

# POST TRAUMATIC STRESS DISORDER AND CHILDBIRTH: INFLUENCES ON BREASTFEEDING.

Bev Pownall  
Midwife/Lactation Consultant

## INTRODUCTION

Far from being a benign and normal experience, for many women, childbirth is a traumatic experience which left untreated, can profoundly and negatively affect her family and her psychological health for the rest of her life (Crompton, 2002). It is my contention that it is important for lactation consultants to understand the events that lead to trauma and how it may impact on the health, the breastfeeding choices and experiences of these women, and on their relationships. The purpose of this article is threefold. First to discuss some of the available literature on Post Traumatic Stress Disorder (PTSD); second to share stories of women who have experienced PTSD and their experiences around breastfeeding; and finally to provide information about support for overcoming PTSD.

## I. PTSD AFTER CHILDBIRTH

PTSD can happen to anyone at any time. It is regarded as the outcome of stress responses which initially may have been adaptive, but continue after the threat has disappeared. It is the person's perception of the event which traumatises them. Beck (2004a) uses the term "in the eye of the beholder" to explain this. Other people (including health professionals) may not perceive the event as traumatic, they may even see it as routine, but it may have serious consequences for the person involved. Identified in soldiers during the Vietnam War and previously known as Battle Fatigue, War Neurosis, or Shell Shock, PTSD is also common in rape or road accident sufferers. Other triggers can be natural disasters such as hurricanes; or as a result of torture, hostage taking, kidnapping, child sexual abuse, assault, bullying, crime, and battering relationships.

The American Psychiatric Association first described PTSD in 1980. To meet the definition of PTSD the trauma had to have been outside the usual human experience. As childbirth was considered a normal human experience, it did not meet the original definition. In 1994, the Association altered the definition to include any event that caused fear for the life or bodily integrity of the person or a loved one. Thus, childbirth has been more recently identified as an event which may contribute to PTSD.

The essential feature of Post Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic experience involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity to another person; or learning about unexpected or violent death, serious harm or threat of death or serious injury experienced by a family member or other close associate .

(American Psychiatric Association, 1994, p.424).

APA literature suggests that PTSD can be **acute** (4 weeks to 3 months after the event; **chronic** (longer than 3 months) or **delayed onset** (showing symptoms 6 months after the event).

As many readers will be aware, when confronted with danger, humans have a repertoire of choices which involve fight, flight, or freeze. Fight and flight are mediated by hormonal events whereas 'freeze' is thought to be a form of reverting to a primitive coping tactic of self-hypnosis. This may take the form of depersonalisation, derealisation, hallucinations, and amnesia which Strutman and Bliss (1985) suggested can in turn, instigate and perpetuate the disabling features of PTSD. Traumatic events are thought to alter brain chemistry (Coleman, 1992) and also the actual structure of the brain (Bremner et al., 1995). Whilst not completely understood, Turnbull (cited in Crompton, 2002) postulated that the emotionally intense shock of intense trauma causes the release of abnormally high levels of adrenaline and noradrenaline into the bloodstream. These appear to inhibit the normal processing of memories. Crompton (op cit.) explains that the sufferer is left with altered brain metabolism which is vulnerable to surges of noradrenaline, thus prompting alarm states. Crompton further explains that in time, the sensation of an adrenaline surge (for whatever reason) acts as a memory and a cue for the sufferer to re-live the trauma in intrusive recollections, known as flashbacks.

Psychic trauma results when an individual experiences an adverse event which causes undue stress, perceived to be beyond their control. When the event is unforeseen and happens quickly, such as obstetric emergency, it can be overwhelming.....When talking about traumatic childbirth, women often use the language of sexual assault.

(Crompton, 2002, p.18).

The reported prevalence of PTSD after childbirth ranges from 1.5% to 6% (Beck, 2004a). According to Beck most of the research around PTSD and childbirth is quantitative, focusing mainly on the prevalence of diagnosed PTSD; PTSD and stress symptoms; or predictors of PTSD which are related to childbirth. Beck undertook a phenomenologic study which set out to ask women the meaning of a traumatic birth for each of them. The 40 women in her study participated via the Internet: 23 in New Zealand, 8 in the USA, 6 in Australia, and 3 in the UK. Beck identified four themes.

