Practice Roundtable

PTSD and Breastfeeding

Let It Flow

Misha Klein, PhD, Douglas Vanderbilt, MD, and Kathleen Kendall-Tackett, PhD, IBCLC

Each issue, we ask different professionals a set of questions about an aspect of their practice or a specific problem or disease condition they encounter. This month's topic is PTSD and Breastfeeding. Our participants are **Misha Klein, PhD, Douglas Vanderbilt, MD,** and **Kathleen Kendall-Tackett, PhD, IBCLC**. Full bios for each of the contributors can be found at the end of this article.

We celebrate Breastfeeding Week in August. In August 2013, we started the conversation about the impact of a mother's mental health on breastfeeding. In this issue, *ICAN* wants to explore the impact of birth trauma experienced by the mother as it relates to breastfeeding.

Posttraumatic stress disorder (PTSD) secondary to perinatal trauma is a new field of study. How has the recognition of postpartum PTSD affected the way you practice within your discipline? What are the insights you have gained from examining this issue?

Klein: As an anthropologist, I look at this issue through the lens of culture, and within that, the way that ideology influences what we notice, what we prioritize, and how we respond, socially rather than individually. (Full disclosure: My perspective on this topic is informed by my own traumatic birth and subsequent diagnosis with PTSD which has led me to think differently about perinatal issues, including breastfeeding.) I would urge practitioners who work with mothers and infants to worry less about technical definitions of trauma, and formal diagnoses such as PTSD, in favor of being attuned to maternal distress and alienation. The critical issues seem to be loss of control during the birth process and unanticipated and invasive procedures. Socially, the emphasis of the birth process is on the newborn. However, the successful birth of a healthy infant is not the only "outcome." Attempts to console a mother who has been physically scarred or emotionally traumatized during birth by telling her that birth is only a short moment in life or that the baby is fine and "that is the important thing," undermine a woman's sense of bodily and mental integrity, by denying both her reality and the symbolic importance that we put on birth as a rite of passage.

In a large-scale and culturally plural society such as the United States, there are many competing views of birth: what it means, how best to prepare and protect the mother and infant, what technologies are appropriate, and so on. Long-standing debates about birth as a natural process have resulted in polarized approaches. When women get caught between these approaches, most notably between the natural birth movement and the medical model, they are often left without resources for coping during and after a complicated birth requiring intervention. In the research I am developing, I hope to further explore these ideological models of birth and offer practitioners ways of bridging these approaches so that women are better prepared for the range of possibilities. In addition, I hope practitioners will be better prepared to recognize the significance of a traumatic birth for a woman's sense of self and her ability to care for her infant and minimize the trauma by humanizing the process of medical intervention and step in with helpful resources after a traumatic birth.

It is also worth mentioning that partners can also experience birth trauma. They are often sidelined during more extreme medical interventions, but not necessarily protected from seeing and knowing the danger that the mother is undergoing. They may in fact be more aware of the dangers faced by the mother than she is herself (as she may be unconscious or in an altered state). Partners are further sidelined by the intensity of the maternal–infant dyad that is typically the focus of subsequent medical follow-up. Two traumatized

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adults in a household only deepens the rupture caused by a traumatic birth and may weaken the intimacies at the family core.

Vanderbilt: My academic work as a developmental-behavioral pediatrician has focused on maternal trauma that is generated when the newborn is medically ill and requires admission to a neonatal intensive care unit (NICU). This can be due to serious medical problems at term birth or prematurity itself. That moment of involuntary separation for a life-threatening condition has the potential to generate traumatic stress for the mother. Even for parents who understand the medical system, this can be overwhelming. Tubes may be placed in the umbilical cord, windpipe, vein, artery, or even through skin into the chest, abdomen, or limbs. Machines take on human functions such as breathing, feeding, or cleaning waste products. In the NICU, monitors constantly sound off, and a parade of health professionals come and go. Parents struggle to find a place to bond with their infant or a role other than as a secondary caregiver.

In my clinical and research practice, I have seen higher rates of immediate and sustained traumatic stress symptoms in these mothers. These events echo throughout the life of the child and color daily interactions. Selma Friaberg described these impactful memories as "ghosts in the nursery." While many of these "ghosts" or traumatic experiences are integrated into an adaptive narrative, others persist or worsen over time.

