Intervention for Mothers Who Have Experienced Childbirth-Related Trauma and Posttraumatic Stress Disorder

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Lactation consultants may be one of the first healthcare providers who see mothers following a difficult birth. As such, they can be key sources of support and information for mothers at this critical time. Several aspects of the International Board Certified Lactation Consultant's (IBCLC) scope of practice can fit within trauma-informed care, including helping mothers identify possible trauma symptoms and posttraumatic stress disorder (PTSD), and addressing breastfeeding issues that may be sequelae of a traumatic birth. IBCLCs can inform mothers about their treatment options and refer them to additional sources of support. This article describes breastfeeding issues that might arise in the wake of a traumatic birth and summarizes evidence-based treatment options for PTSD so that IBCLCs can share this information with mothers.

Keywords: trauma, PTSD, treatment, CAM, breastfeeding, birth

As described in the previous article in this issue (Kendall-Tackett, 2014), traumatic births are common in the U.S. and can lead to many serious consequences for mothers and babies (Beck, Gable, Sakala, & Declercq, 2011). Fortunately, there are many things that lactation consultants can do to help mothers heal in the wake of a traumatic birth. In this article, I describe some specific ways that International Board Certified Lactation Consultants (IBCLCs) can provide trauma-informed care to new mothers with breastfeeding issues and provides a brief overview of trauma treatments. By intervening, lactation consultants can make a substantial difference in the lives of these mothers and potentially save them from years of suffering.

Trauma-Informed Care: What Lactation Consultants Can Do

Several aspects of the IBCLC scope of practice are consistent with providing trauma-informed lactation support: helping mothers develop a feeding plan in the wake of a traumatic birth, providing evidence-based information on treatment options, integrating psychosocial aspects of breastfeeding, and using their counseling skills in working with clients. In addition, IBCLCs should make referrals to other specialists and sources of community support and continue to collaborate with members of the mother's healthcare team (International Board of Lactation Consultant Examiners, 2013).

Recognize Trauma Symptoms and Provide Basic Patient Education

A first step in trauma-informed lactation care is recognizing the signs of psychological trauma. Simply listening to a mother's story can, by itself, be healing. If you believe a mother has posttraumatic stress disorder (PTSD), trauma symptoms, or other sequelae of trauma, such as depression or anxiety (as described in Kendall-Tackett, 2014), you can help her recognize symptoms and make referrals to specialists. You can also provide information about resources that are available, including self-help and online resources (see listing in the following text). Trauma survivors often believe that they are going "crazy." Letting mothers know that posttraumatic symptoms are both predictable and treatable can reassure them. The following are some basic components of patient education about trauma that can be quite helpful for mothers who have experienced traumatic births. Friedman (2001) described the key components of trauma-related patient education, which are summarized in the following text.

Normalization

Normalization lets mothers know that their symptoms are similar to those experienced by others who have been through traumatic events, which can be a relief. Mothers learn that their symptoms are not a result of their "weakness."

Removing Self-Blame and Self-Doubt

Mothers may blame themselves for their traumatic births and be ashamed that they did not take some kind of heroic steps to stop the trauma from happening to them. Education can help patients realize that they did the best

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they could under the circumstances (such as dealing with an overwhelming hospital environment) and with the information that was available at the time. Education can also help mothers realize that their "failure" to act was because of the overwhelming nature of the event itself. This can also be true for partners.

Correcting Misunderstandings With Family Members

It can also be helpful to educate the mother's family about PTSD. This can help explain the mother's behavior, such as wanting to avoid the doctor or hospital, which may seem strange to her family or friends. Education can help those in a mother's support network to work with rather than against her.

