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PROGNOSTICALLY ORIENTED MODEL OF A THERAPEUTIC AND PREVENTIVE COMPLEX FOR PREGNANT WOMEN WITH POST-TRAUMATIC STRESS DISORDER

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Post-traumatic stress disorder (PTSD) in the perinatal period is now considered not only as a psychiatric diagnosis, but as a multisystem condition that affects the course of pregnancy and the condition of the fetus. ***The aim*** *is to assess the effectiveness of the treatment and prevention complex (TPC) for the prevention of perinatal disorders in women with PTSD.* ***Materials and methods.*** *60 pregnant women with PTSD with moderate and high risk of perinatal complications were examined, who were randomly divided into 2 groups. The main group consisted of 30 women whose pregnancy was managed using the recommended LPK, the comparison group - 30 women with standart pregnancy management according to the recommendations of the Ministry of Health of Ukraine.* ***Results of the study.*** *As a result of the use of the recommended LPK, it was possible to improve the psycho-emotional state of the patients of the main group: a decrease in symptoms and severity of PTSD on the CAPS-5 scale by 19.4±5.2 points was noted (pronounced clinical effect), while in the comparison group the average decrease in the indicator was 8.7±4.1 points ($p<0.001$), i.e. no significant improvement was achieved in most women. The level of somatic manifestations significantly decreased: the proportion of patients in the main group with minimal manifestations increased 6 times (from 3.3% to 20.0%, $p<0.05$). Normalization of sleep, a decrease in the severity of anxiety and depression, vegetative and neuroendocrine regulation were also observed. It was possible to achieve a significant reduction in the frequency of perinatal complications, in particular placental insufficiency (23.3% in the main group versus 53.3% in the comparison group, $p<0.05$), and as a result, the frequency of developmental delay and fetal distress decreased 3 times.* ***Conclusions.*** *The proposed complex is effective, clinically reproducible and practically applicable in healthcare institutions of various levels and can be adapted to the realities of wartime without violating the principles of evidence-based medicine.*

Keywords: *pregnancy, post-traumatic stress disorder, perinatal disorders, treatment, prevention*

Post-traumatic stress disorder (PTSD) in the perinatal period is now considered not only as a psychiatric diagnosis, but as a multisystem condition that affects behavioral patterns, neuroendocrine and immune-inflammatory regulation, adherence to antenatal care, and ultimately the course of pregnancy and fetal health. Current reviews emphasize that effective strategies should combine early detection, safe psychosocial interventions, and integration of care into routine obstetric care protocols [1]. The urgency of the problem is reinforced by data on the high prevalence of PTSD symptoms during pregnancy in different populations: according to a recent systematic review with meta-analysis in low-/middle-income countries, about 1 in 10 pregnant women has PTSD symptoms, and clinically diagnosed PTSD occurs in about 1 in 20 [2]. In addition, statistical data indicate that the frequency of PTSD diagnosis during pregnancy is increasing, which is of concern and creates an additional burden on health care systems [3]. This indicates the need to build a predictive-oriented model: from screening and risk stratification to individualized prevention of complications. An important argument in favor of such a model is the evidence base on the relationship of PTSD with adverse perinatal outcomes. In particular, a meta-analysis showed an association of prenatal PTSD

with an increased risk of preterm birth and low birth weight, as well as with a decrease in gestational age [4]. A more recent systematic review and meta-analysis (2025) further summarizes data on the spectrum of obstetric and neonatal outcomes and emphasizes the likely bidirectionality of the relationships (PTSD - complications), which methodologically justifies the need for prediction and prevention as a single contour [5]. This approach corresponds to the concept of personalized medicine and allows for the optimization of obstetric tactics taking into account the individual adaptive reserves of the woman.

In the context of today's Ukraine (taking into account the stressors of wartime), works that describe specific obstetric "targets" potentially related to stress-associated mechanisms are of particular importance: for example, placental dysfunction in pregnant women with PTSD has been reported [6]. There are publications devoted to the relationship between PTSD and habitual miscarriage and the formation of a "closed cycle" of psycho-trauma and reproductive losses, which strengthens the feasibility of preventive programs [7,8].

