Answer positive (with a score of at least one point) to two questions in both subsections 3 and 4 (Negative cognitions and mood and Hyperarousal)
  + Answer positive (with a score of at least one point) to question 28 (duration)
  + Answer positive (with a score of at least one point) to question 29 or 30 (Distress and impairment)

If a woman answers positive to question 31; “Could any of these symptoms be due to medication, alcohol, drugs or physical illness?” the woman is to be excluded from diagnostic PTSD-PC. It is important to note that some women will not meet full diagnostic criteria for PTSD-PC, but nevertheless be experiencing distressing symptoms that require further assessment and support.

*PTSD-PC: Treatment*

Although midwives are not expected to treat women with PMHP, a working knowledge enables explanations to be given to women, partner and family. Amongst other possible treatments, one contemporary treatment for PTSD-PC involves Eye Movement Desensitisation and Reprocessing (EMDR) therapy. Shapiro’s (2001) Adaptive Information Processing (AIP) model assumes that the human mind has a natural processing system, which controls, filters and reacts to incoming information. When confronted with a trauma, this information processing system can become disrupted, and as a result produce traumatic symptoms. A traumatic birth has potential to overwhelm usual neurological coping mechanisms, with associated stimuli inadequately processed and stored in an isolated memory network. When these isolated memories are repetitively replayed, they arouse associated maladaptive emotions, unpleasant intrusive thoughts, images, and sensations. The goal of EMDR therapy is to unlock and reprocess dislocated memories and integrate them into the body of adaptive recollections, and by doing so remove the psychopathology. An experienced EMDR therapist will deliver a standardised 8-phase EMDR program designed by Shapiro (1995) (see Table 3).

TABLE 2 HERE

A further treatment for PTSD-PC is Emotional Freedom Technique (EFT) (Karatzias et al., 2011). EFT is an easily administered self-applied meridian-based therapy (Craig, 1999), which assumes that emotional disturbance, including PTSD, is a by-product of disturbances in the body’s energy field (meridian system) caused by exposure to a traumatic event. EFT involves light manual stimulation of acupuncture meridian points of the face, upper body and hands, whilst the individual focuses on the traumatic event (Craig, 2009). There are significant therapeutic gains from having received EFT, with a slightly higher proportion of patients in an EMDR group producing substantial clinical changes compared with an EFT group (Karatzias et al. 2011).

**PND: symptoms, diagnosis and treatment**

*PND: Symptoms*

PND is a non-psychotic major depressive episode that begins within one-month post childbirth (APA, 2013). The symptoms experienced by a woman with PND are similar to those of generic depression. PND affects how a woman thinks, feels, and acts, arousing feelings of sadness and loss of interest in day-to-day activities. PND instigates both physical and psychological reactions, such as depleted energy, increased fatigue, difficulty concentrating, feeling worthless, guilt, anxiety etc. (see *Table* 1).

For a diagnosis of PND to be secured, clinical features must present for a minimum of two weeks (APA, 2013). Risk factors for developing PND are multi-factorial, and include biochemical, genetic (family history of depression), personality, and environmental factors. It is estimated that 10-45% of women experience some symptoms of PND post childbirth in varying intensities (Noonan et al., 2016).

*PND: Diagnosis*

Symptoms associated with PND may be masked by natural characteristics of having a newborn. For example, it is usual for a woman to suffer from sleep depletion, increased fatigue, and low mood as a result of hormonal changes during the postnatal period. Applying clinical judgement, holding strong knowledge of the condition, and using a screening tool (e.g., the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987), helps midwives distinguish between normality and authentic PND. The EPDS is a psychometrically robust self-reporting questionnaire, and in the UK is the most widely used instrument for initially diagnosing childbearing women. The EPDS consists of 10 questions:

* The scoring system is 0-30, with a score range of 0-3 for each question, and an increasing score indicating escalating severity.
* Total scores over 10 indicate PND.
* Total scores over 12 indicate need for assessment by a qualified mental health professional.
* Answering positively to question 10 (The thought of harming myself has occurred to me)indicates *immediate* need for assessment by a qualified mental health professional.