Address Breastfeeding Issues

As described in the previous article (Kendall-Tackett, 2014), breastfeeding can be an important part of the process of healing from birth trauma. But there can be barriers to breastfeeding caused by the trauma. It is helpful if IBCLCs can anticipate and address possible breastfeeding problems mothers might encounter following a traumatic birth. Severe stress during labor can delay lactogenesis II by as much as several days (Grajeda & Perez-Escamilla, 2002). Mothers who have experienced traumatic births need close follow-up until lactogenesis II has occurred. If you are alert for this possible complication, you may help a mother avoid the situation where lactogenesis is delayed, the mother doesn't realize anything is wrong, and the baby ends up back in the hospital because of jaundice or dehydration. A rehospitalized baby could compound the trauma that the mother has already experienced.

Mothers may need to add feedings and/or pumpings to counter the effects of their stressful births. When working with these mothers, we need to express confidence that they can overcome this difficulty and help them develop a plan that will do that. In some cases, mothers may need to briefly supplement with formula or donated milk. But that will not be necessary in all cases and is not the first thing to try. If it is necessary to supplement (e.g., when a baby has become severely dehydrated and mother has a low supply), this option should be presented as a short-term strategy to help breastfeeding get back on track.

Skin-to-skin contact can be helpful in helping mothers overcome birth trauma, but for some mothers, it can be overwhelming. Be alert to subtle signs that a mother is feeling overwhelmed. She may recoil when the baby is placed on top of her, or she may dissociate or "check out." It may not be necessary for her to even have direct skin-to-skin. Colson (2010) has found that many of the same benefits of skin-to-skin contact can occur if the mother is lightly dressed. For women who have experienced traumatic births, being clothed may be more comfortable and can lead to the same positive effects.

If the mother is experiencing any pain while breastfeeding, it must be addressed promptly, because pain can trigger traumatic-stress reactions. If she is experiencing bodily pain following her birth, teaching her some self-care for pain can be quite helpful. She may also need to see her healthcare provider for pain medication.

Finally, lactation consultants must recognize that some mothers may be too overwhelmed by the trauma of their births to initiate or continue breastfeeding. Sometimes, with gentle encouragement and lots of support, mothers may be able to overcome difficulties with breastfeeding following a traumatic birth. But if they can't, we must respect their wishes. Even if a mother decides not to breastfeed, we must gently encourage her to connect with her baby in other ways, such as skin to-skin contact (with limits described earlier), co-bathing, baby wearing, or infant massage. This is essential for mothers as well as their babies. Previous studies found that many mothers did not bond with their babies following a traumatic birth or eventually bonded—*one to five years later* (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010)—a tragic outcome, to be sure. Bringing mother and baby together will do much to help mothers recover from their difficult beginnings—even if they do not breastfeed.

Evidence-Based Treatments for Posttraumatic Stress Disorder

There are a number of treatments for trauma that are quite effective in reducing symptoms and helping trauma survivors move on with their lives. These approaches have been extensively studied, and we now have solid evidence about which treatments work and which don't. As described earlier, IBCLCs can provide mothers with information and refer her to resources. That being said, it's helpful to know what treatment options are available.

The frontline treatment for PTSD continues to be psychotherapy (Friedman, Cohen, Foa, & Keane, 2009). In addition, there are a growing number of complementary and alternative medicine (CAM) treatments that are also effective. The following text is a brief description of some of the most commonly used approaches.

Psychotherapy

When people experience traumatic events, they develop a conditioned response. This response pairs the traumatic event with certain cues. These can be sights, sounds,

smells, or physical sensations (including pain). Following trauma, trauma survivors may believe that they are helpless and vulnerable, and people in the world are out to harm them. Psychotherapy for PTSD has two specific goals. The first is to unlearn the conditioned response to cues that trigger PTSD symptoms. The second is to address cognitions about themselves and others that accompany PTSD (Kendall-Tackett, 2013).