Therefore, a prognostic-oriented model of medical and preventive care for pregnant women with PTSD should be based on three interrelated principles: 1) early detection and quantitative stratification of the risk of perinatal complications, 2) integrated management by a multidisciplinary team (obstetrician-gynecologist, psychiatrist or psychologist as needed) with safe evidence-based interventions, 3) monitoring of intermediate risk markers and correction of the prevention plan in dynamics [1–8]. It is this concept that allows us to move from the statement of the fact of PTSD to the guided prevention of obstetric and neonatal disorders.

The purpose of the study is to assess the effectiveness of a medical and preventive complex for the prevention of perinatal disorders in women with PTSD.

MATERIALS AND METHODS OF THE RESEARCH

The treatment and prevention complex (TPC) for the prevention of perinatal disorders in women with PTSD is built as a multi-level system integrated into standard pregnancy management (Fig. 1).

Level	Goal	Components (tools)
I. Diagnostic and prognostic (basic)	early identification of women at high risk of perinatal complications.	• psychometric screening of PTSD (severity, phenotype); • assessment of psychosocial and medical-behavioral factors; • analysis of autonomic regulation; • hormonal indices and their correlations; • integral prognostic risk index.
II. Psychocorrectional and adaptive level (key)	reduction of stress-induced neuroendocrine and autonomic dysfunction	• brief structured psychotherapeutic interventions (without overload); • stabilization of sleep and circadian rhythms; • techniques of bodily self-regulation (respiratory, sensorimotor); • formation of a sense of control and security (especially relevant in war conditions).
III. Medical and preventive level (obstetric-somatic)	reduction of somatic and obstetric triggers of complications	• personalized pregnancy management taking into account PTSD; • control of factors that enhance the stress response (pain, infections, anemia); • correction of somatic comorbidity; • enhanced fetal monitoring in high-risk groups.
IV. Behavioral and social level (supportive)	stabilization of outcomes and prevention of exacerbations of PTSD	• work with medical and behavioral risk factors; • social support and training in adaptive strategies; • preparation for childbirth taking into account the psychological profile of the woman; • continuity of care from the preconception to the perinatal and postpartum periods.

Figure 1 Levels of treatment and prevention complex for pregnant women with PTSD

The diagnostic and prognostic level of the treatment and prevention complex creates a scientifically sound basis for personalized management of pregnant women with PTSD, stratified by risk level.

The psycho-correctional and adaptive level is a key component of the treatment and prevention complex for pregnant women with PTSD, since it is psycho-traumatic stress that is the central link in

the pathogenesis of neuroendocrine, autonomic and behavioral disorders, which, in turn, are associated with an increased risk of perinatal complications. The following methods are used: CBT - cognitive behavioral therapy; TF-CBT - trauma-focused cognitive behavioral therapy; CBT-I - cognitive behavioral therapy for insomnia; IRT - image rehearsal therapy, a method of treating nightmares; EMDR – Eye Movement Desensitization and Reprocessing

Correction of autonomic dysfunction in pregnant women with post-traumatic stress disorder should be carried out mainly by non-drug methods with a proven ability to increase vagal activity and normalize heart rate variability indicators, while drug support is used exclusively as an auxiliary component, taking into account the principles of perinatal safety.

If necessary, antidepressants are prescribed, only by a multidisciplinary team.

The medical and prophylactic (obstetric and somatic) level of the treatment and prevention complex is aimed at directly reducing the frequency and severity of perinatal complications through personalized pregnancy management, taking into account PTSD as a systemic risk factor. Special attention is paid to the individualization of the pregnancy and childbirth management plan, reducing pain and stress, as well as continuity of medical supervision.

Supportive drug correction of hormonal disorders in pregnant women with posttraumatic stress disorder should be based on the principles of obstetric safety and should not be aimed at treating PTSD, but at stabilizing the neuroendocrine and hormonal environment of pregnancy in order to prevent placental dysfunction and perinatal complications. Magnesium, melatonin, vitamin D3, Omega-3 preparations are used according to indications.

The behavioral and social level of the LPC is supportive in nature and is aimed at consolidating the achieved effects of previous levels, as well as preventing the recurrence of psycho-emotional maladaptation during pregnancy and the postpartum period.

To test the effectiveness of the proposed LPK, 60 pregnant women with PTSD with moderate and high risk of perinatal complications were selected, who were randomly divided into the main group - 30 women, whose pregnancy was managed using the LPK recommended by us, and the comparison group - 30 women with standard pregnancy management according to the recommendations of the Ministry of Health of Ukraine. The groups were comparable in age, history, medical and social factors, severity of PTSD, comorbidity and somatization.