### Theme 1. To Care for Me: Was That Too Much to Ask?

Women felt betrayed by a system that was meant to care for them. Words used to describe their care included mechanical, arrogant, cold, technical and lack of empathy. Some mothers reported feeling stripped of their dignity. Others, abandoned and alone.

*I was very frightened, and then it hit me. I might not make it! I can still recall the sick dread of real fear. I needed urgent reassurance, but none was offered (Beck, 2004a, p.32).*

### **Theme 2: To Communicate With Me: Why Was This Neglected?**

Mothers perceived that some staff failed to communicate with them. Clinicians spoke to each other as if the woman was not present. Women reported being horrified,

*By now the doctors are acting like I'm not there. The attending physician was saying, "We may have lost this bloody baby." The hospital staff discussed my baby's possible death in front of me and argued in front of me as if I wasn't there (Beck, 2004a, p.33).*

### **Theme 4: To Provide Safe Care: You Betrayed My Trust and I Felt Powerless.**

At times women perceived they received unsafe care but felt powerless to rectify the dangerous situation.

*I remember believing that the labor and delivery team would know what was right and would be there should things go wrong. That was my first mistake. They didn't and they weren't! I strongly believe my PTSD as caused by feelings of powerlessness and loss of control of what people did to my body (Beck, 2004a, p.33).*

### **Theme 4: The End Justifies the Means: At Whose Expense? At what price?**

Some mothers perceived that if the baby was born and alive, that was all that mattered to the staff. Beck suggests that as these mothers were engaged in battle, their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma.

*(I was) congratulated for how "quickly and easily" the baby came out and that he scored a perfect 10. The worst thing was that nobody acknowledged that I had a bad time. Everyone was so pleased it had gone so well. I felt as if I had been raped! (Beck, 2004a, p.34).*

In a subsequent article, Beck (2004b) discussed further findings from her study above. Rather than the immediate experiences of birth trauma she discusses the longer-term sequelae of birth trauma, in the same sample of women. Five themes emerged.

### **Theme 1: Going to the Movies: Please Don't Make Me Go!**

Mothers were bombarded with flashbacks and also with terrifying nightmares whilst trying to sleep. Some described images similar to a video which kept replaying constantly. Relationships with her child, her husband, and medical staff can be affected.

*After about 6 months, my husband and I still hadn't had sex since before the birth. When we began to try, I had flashbacks to the birth. At the moment of penetration, I would have a flashback to the instant when my body was pulled down the operating table during one of the failed forceps attempts (Beck, 2004b, p.219).*

### **Theme 2: A Shadow of Myself: Too Numb to Try and Change**

Women gave examples of numbing of self and dissociation - some immediately after the birth, some once they were at home.

*Mechanically I'd go through the motions of being a good mother. Inside I felt nothing. If the emotion did start to leak, I quickly suppressed it. I'd smack myself on the hand and put my "robot suit" back on (Beck, 2004b, p.220).*

### **Theme 3: Seeking to Have Questions Answered and Wanting to Talk, Talk, Talk.**

This included an intense need to know the details of their traumatic birth and to get answers to their questions. For some women, it entailed making repeated appointments with the physicians and midwives who had delivered their infants to have their questions answered and to go over their records. Revisiting the delivery room became necessary for some women.

*Not only does PTSD isolate me from the outside world; it isolates me even from those I love. How do I explain the sort of blind terror that overtakes me without warning and without obvious logical cause? And what of my family and friends? They don't know how feel. They don't know what to say, and they cannot make it better, so they end up feeling useless (Beck, 2004b, p.221).*

### **Theme 4: The Dangerous Trio of Anger, Anxiety, and Depression: Spiralling Downward.**

The women experienced these emotions on a heightened level. Anger was rage; anxiety turned into panic attacks; and depression left many mothers suicidal.