There are many types of psychotherapy available, and most of these require specialized training. Two of the most effective individual treatments are cognitive behavioral therapy and eye movement desensitization and reprocessing.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is designed to counter the conditioned fear responses that follow trauma and to help clients identify and address the dysfunctional beliefs, thoughts, behaviors, and feelings that accompany PTSD (Friedman et al., 2009). These thoughts cause stress and make trauma symptoms worse. CBT helps to replace these thoughts with more accurate and less distressing ones. It's common after experiencing a traumatic event for people to blame themselves for things they could not have changed. CBT helps people realize that the events they have experienced are not their fault (National Center for PTSD, 2014).

CBT is the most studied intervention for PTSD, and all clinical guidelines recognize its effectiveness as a treatment modality (Friedman et al., 2009). Most state psychological associations can provide a listing of psychologists in your community who practice with CBT and who specialize in trauma.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is another treatment that has proven highly effective for many clients with PTSD, and most (but not all) clinical practice guidelines consider it an evidence-based treatment for PTSD (Friedman et al., 2009). EMDR is based on the hypothesis that saccadic eye movements can reprogram the brain and can be used to downregulate hyperarousal and other trauma symptoms, thereby helping to alleviate the emotional impact of trauma. (Saccadic eye movements are those quick eye movements that jump from one fixation point to another.)

During EMDR, clients will think or talk about their memories while focusing on other stimuli, such as eye movements, hand taps, or sounds. For example, a therapist may move her hand in front of a client's face and the client will follow this movement with her eyes. Researchers still do not understand fully how EMDR works, but studies have consistently shown that it reduces PTSD symptoms (National Center for PTSD, 2014). Treatment with EMDR tends to be short-term. For more information about EMDR, or to find a practitioner in your community, go to the EMDR Institute, Inc., website (http://emdr.com/).

Complementary and Alternative Medicine Treatments

Use of CAM techniques to treat PTSD is relatively new in the field and is a direct result of consumer demand. Even the U.S. Veterans Administration, which has been traditional in its approach to trauma treatment, has recognized the demand for these modalities and is beginning to incorporate them into treatment for PTSD (Williams, Gierisch, McDuffie, Strauss, & Nagi, 2011). Many of the mothers we work with may be interested in a more holistic or CAM approach. The following text is a brief summary of some of these recent findings on these techniques. Although research on these approaches is preliminary, they show a great deal of promise.

Acupuncture

Acupuncture is based on traditional Chinese medicine and involves inserting very thin needles into certain points along meridian points to stimulate the flow of life energy, or *chi* (Kim et al., 2013). Recent studies have found it effective in lessening PTSD symptoms. For example, in a randomized trial of 138 Chinese participants following the Wenchuan earthquake, researchers compared the effectiveness of electroacupuncture to paroxetine (Wang, Hu, Wang, Pang, & Zhang, 2012). Both groups were treated for 12 weeks. After treatment, participants in the acupuncture group had lower levels of PTSD, depression, and anxiety than those in the paroxetine group at every assessment point (6 and 12 weeks, 3 and 6 months).

Mindfulness

Mindfulness involves teaching clients to become more aware of their present experiences. It is a secular application of a technique originally derived from Buddhism, which has been integrated into trauma treatment. Mindfulness involves paying attention to everyday experiences that people might usually ignore: the taste of coffee, the sensation of walking down the stairs, the sound of rain on the roof. Practicing mindfulness has two key components:

- Being *aware* in the present moment, and
- *Accepting* thoughts and feelings without judging them

Being mindful means allowing thoughts and feelings to pass without either clinging to them or pushing them away. They just take their natural course.

Dutton, Bermudez, Matas, Majid, and Myers (2013), in a recent review, described the impact of mindfulness. Mindfulness can help trauma survivors cope with difficult emotions, such as anxiety and depression. Mindfulness can help trauma survivors develop more compassion toward themselves and others and become less critical of themselves. It results in symptom reduction and behavior change, cognitive change, self-management, relaxation, and acceptance (Dutton et al., 2013; National Center for PTSD, 2010). It also helps reduce rumination over traumatic events, which increases PTSD symptoms (Kearney, McDermott, Malte, Martinez, & Simpson, 2013). Mindfulness could be used by itself or together with standard treatments (National Center for PTSD, 2010).