The criteria for assessing effectiveness were: severity of PTSD (Clinician-Administered PTSD Scale CAPS-5), manifestations of insomnia (Insomnia Severity Index ISI), presence and severity of anxiety and depression (Hospital Anxiety and Depression Scale HADS), level of somatization (Patient Health Questionnaire-15 PHQ-15), state of autonomic regulation (Kerdo index, heart rate variability indicators), state of neuroendocrine regulation (ratio of indicators Noradrenaline/Dopamine, Cortisol/DHEA-S, Progesterone/Testosterone), frequency of perinatal disorders.

The study was conducted in compliance with the principles of bioethics, Ukrainian legislation and requirements for conducting clinical and biomedical research. The study was approved by the Commission on Ethics and Academic Integrity of the Shupyk National Healthcare University of Ukraine. The study of patients was conducted after obtaining informed consent.

Statistical processing of results for comparison of indicators between groups was carried out using parametric statistics methods using the standard software package Microsoft Office Excel 2010 and the statistical complex STATISTICA 6.0. For intergroup comparison of quantitative values, Welch's t-test was used, which does not require the assumption of equality of variances and is correct for unequal sample sizes. To analyze differences between qualitative indicators in independent groups, Pearson's χ^2 criterion (chi-square test) was used, for dependent (in the dynamics of treatment) - McNemar's criterion. Results were considered statistically significant at $p<0.05$.

RESULTS OF THE STUDY AND THEIR DISCUSSION

As a result of the use of the recommended LPK, it was possible to improve the psycho-emotional state of the patients of the main group, as indicated by the reduction of symptoms and severity of PTSD on the CAPS-5 scale in the dynamics of treatment, on average, a decrease in the score was noted by 19.4±5.2 points, which indicates a pronounced clinical effect, while in the comparison group the average decrease in the indicator was 8.7±4.1 points ($p<0.001$), i.e. no significant improvement was achieved in most women. As a result, it can be noted that in 9 (30.0%) patients with severe PTSD before treatment, in the dynamics of treatment the assessment began to correspond to a moderate level of PTSD, in the comparison group there were only 3 (10.0%). In 4 (13.0%) patients of the main group with mild PTSD, subclinical manifestations were achieved, while in the comparison group such improvement of symptoms was observed only in 1 (0.3%) woman. Fig. 2 shows changes in the distribution of pregnant women with PTSD in the dynamics of treatment (assessment was carried out every 4-6 weeks,

the figure shows the results of assessment at 16-20 and 34-36 weeks of pregnancy). In the main group, the proportion of patients with severe PTSD decreased 4 times (40.0% vs. 10.0% before treatment, p<0.01), in the comparison group, despite some improvement, no significant change in the distribution in the dynamics of treatment was observed.

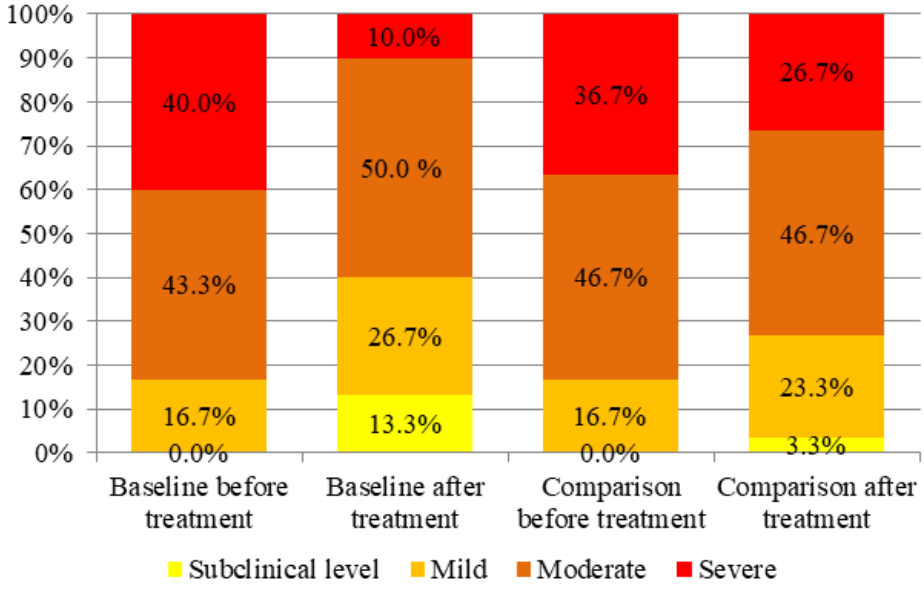

Figure 2 Distribution of pregnant women in subgroups by severity of PTSD according to the CAPS-5 scale in the dynamics of treatment, %