*Powerful seething anger would overwhelm me without warning. To manage it I would go still and quiet, then eventually "come to," realizing that one or all of the children were crying and I had no idea for how long (Beck, 2004b, p.221).*

### **Theme 5: Isolation From the World of Motherhood: Dreams Shattered**

Some women shared that PTSD distanced them from their children. PTSD caused some mothers to isolate themselves from other mothers and babies. Some chose not to have another baby; others opted to have another one, but said they were terrified of another labour and birth.

*I couldn't envision ever having another baby. There was no way I could expose myself again to that degree of vulnerability and abandonment (Beck, 2004b, p.222).*

Beck (2004b) points out that obviously the best intervention is to prevent birth trauma in the first place. Knowledge of predictors of PTSD such as high levels of obstetric intervention, is crucial so health care providers can be alert to signs of high-risk. Similarly clinicians should be able to recognize signs of previous trauma, such as extreme fear and lack of trust of health care providers, flashbacks, dissociation, and an intense need to control their next labour.

Beck warns that not only can PTSD have devastating effects on the mother; it can also affect the developing relationship with her child. Mother infant attachment problems have been addressed in a few studies on PTSD associated with childbirth (Allen, 1998; Ballard, Stanley, & Brockington, 1995; Reynolds, 1997; Weaver, 1997). The infants may become reminders of the trauma. Further complicating this may be the feeling of numbness reported by some mothers.

Debriefing sessions may be helpful (Allen, 1998; Gamble, Creedy, Webster, and Moyle, 2002). Support and trauma counselling are essential for diminishing the impact of traumatic childbirth (Beck, 2004b). Crompton (2003) stresses the importance of access to groups such as TABS (Trauma and Birth Stress) which are composed of other women who have experienced birth trauma and PTSD attributable to childbirth.

## **II. PTSD AND BREASTFEEDING**

A search of the literature around PTSD and breastfeeding revealed very little, so I contacted TABS. TABS was formed because of the need to make PTSD known as a form of mental illness which can happen following childbirth, and also to highlight the fact that PTSD is quite distinct from the Baby Blues, Post Natal Depression (Post Partum Depression) and Post Natal Psychosis.

Suffering PTSD and having a new born baby at home can be very difficult and distressing for the mother and also the partner and other family members. The mother's confidence can be severely jeopardised and judgement calls may be made which she might later regret. One of the first challenges is of course breastfeeding. Breastfeeding can make some mothers feel out of control and if not successful at the first attempt can lead to feelings of 'failure'. To help the mother to understand what she has gone through, to instil some trust in herself will assist her to develop confidence in her ability to care for her baby and develop positive maternal-baby attachment (Watson, 2004).

Four members of TABS provided their stories in relation to breastfeeding and I am grateful for their help and courage in sharing their stories.

### **One Mother's Story**

*I began my first pregnancy at 33 years of age, full of optimism, confidence and joy - after all, having a baby is a normal event for a woman. However mine was anything but normal, by 28 weeks my ever growing size was attributed to polyhydramnios, but sadly I was treated very conservatively "measure your size each day, visit your GP twice weekly and if you go into labour, then I will hand you over to the hospital team to manage the situation". Sadly, not knowing the full ramifications and being a trusting person, I soldiered on, until at 31/6 I could no longer cope with my huge belly, and on admission learned the awful truth of my situation. It was downhill from there, a c/s was performed on the Saturday afternoon due to unstable lie and poor heart trace, an admission to NICU, and life support being removed the next morning at dawn. Then the five days in the postnatal ward, discharge, home to a funeral and basically back to life as a couple. However it did not end there, with a PPH due to retained placenta, readmission to the same hospital ward, it all was a dizzying experience.*