Expressive Writing

Another CAM treatment for trauma and PTSD is expressive writing. Expressive writing is based on the work of James Pennebaker, who found that writing about major stressful life events for a brief period, even as little as 20 minutes per day, over several days, resulted in significant reductions in depression, anxiety, PTSD symptoms, and health problems. Expressive writing is thought to be helpful because it helps trauma survivors understand their experiences in a broader perspective and derive some meaning from them (Koopman et al., 2005).

Expressive writing has been helpful for those who have experienced combat or interpersonal violence. For example, one study included 47 women who had experienced severe intimate partner violence 5 years prior to the study. The women were randomly assigned to either an expressive or neutral writing conditions (Koopman et al., 2005). The expressive writing group was asked to write about their most stressful or traumatic life experience. The neutral writing group was instructed to write about their daily schedules. There were four writing sessions that were 20 minutes each. The effects of expressive writing were strongest for women who were depressed. Expressive writing reduced the symptoms of depression in these women.

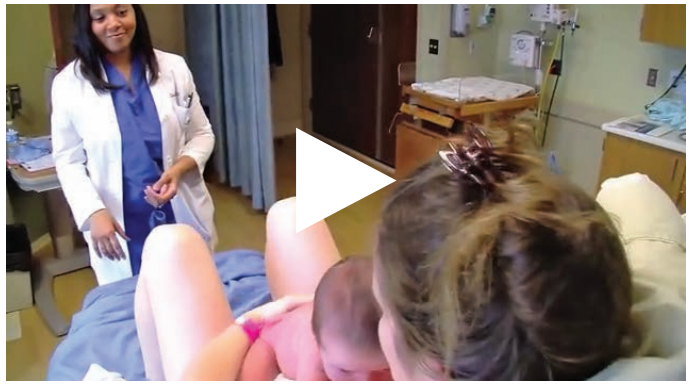
Expressive writing can be a great self-help technique for mothers who are reluctant to seek psychotherapy or take medications. To get the most out of this approach, I recommend Pennebaker's book, *Writing to Heal*. (To learn more, see http://www.apa.org/monitor/jun02/writing.aspx.)

Consider Some Activism on Behalf of Birth

After working in this field for a while, you may get tired of having to cope with the aftermath of traumatic birth and want to do something that is more proactive and preventive. If you feel this way, you should consider partnering with other groups and organizations who want to reform birth in the U.S. and abroad. Organizations, such as Childbirth Connection (http://transform.childbirthconnection.org/), are working to reform birth in the U.S. This is a great time to get involved because there are many hopeful signs. One positive change is the dramatic increase in the number of hospitals in the U.S. starting the process to become baby friendly. This will encourage better birthing practices.

Hopefully, more hospitals will implement practices recommended by the Mother-Friendly Childbirth Initiative as well (http://www.motherfriendly.org/MFCI).

A Tale of Two Births: The Baby-Friendly Rap



http://www.youtube.com/watch?v=N9KptD3t110

Organizations, such as March of Dimes, are also weighing in and using their clout to discourage high-intervention procedures, such as elective inductions, because they increase the number of late preterm babies. This movement away from induction will also be helpful for mothers, because induced labors are often difficult and lead to increased use of other interventions, including cesarean deliveries (http://www.marchofdimes.com/pregnancy/vaginalbirth_inducing.html). Hospitals with high cesarean rates are also under scrutiny. The percentage of mothers in the U.S. who have cesarean births is also quite high and hospitals are under pressure to reduce these percentages.

In summary, the rate of traumatic birth in the U.S. is simply too high (Beck et al., 2011). The good news is that change may indeed be in the wind. It's about time.

Online Resources for Posttraumatic Stress Disorder

If you would like to learn more about trauma, the U.S. National Center for PTSD has many resources including a PTSD 101 course for providers (http://www.ptsd.va.gov/professional/ptsd101/course-modules/course-modules.asp).