Pregnant women with PTSD are characterized by a high level of somatization, which was observed in women of both groups before treatment. As a result of the treatment, the level of somatic manifestations in patients of the main group significantly decreased: the proportion of patients with minimal manifestations increased 6 times (from 3.3% to 20.0%, p<0.05), and the percentage of women with a high level decreased 2 times (from 46.7% to 23.3%). Women in the comparison group had only a slight improvement in somatoform disorders.

PTSD is often associated with sleep disorders (Table 1). Before treatment, a normal sleep assessment (absence of insomnia) was observed in only 1 (3.3%) woman in each group. In the main group, the use of hygiene, specialized psychotherapeutic techniques and melatonin in some cases allowed to completely normalize sleep in 3 (10.0%) women, the proportion of patients with subclinical insomnia increased from 16.7% to 46.7% (p<0.05), and the percentage of patients with severe insomnia decreased almost 5 times (from 36.7% to 6.7%, p<0.05). In the comparison group, only a tendency to improve sleep disorders was noted, the distributions by categories of insomnia before and after treatment did not differ significantly.

Table 1. Distribution of pregnant women by categories of ISI results (level of insomnia) in the dynamics of treatment, abs.ch. (%).

ISI Category	Main Group		Comparison Group	
	Before Treatment	After Treatment	Before Treatment	After Treatment
Norm	1 (3.3 %)	4 (13.3 %)	1 (3.3 %)	2 (6.7 %)
Subclinical insomnia	5 (16.7 %)	14 (46.7 %)*	7 (23.3 %)	10 (33.3 %)
Moderate insomnia	13 (43.3 %)	10 (33.3 %)	12 (40.0 %)	7 (23.3 %)
Severe insomnia	11 (36.7 %)	2 (6.7 %)*	10 (33.3 %)	8 (26.7 %)

Note. * - the difference is significant compared to the indicator before treatment (p<0.05)

It is known that PTSD has a high comorbidity with anxiety and depression, which are also quite often observed in pregnancy with perinatal disorders. When surveyed using the HADS scale before treatment (I trimester of pregnancy), about 70.5% of women in both groups had clinically pronounced anxiety, and about 60.0% had clinically pronounced depression (Table 2). In the dynamics of the treatment with the

use of psychotherapeutic methods, and in the most severe cases - the use of antidepressants prescribed by a psychiatrist, the proportion of women with both clinically pronounced anxiety (from 73.3% to 36.7%, $p<0.05$) and clinically pronounced depression (from 60.0% to 33.3%, $p<0.05$) decreased by 2 times. In contrast, in the comparison group, with some improvement in the psycho-emotional state in several women, no statistically significant changes were observed in the distributions of anxiety and depression severity according to the HADS scale.

Table 2. Distribution of pregnant women by anxiety and depression subscales of the HADS scale in the dynamics of treatment, abs.ch. (%)

Category	Main Group		Comparison Group	
	Before Treatment	After Treatment	Before Treatment	After Treatment
Anxiety				
Norm	2 (6.7 %)	7 (23.3 %)	3 (10.0 %)	4 (13.3 %)
Subclinical	6 (20.0 %)	12 (40.0 %)	7 (23.3 %)	10 (33.3 %)
Clinical	22 (73.3 %)	11 (36.7 %)*	20 (66.7 %)	16 (53.3 %)
Depression				
Norm	4 (13.3 %)	7 (23.3 %)	3 (10.0 %)	5 (16.7 %)
Subclinical	8 (26.7 %)	13 (43.3 %)	8 (26.7 %)	10 (33.3 %)
Clinical	18 (60.0 %)	10 (33.3 %)*	19 (63.3 %)	15 (50.0 %)

Note. * - the difference is significant compared to the indicator before treatment ($p<0.05$)

According to the obtained data, PTSD during pregnancy is accompanied by significant disorders of autonomic regulation. Sympathicotonia detected by the calculation of the Kerdo index before treatment in 76.7% of pregnant women in the main group, after treatment was noted only in 46.7% of women ($p<0.05$), while in the comparison group a significant decrease in the frequency of sympathicotonia in the dynamics of treatment was not observed.