Extensive research has shown that postpartum depression disrupts the infant–mother relationship and leads to worse developmental and behavioral outcomes in the developing child. Fewer studies have explored the effect of traumatic symptoms on the developing child, but early work suggests that there are problems with dyadic interactions and child cognition and behavioral regulation of sleep and eating.

Kendall-Tackett: Actually, I would argue that postpartum PTSD it is not all that new. I first described postpartum PTSD in my first book, *Postpartum Depression: A Comprehensive Approach for Nurses*, written in 1992. I had had a traumatic birth 2 years earlier. I was seeking to understand my own experience and that drew me into the formal PTSD literature. At the time, no one in the trauma world was talking about PTSD related to birth. But reading those early writings, especially in Charles Figley's 2 amazing books, *Trauma and Its Wake* (Volumes 1 and 2), I knew that they were describing what women were experiencing following birth. In my first book, I described this, and borrowed a model from the child abuse world, and talked about trauma following a difficult birth. I wove women's stories into the narrative.

At the time, you could not officially diagnose PTSD related to birth since the exposure criteria (criteria that says you have experienced a potentially trauma-producing event) was that you had to experience something outside the "normal range of human experience." Obviously, birth does not qualify for that, and I think that criteria held things back a bit, at least with regard to perinatal trauma. Even with that limitation, if you just wanted to describe women's experiences using a trauma framework, you could.

The exposure criteria are much better now. The criteria for a traumatic event are actual or threatened death, actual or threatened bodily harm, or actual or threatened sexual violation. Unfortunately, birth can include all 3 types. Believe me, I have heard it often enough. And these criteria also state that you can meet criteria for PTSD if you have experienced the event directly, witnessed the event (which includes partners, doulas, labor and delivery nurses, and physicians), or if the event happens to a close friend or relative.

This year, I am serving as the president for the American Psychological Association's Division of Trauma Psychology. I am a founding officer for this division. I am also the incoming editor of their journal, *Psychological Trauma*. This puts me in a great position to educate professionals about perinatal trauma, and I have been lecturing all over the world about it. My work is specifically with lactation consultants, doulas, and nurses, and about what they can do to help a mother who has been traumatized by birth. I firmly believe that if someone can get to a mother early in the process, she can stop the cascade into PTSD or get her directed toward competent care. Otherwise, mothers and their families can suffer for years. We need to get in there if we can and help.

For women, breastfeeding can be a natural extension of the birth experience. When a mother has experienced trauma, how might that affect her breastfeeding? From your discipline perspective, what are the signs and symptoms that you would look for that would suggest that a woman is suffering from PTSD and that it is affecting her ability to breastfeed?

Klein: Many of the perinatal ideologies extend to breastfeeding. For example, strong proponents of "natural birth" are also strongly opposed to the use of formula as a supplement or substitute for breast milk under any circumstance. The underlying explanations reference the innate "knowledge" of the body and assume that we can tap into our animal nature if only we could shed our cultural mantle. These assumptions unfortunately draw on ethnographic work conducted among foraging peoples (and horticulturalists, to a lesser extent) and are based on the incorrect assumption that contemporary foragers live like our human ancestors; these decontextualized examples suggest that the cultural practices of contemporary foragers may be followed as a guide to being more natural, as if these peoples were somehow closer to nature, and as if we could attain some imagined pristine natural state that existed before culture. Breastfeeding is natural, of course, but just like eating, it is

mediated by layers of cultural meaning and practice.

When a mother has experienced a traumatic birth, she may have difficulty breastfeeding because of problems with milk production, physical discomfort (holding, sitting, finding the right position), alienation, or emotional detachment. Key to understanding the latter is the recognition that for some women, especially those who prepared for and expected a largely "natural" birth, if medical intervention was needed, they may feel that they have failed at this primary womanly accomplishment. Additionally, a mother may feel that her body has failed her, and she may not be confident in her body's ability to provide sustenance for her child. Depending on the procedures involved in the birth, she may even feel that rather than giving life (as birth is so often described), she may feel that she (her body) endangered the child (as is so often the justification for emergency procedures), and therefore is not capable of nurturing the child.