The NCPTSD offers a free app for patients called the *PTSD Coach* (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp) and a PTSD Coach Online (http://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm).

The website http://www.helpguide.org has many great resources including a summary of available treatments, lists of symptoms, and possible risk factors (http://helpguide.org/mental/emotional_psychological_trauma.htm).

And the American Psychological Association's Division of Trauma Psychology has a number of resources available for professionals, including the journal *Psychological Trauma*. Healthcare providers can become professional affiliate members (www.apatraumadivision.org).

Resources on Birth Trauma

- Reports from Childbirth Connection on important issues regarding birth in the U.S., http://www.scienceandsensibility.org/?p=5969&utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+science-sensibility+%28Science+%26+Sensibility%29
- Prevention and Treatment of Traumatic Childbirth (PATTCh), http://pattch.org/
- Midwifery Today, http://www.midwiferytoday.com/articles/healing_trauma.asp
- Trauma and Birth Stress, http://www.tabs.org.nz/
- Posttraumatic Stress After Childbirth, http://www.angelfire.com/moon2/jkluchar1995/
- Birth Trauma Association, http://www.birthtraumaassociation.org.uk/

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Study Claims Formula Supplementation Increases Breastfeeding Duration

Have you been approached by colleagues and/or mothers who assert that formula supplementation extends breastfeeding duration? Or worse yet, that a new study shows that your efforts to assure exclusive breastfeeding are unnecessary, extreme, or no longer valid? This is not surprising given the headlines that proclaim, "Early baby formula is not your enemy," and "Feeding babies formula and breastmilk can help mothers breastfeed longer." A small study published in the June 2013 issue of *Pediatrics* concluded that early limited formula supplementation after every breastfeed during the hospital stay improved breastfeeding duration and that "reducing the use of formula during the birth hospitalization could be detrimental for some subpopulations of healthy term newborns." Mothers randomly assigned to the experimental group were instructed to syringe-feed 10mL of formula after each breastfeeding while mothers in the control group (the exclusively breastfeeding group) were taught infant soothing techniques. The inclusion criteria for infants was >5% weight loss at <36 hours of age. There are a number of limitations and problems with this study that render the conclusion highly questionable. First and foremost is that the study enrolled infants who were not in need of intervention. Most authoritative guidelines do not consider a 5% weight loss as placing an infant in an at-risk category. The amount of formula given to these infants constituted a full feeding and could serve to increase maternal anxiety regarding their milk supply. There were also more multiparous mothers in the experimental group with multiparity being a potent predictor of exclusive breastfeeding. One also wonders why formula was chosen as a supplement rather than expressed colostrum or donor human milk. Other factors related to early weight loss were not accounted for such as diuresis of excess fluids transferred to the infant from large volumes of IV fluid given to the mother during labor. Nor was meconium stooling considered as a potential contributor to the early weight loss. Mothers were not informed that infant formula could alter the gut flora of the newborn intestine and could have adverse effects on the programming of the immune system. Also there is the fact that one of the authors is a paid consultant for four formula companies. Would this alone introduce some bias into the methodology and conclusions of this study?

Parallel to the publication of this study is the recent introduction by Abbott of a formula called "Similac for Supplementation" ("for breastfeeding moms who choose to introduce formula"). Is this merely a coincidence or a brilliant example of stealth formula marketing? The same issue of *Pediatrics* contains a commentary that critiques the study and is entitled, "Early limited formula is not ready for prime time." This appears to say it all. Rather than a six-pack of "supplementation" bottles in every bassinet, perhaps what is needed is adequate IBCLC staffing. When your colleagues wave this study at you, have your response ready to go. Give them a copy of the rebuttal in *Pediatrics*. Refer them to a blog from the Academy of Breastfeeding Medicine that alerts clinicians to drawbacks of this study, and urge caution before changing clinical practice.

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