*PND: Treatment*

Treatments for PND are similar to those of non-postnatal depression. For example psychosocial interventions, hormone therapy, and pharmaceutical medication. Individualised variants such as efficacy, treatment response, side-effects, compliance, patient preference, and breastfeeding should be considered when discussing treatment regimens with women (SIGN, 2012). NICE (2014) and SIGN (2012) recognise that 4-6 sessions of Cognitive Behavioural Therapy (CBT) is an effective psychosocial treatment for PND. CBT is designed to equip the woman with tools to cope with her new situation and help her build resilience. During delivery of CBT, perceived problems are differentiated into thoughts, feelings, and actions (associated behaviours). Once identified, the therapist discusses skill sets to manage thoughts, feelings, and actions, with the ultimate goal of reducing clinical features. In the event that CBT is unsuccessful, pharmacological management should be considered, with NICE (2014) not recommending any particular pharmaceutical treatment.

**Discussion**

A diagnosis of PTSD-PC or PND can have devastating effects at a psychological, physical and social level. Despite being two separate conditions, a woman with PTSD-PC may proceed to develop a dual diagnosis of PND. It is also important to note that the predisposing trauma that triggers arousal of memory flashbacks may not be regarded as a significant threat by a bystander. The principle is ‘that what the woman experienced as the perceived threat to her own or baby’s life’ is what counts, which is easier for the midwife to quantify when the trauma can be visualised. Overt examples include; the woman experiencing a third or fourth degree tear, post-partum haemorrhage, poor neonatal outcome, or an obstetric or neonatal emergency. However, more commonly reported trauma experiences include unmanageable pain, lack of control, or feeling mistreated by maternity care staff. Therefore, women who have had a straightforward labour and have produced a healthy infant, may still report PTSD-PC symptoms (Borg Cunen et al., 2014). Also, the related traumatic experience could simply be a birth that deviated from perceived expectations (O’Donovan et al., 2014).

Women who present with symptoms and describe events surrounding childbirth as traumatic, should be assessed for PTSD-PC and possibly also PND depending on clinical presentation (see *Table 1*). Symptoms of PTSD-PC and PND may possess an element of overlap (see *Table 1*). These intersects may cause a PTSD-PC diagnosis to be overlooked in favour of PND, with a dual diagnosis present (White et al., 2006).The cause of a positive correlation between PTSD-PC and PND may be a dose response between the two conditions. That is, as PTSD-PC symptoms exacerbate, those of PND adjacently intensify (White et al., 2006), with figures evidencing this co-morbidity to range from 20-75% (McKenzie-McHarg et al., 2015). When symptoms match PTSD-PC, the City BiTS scale is issued. In contrast, when PND Symptoms present the EPDS is issued and scored. When a self-reported diagnosis of either or both conditions is secured, the woman should be referred down the appropriate referral mental health pathway for formal diagnosis from a mental health expert.

In terms of management, guidelines warn against midwives providing a formal debriefing when mental health symptoms arise (NICE, 2007), with a less standardised postnatal discussion evidenced to benefit women through providing opportunity to evaluate their experiences and ask questions. Actively listening to women’s experiences with compassion and understanding is helpful (McKenzie-McHarg et al., 2015), although if conducted in isolation of referral and treatment may be ineffective in terms of accelerating recovery (Borg Cunen et al., 2014). Nonetheless, such discussions offer opportunity for knowledgeable midwives to assess women for signs and symptoms of PMHP and follow up.

Such ability requires the midwife to have:

* Knowledge of the signs and symptoms of PTSD-PC and PND, and be able to differentiate between these two conditions.
* Understand how to access and use appropriate screening tools and know their place in referral for diagnosis by a mental health professional.
* Knowledge of and access to the appropriate referral pathway when scores are above the cut-off point (see *Figure 1*).

FIGURE 1 HERE

One problem for midwives using psychometric instruments, such as the City BiTS or EPDS, is that they can act as a barrier to detection of PTSD-PC and PND when no well-developed or trusting relationship has been developed between midwife and woman, partner and family. Continuity of care models are beneficial for increasing recognition of PMHP, quite simply because the midwife is more likely to develop a trusting relationship with the women.

Renfrew et al. (2014) derived from a new evidence-informed framework that ‘models of midwifery care’ and midwifery interventions during pregnancy promote more positive outcomes. Renfrew et al. (2014) identified 50 short-term, medium-term, and long-term outcomes that could be improved by care within the scope of midwifery practice. These included reduced maternal and neonatal mortality and morbidity, reduced stillbirth and pre-term birth, decreased number of unnecessary interventions, and ultimately improved psychosocial and public health outcomes (Renfrew et al., 2014). Developing a one-to-one relationship with the woman will permit the midwife to distinguish between more usual behaviour and an emerging mental health problem. ‘The Best Start’ document (Scottish Government, 2017) recommends that a continuity of carer model be rolled out in Scotland over the next 5 years, with this approach firmly placing the woman and family at the centre of care.