The decrease in the imbalance of autonomic regulation as a result of the recommended treatment is also indicated by the dynamics of HRV indicators. In particular, in the main group there is an increase in the total variability (SDNN) from 24.7 ± 6.3 ms to 36.2 ± 7.5 ms ($p<0.05$). A decrease in the index of vagosympathetic interaction LF / HF reflects a relative decrease in sympathetic activation.

Analysis of the distribution in groups by the SI stress index demonstrates the positive effect of the recommended treatment on reducing the level of stress and stressogenic load: in the main group, the proportion of women with high or very high levels of stress decreased by more than 3 times, and the normal level of stress, which was recorded before treatment in only every fifth woman (20.0%), was observed in half of the women after treatment (53.3%, $p<0.05$). The recommended LPC also had a positive effect on neuroendocrine regulation in patients in the main group, as indicated by the improvement in the ratios of hormonal indicators (Table 3). If in the first trimester before treatment the ratios of Noradrenaline/Dopamine and Cortisol/DHEA-S of both groups did not differ from each other and indicated the dominance of sympathoadrenal activation and hyperactivation of the GGNV against the background of chronic stress (compared to the indicators of the control group), then as a result of the use of the recommended LPC, neuroendocrine tension decreased and the indicators approached the values of the control group.

The reduced ratio of progesterone/testosterone before treatment reflects relative androgenization and a shift of the hormonal balance towards a stress-reactive, anti-adaptive profile, after the treatment, normalization of the indicator was noted.

All hormonal indicators of the comparison group changed in the dynamics of pregnancy similarly to other groups, however, in the 3rd trimester, the changes in the ratio of Noradrenaline/Dopamine and Cortisol/DHEA-S remained significantly increased relative to the control group, and the ratio of progesterone/testosterone was reduced, and all values of the ratios were statistically significantly different from the corresponding indicators of the main group.

The main goal of implementing the recommended LPC was to reduce the frequency of perinatal complications in pregnant women with PTSD. As can be seen from the data in Table 4, this goal was achieved.

Таблиця 3. Співвідношення гормональних показників в динаміці лікування, абс.ч. (%)

Indicator	Main Group		Comparison Group		Control Group	
	Before Treatment	Before Treatment	Before Treatment	Before Treatment	I trimester	III trimester
Noradrenaline/ Dopamine	21.2 ± 5.3#	23.2 ± 6.8*	23.1 ± 4.0#	33.1 ± 6.5#	10.2 ± 3.4	13.5 ± 4.4
Cortisol/ DHEA-S	127.6 ± 21.7#	251.2 ± 29.3*	133.6 ± 25.8#	302.5 ± 31.3#	75.0 ± 28.1	228.6 ± 65.3
Progesterone/ Testosterone	17.2 ± 6.1#	83.7 ± 9.4*	19.0 ± 4.9#	63.6 ± 8.2#	38.4 ± 7.2	95.2 ± 18.2

Note: * - the difference is significant compared to the indicator of the comparison group ($p<0.05$);

- the difference is significant compared to the indicator of the control group ($p<0.05$)

Table 4. Complications of pregnancy, childbirth and the condition of newborns in patients with PTSD

Indicator	Main Group		Comparison Group		χ^2	p
	abs.n.	%	abs.n.	%		
Placental insufficiency	7	23.3*	16	53.3	5.71	0.0169
PRF	3	10.0*	10	33.3	4.81	0.0283
Fetal distress	4	13.3*	10	33.3	5.71	0.0169
Preeclampsia	2	6.7*	7	23.3	4.81	0.0283
Threatened preterm labor	4	13.3	10	33.3	3.35	0.0670
Caesarean section	5	16.7	12	40.0	3.27	0.0706
Preterm labor	5	16.7	11	36.7	3.35	0.0670
Birth asphyxia	3	10.0*	10	33.3	4.02	0.0449
Birth weight < 2500 g	2	6.7*	9	30.0	4.81	0.0283
Early neonatal adaptation disorder	3	10.0*	10	33.3	4.02	0.0449

Note. * - significant difference in the indicator relative to the comparison group (χ^2 and p-value)

The incidence of placental insufficiency, which is the cause of most significant perinatal disorders, decreased by 2 times (23.3% in the main group versus 53.3% in the comparison group, $p<0.05$), and as a result, the frequency of pathological conditions of the fetus decreased by 3 times: developmental delay and distress. The frequency of such a dangerous complication for both the mother and the fetus as preeclampsia decreased by more than 3 times (6.7% versus 23.3%, respectively, $p<0.05$). There was a tendency to reduce operative delivery and premature birth. The frequency of asphyxia and low birth weight of the child decreased by more than 3 times, as well as the frequency of various disorders of early neonatal adaptation.