Following a traumatic birth, I would recommend looking for signs of frustration with breastfeeding, discomfort or difficulty holding the infant, and delay in milk production. Breastfeeding frustrations may aggravate feelings of failure. If there is a delay in milk production, or insufficient milk, rigid refusal to supplement with formula can lead to further problems (infant weight loss, or even simply a screaming hungry baby). Based on personal experience, and talking with women in multiple countries, I would urge that mothers be referred to an international board certified lactation consultant as opposed to lay counselors. The focus needs to be on meeting the needs of mother and child rather than pushing an ideological agenda.

I would also recommend that partners be present at appointments. If the partner has also been traumatized by the birth experience, the mother may feel torn between caring for her infant, herself, or her partner. These conflicting commitments can deepen feelings of frustration, alienation, and loss of control.

Vanderbilt: Mothers of high-risk infants begin that relationship building with unique challenges. Physical separation reduces normal hormonally inducements for lactation. The infant's gastrointestinal track may not be able to take milk for weeks to months and the infant may not be able to feed at the breast for an extended period. Added to these, the maternal traumatic stress and depression may inhibit effective bonding and surmounting the stress due to breastfeeding dissynchronies. Finally, once medically stable to take breast milk, the infant may have ongoing organic feeding problems requiring G tubes or oral sensory integration sensitivities that can impede an enjoyable feeding relationship.

In a study by Forcada-Guex on longer term effects in which greater traumatic stress symptoms due to infant prematurity increased child feeding problems at 18 months. These patterns most likely were set early in that relationship building phase and play out over time.

Mothers with traumatic stress may experience the breastfeeding process as aversive due to traumatic reminders of the life-threatening illness of the infant or feelings of inadequacy in being able to care for the child while there. These feelings may result in early termination or lack of initiation. Those stresses may also come out as breastfeeding problems, maternal psychosomatic complaints, or negative attributions about the infant.

Kendall-Tackett: Breastfeeding is interesting. Yes, it is an extension of the birth. For some women, it can be a source of further trauma. For others, it can be a source of healing. We need to be sensitive with women who have experienced a traumatic birth and who are now having trouble breastfeeding. We need to let them know that they can overcome their birth experience and successfully breastfeed. We need to treat women as partners in their own care.

With regard to specifics, there are 2 things I think are important to watch for. First, skin-to-skin contact is great most of the time. But it can be overwhelming for mothers who have experienced trauma. So watch for subtle signs that she may be recoiling or pulling away. Many times, you can ease women into skin-to-skin by starting with a little bit. You can also say something like, "You seem uncomfortable. What can I do to help you be more comfortable?"

The second problem you might run into is a delay in lactogenesis II, when the milk "comes in." This delay can be several days, so as mentioned above, it is important to follow these mothers. A problem that can occur is when the mother is home and does not realize that her baby is not eating. Suddenly, it becomes an emergency and the baby can even end up back in the hospital, further traumatizing the mother. To help bring her supply in, we might try more skin-to-skin (if she can handle it) and pumping. If necessary, we might use some brief supplementation until the mother's supply comes in. We can tell her what is happening and present these interventions as a strategy to get breastfeeding back on track. We want to avoid her experiencing the delay in lactogenesis II as another failure.

What resources have you found helpful for women with postpartum PTSD? In your opinion what resources are still needed in order to meet the needs of women with PTSD as it relates to breastfeeding?

Klein: As with other forms of PTSD, maternal trauma is not something that goes away entirely. For some, medication may help, but there are limits to which psychotropic drugs may be used during breastfeeding, and not everyone is comfortable with pharmaceutical solutions, their side effects, or the flat affect that comes with these drugs. Counseling is critical, to identify the source of trauma, and arrive at a new and more positive narrative about the birth process and the mother's relationship with the child. This should not be left only to professional

counselors, but to all health practitioners who come in contact with mother and child. Ask about the birth, give her an opportunity to talk about it, about what went wrong and what went right. Sometimes practitioners are afraid to ask afterwards for fear of legal repercussions, but this further dehumanizes the process and deepens the alienation. By avoiding uncomfortable conversations, practitioners do not get the feedback from patients, the patients do not get the benefit of the practitioner's explanations of what happened, and patients do not get the opportunity to express fears and frustrations, all of which is essential to both prevention and healing.