**Conclusion**

This paper summarises the differences between PTSD-PC and PND, which is key knowledge a midwife should have to correctly identify and screen women for appropriate diagnosis, referral, and treatment of these conditions. Having these understandings will inevitably improve morbidity and mortality outcomes for childbearing women with PTSD-PC and/or PND. In summary, as the woman’s primary carer throughout her childbearing experience, it is the midwife’s responsibility to develop knowledge and skills to appropriately assess PMHP.

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**Figure 1**: Example of a referral pathway designed to aid the midwives decision-making

Woman appears to be displaying altered mood and behaviours which you don’t consider to be ‘normal’ adaptive behaviours of a new mother

Avoids talking about her childbirth experience and/or reports flashback, disturbing memories of the experience

Displaying symptoms similar to those in figure 1 relating to PND

Noes

Yeses

Continue to provide routine postnatal care and observe mood

Offer City BiTSto complete

Yeses

Noes

Exclude from diagnostic PTSD-PC, continue to provide routine postnatal care, and observe mood

Symptoms have been present for 2 weeks or more

Noes

Answers positive to question 31

Symptoms continue to be present for 2 weeks or more

Yeses

Yeses

Offer EPDS to complete

Immediate referral to Mental Health Professional

Noes

Answered positive to question 10 on EPDS

Yeses

Scored 6+ points in subsections 1, 2, 3, & 4 as in table 1.

Yeses

Noes

Displaying symptoms similar to those in figure 1 relating to PND

Continue to provide routine postnatal care and observe mood

Scored 10+ points on EPDS

Noes

Noes

Yeses

Yeses

Referral for PNDdiagnosis and treatment

Referral for PTSD-PC diagnosis and treatment

Referral for PND/PTSD-PC dual diagnosis and treatment

**Table1**: Signs and symptoms of PTSD-PC and PND as defined by the DSM-V

|  |  |
| --- | --- |
| **Signs and symptoms of PTSD-PC** | **Signs and symptoms of PND** |
| * Experienced an event perceived as traumatic by the woman * Experienced an actual, or perceived threat to her own or her baby’s life * Experiences uncontrollable, vivid flashbacks and memories of the event * Experiences nightmares of the event * Avoids any triggers associated with the event such as;   + People   + Places   + Activities   + Objects   + Situations * Avoids thinking or talking about the event or how they feel about what happened * Displays distorted or negative feelings about herself or others such as;   + No-one is to be trusted   + I am a bad mother * Displays ongoing and constant fear, horror or anger * Displays ongoing and constant guilt and shame surrounding, and anything associated with her experience * Becoming detached or estranged from people and activities previously enjoyed * Appears irritable, with angry outbursts * Behaves recklessly and self-destructively * Appears hyper-vigilant, constantly ‘on guard’ or easily startled * Has trouble concentrating and/or sleeping | * Feeling sad or in a depressed mood; tearfulness, hopelessness or a feeling of emptiness * Appears to have a loss of interest or taking no pleasure in previously enjoyed activities * Changes to appetite and weight; without diet change * Trouble sleeping or excessive sleeping * Increased fatigue and loss of energy * Appears restless in activities for example; hand wringing, pacing * Changes in actions such as; slow or sluggish walking and/or talking * Expresses feelings of worthlessness and/or guilt * Difficulty concentrating, thinking or decision making * Expresses or has thoughts of suicide, death related to herself or the baby. When related to the infant, these thoughts tend to be fearful rather than with intent to harm |

|  |
| --- |
| **Table 2**: Standardised 8-phase EMDR program (Shapiro, 1995)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Taking the client’s history and an assessment. 2. EMDR preparation - enhancing, stabilizing & strengthening personal resources, e.g., self-compassion. 3. Assessment of targeted memory to identify associated images, negative cognitions, preferred positive cognitions, emotions & associated body sensations. 4. Desensitisation of the distressing memory. 5. Installation of positive cognition. 6. Body scan. 7. Session closure. 8. Re-evaluation. |