CONCLUSIONS

Post-traumatic stress disorder in pregnant women is a systemic condition that goes beyond the limits of an exclusively mental disorder and is accompanied by persistent disorders of neuroendocrine, autonomic and psychoemotional regulation, which directly affect the course of pregnancy and the formation of perinatal complications. This justifies the need for a comprehensive treatment and prevention approach, not isolated interventions.

The developed treatment and prevention complex has a multi-level structure, which includes diagnostic and prognostic, psycho-correctional and adaptive, medical and preventive and behavioral and social levels, and ensures continuity between risk assessment, choice of management tactics and

prevention of adverse perinatal consequences.

The use of risk stratification (low / moderate / high) allows individualizing the volume and intensity of therapeutic and preventive measures, avoiding both hyperinterventions and insufficient care, and increases the clinical feasibility of the complex in conditions of limited resources of the health care system.

The proposed complex is clinically reproducible and practically applicable in health care institutions of various levels and can be adapted to the realities of wartime without violating the principles of evidence-based medicine.

The assessment of the effectiveness of the proposed therapeutic and preventive complex for pregnant women with PTSD demonstrated its ability to improve the psycho-emotional state of the woman, reduce the severity of PTSD, reduce the manifestations of insomnia, anxiety and depression, somatomorphic dysfunction, balance autonomic and neuroendocrine regulation, and as the main result of achieving the main goal of the study - reducing the frequency of the most severe perinatal disorders by up to 3 times.

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РЕЗЮМЕ

ПРОГНОСТИЧНО-ОРІЄНТОВАНА МОДЕЛЬ ЛІКУВАЛЬНО-ПРОФІЛАКТИЧНОГО КОМПЛЕКСУ ДЛЯ ВАГІТНИХ ІЗ ПОСТТРАВМАТИЧНИМ СТРЕСОВИМ РОЗЛАДОМ

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Посттравматичний стресовий розлад (ПТСР) у перинатальному періоді сьогодні розглядають не лише як психіатричний діагноз, а як мультисистемний стан, що впливає на перебіг вагітності та стан плода.

***Мета** – оцінка ефективності лікувально-профілактичного комплексу (ЛПК) для попередження перинатальних розладів у жінок з ПТСР.*

***Матеріали та методи.** Обстежено 60 вагітних з ПТСР з помірним та високим ризиком перинатальних ускладнень, яких випадковим чином розділили на 2 групи. Основну групу склали 30 жінок, ведення вагітності яких проводилось із застосуванням рекомендованого ЛПК, групу порівняння – 30 жінок з стандартним веденням вагітності згідно рекомендацій МОЗ України.*

***Результати дослідження.** В результаті застосування рекомендованого ЛПК вдалось покращити психоемоційний стан пацієнток основної групи: відмічено зниження симптомів та вираженості ПТСР за шкалою CAPS-5 на 19,4±5,2 балу (виражений клінічний ефект), тоді як у групі порівняння середнє зниження показника склало 8,7±4,1 балу ($p<0,001$), тобто не було досягнуто суттєвого покращення у більшості жінок. Суттєво знизився рівень соматичних проявів: частка пацієнток основної групи з мінімальними проявами збільшилась у 6 разів (з 3,3 % до 20,0 %, $p<0,05$). Спостерігалась також нормалізація сну, зниження вираженості тривоги та депресії, вегетативної та нейроендокринної регуляції. Вдалося досягти достовірного зниження частоти перинатальних ускладнень, зокрема плацентарної недостатності (23,3 % в основній групі проти 53,3 % у групі порівняння, $p<0,05$), і як наслідок у 3 рази знизилась частота затримки розвитку та дистресу плода.*

***Висновки.** Запропонований комплекс є ефективним, клінічно відтворюваним і практично застосовним у закладах охорони здоров'я різного рівня та може бути адаптований до реалій воєнного часу без порушення принципів доказової медицини.*

***Ключові слова:** вагітність, посттравматичний стресовий розлад, перинатальні порушення, лікування, профілактика*

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