Vanderbilt: With Drs Hynan and Mounts, I made some recommendations in an article in the *Journal of Perinatology* to increase screening for traumatic stress and depression to normalize the caregiver stress generated in NICUs.[1] We suggested several tools such as the Primary Care PTSD Screen, Davidson Trauma Scale, or Perinatal Posttraumatic Stress Questionnaire to identify mothers at risk. Once identified, anticipatory guidance on normalizing the experience and symptoms can occur.

If there is significant distress or symptoms that affect the ability to care for the infant, further referrals can occur. Many areas have Perinatal Mental Health Coalitions to facilitate screening and referrals. Los Angeles County has a good Web site: http://www.maternalmentalhealthla.org/. In our High Risk Infant Follow-up clinic, we have a team of professionals from nutrition, occupational and physical therapy, social work, and/or psychology who all look for these symptoms and support families in optimizing functional relationships.

Kendall-Tackett: There are several Web sites that have great information on postpartum PTSD. I would start by sending a mother to those sites. I have a page on BreastfeedingMadeSimple.com on birth trauma (under "Common Challenges"). There are lots of resources there for mothers. For PTSD in general, I would recommend the National Center for PTSD site, NCPTSD.org. It is mostly geared toward veterans, but there are many excellent resources for someone who wants a good primer in PTSD.

As for breastfeeding mothers, I would like to see every lactation consultant and volunteer peer counselor (and doulas too) have trauma-informed practices. We are on the frontlines. I believe it is within our scope of practice to listen to mothers and provide them with information. We can help them recognize what is happening to them and refer them to sources of help. That alone would be huge and could save families years of heartache.

I also have 2 articles available on postpartum PTSD and breastfeeding in the journal *Clinical Lactation*, (Volume 5).[2,3] They are available for free online at ClinicalLactation.org.

You have been asked to speak to a group of health care providers about postpartum PTSD, and to present your audience with 3 pearls to remember. Please list your 3 pearls and with a brief explanation for each and why you think they are important.

Klein: *First, remember that the mother is also your patient* (not only the child), and her well-being is also a primary outcome. The child's well-being is directly tied to the mother's, and a traumatized mother is emotionally depleted and unable to care for her family.

Second, remember that the mother is a person, one who needs attention and explanation, even during—*especially* during—emergency procedures. Do not forget her mind when you turn your attention to her body. And do not avoid her afterwards if things did not go as hoped.

Third, be open to other perspectives. Most of your patients will have a different worldview, because of different cultural background, different education, or different ideology. Being open, tolerant, and even accepting of such differences will make you a better practitioner, and increase the likelihood of good communication between you and your patients, which always contributes to good outcomes for all.

Vanderbilt: I talk to groups often about the need to focus on maternal mental health among those with high-risk infants. The rationale is to optimize maternal and infant outcomes through clinical care and ongoing research. My 3 points revolve around the following:

- *High-risk infant parents have emotional responses* due to the NICU experience.
- *These emotional responses affect the infant's* behavior and development.
- *An interdisciplinary, culturally informed, and family-centered* infant mental health approach is needed to identify and manage these traumatic experiences and stress.

Kendall-Tackett: *Birth can cause PTSD.* Mothers in our country are being traumatized by their birth experiences. We need to recognize that birth can meet the threshold of a traumatic event and stop acting like it does not. A woman who has a traumatic birth can show the same symptoms as someone returning from combat. It is that serious. We need to recognize that and respond accordingly.

Trauma is treatable. We need to communicate to mothers and their families that they can recover from traumatic events. PTSD symptoms following traumatic events are predictable—and treatable. They can get better. In fact, they may even experience growth as a result of their traumatic experience. We must communicate hope.

We need to help mothers connect with their babies whether or not they breastfeed. To my mind, one of the most frightening finding in recent studies was the amount of disconnect mothers had from their babies following a traumatic birth. One study mentioned that mothers eventually bonded with their babies—in 1 to 5 years! That is a tragedy. If a mother is feeling disconnected from her baby following a traumatic birth, we need to step in if we can. We can help that mother connect with her baby through helping her learn to read her baby's cues via mother–infant coaching, baby-wearing, or infant massage. These are simple and easy interventions. If she is depressed, treat depression because that can also impair a mother's ability to read her baby's cues. And support breastfeeding. Even if a mother is not breastfeeding, the other interventions will help. I think this is one of the most important things we can do.

References

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