*So, when it was discovered that I was pregnant 16 months later it was time to be responsible, commence good nutrition, to grow this baby inside of me, to find a good care-giver and basically chop myself off at the neck emotionally. With the help of the mental health team and a social worker, an expansive birth plan was put together with for me, one of the major issues being breastfeeding. Will I or won't I? The grounds for my concern were all emotional factors - how would I be with a live, healthy baby at the conclusion of this second pregnancy? In my heart I knew this baby was perfect - and the type of birth was of minimal concern - all I wanted was the care-giver to "just talk and communicate with me no matter what and I will cope." But to breastfeed? Oh no, my emotional well being and stability surely were of priority this time round - yes, I had suffered leaking and full breasts at day 8 after the c/s and that was a trauma in itself - so what to do to lay down the best plans to survive.*

*Thankfully I had an excellent GP, who did more than his duty in settling me into a good obstetric care and relationship for this pregnancy - so what if I do not breastfeed? His words were like gold "a happy mother is a happy baby, let's work on this" But in my mind, knowing that breastfeeding is a hot potato often overshadowed by political correctness considerations, and also that breastfeeding IS the best start for a baby, I really had to do my homework thoroughly.*

*Therefore I gave myself six weeks to sort this out. I gingerly phoned the local family centre, terrified of the reception I might receive, but I was very up front about my concerns: "In view of what happened last time, I am not sure if I can or should breastfeed this time." Thus began my journey. I sat for two hours, and mothers passing through were invited to sit with me and tell me their stories of*

*breastfeeding. It was an enlightening time, hearing a good range of stories and quickly learning that unless I could get good and guaranteed support around me, then breastfeeding was not to be. In view of my emotional state and not being sure how I would react at birth, then surely bottle feeding was the best, and it was ok to know that I would have to go with the flow at birth for me first of all, and THEN we as a couple would make this decision together.*

*So I journeyed through this second very healthy pregnancy juggling the decision to breastfeed or not to breastfeed on a daily basis. And it was only at the birth, that we opted for the bottle. Do I have regrets? Yes - of course, the volumes of information 'out there' remind me of what we denied our daughter. Could we have set ourselves up better to be able to breastfeed? Most definitely - had we known where we could have obtained such help - for us family members were thin on the ground and being a private couple, we were not ones to seek attention - enough was already being focused on having a successful outcome, without the stress of what to do next.*

*Mothers who have PTSD, whether they have an official diagnosis, are at a disadvantage emotionally. Often one is purely juggling with the triggers and reminders that 'set you off', so unless breastfeeding is successful or well supported, it might be the first thing to go.*

#### **From another Mother**

*I did find the pressure to breastfeed or express was a bit hard to deal with when I was still coming to grips with the fact I'd had a baby. I was not comfortable with emphasis on my breasts or milk production so soon after the birth because I already felt very violated and withdrawn. The last thing I wanted to do was expose more of my body to another stranger. Being very detached from baby didn't help anything either. And yet it was in my mind all the time. I had to feed this baby or it would die. Chances were he was going to die anyway - how can you produce milk under that pressure? The neonatal nurses were good, and treasured whatever I managed to produce, but I felt very inadequate, and even more of a failure.*

*In a subsequent pregnancy and birth, while still suffering the effects of PTSD, there was no pressure to feed. My midwife left it "up to me to do in my own time. It gave me a chance to take in what had occurred at the birth, and get used to this new little person, who I had no attachment to at all. She had a good feed a few hours after the birth, and by then I was a little (not a lot, but a little) more comfortable with feeding her. My midwife also was considerate in asking if she could touch and help - this meant a lot to me, letting me have choice and some control.*

*Every woman needs to debrief after her birth, whether it was a good or bad experience. Having a baby is a huge, huge experience for every woman, whether it is her first or fifth baby. Debriefing with her LMC will help fill little gaps in time and information, and give another perspective i.e. the mother may have felt she wasn't doing something right, LMC can praise her for her efforts and let her know she did just fine. This can be important because the mother might hold on to that little thought for ages, never being comfortable about it. If things go wrong there will be more questions, blanks, trauma, loss of time and memory, and a lot more debriefing to be done. I believe if a mother doesn't get to debrief, a little (or huge) part of them sticks in time at the birth, possibly forever.*

#### **From A Childbirth Educator and Member of TABS**

*One of the things I discuss is the impact of the birth on breastfeeding. Multiple births are well known for higher than average levels of intervention. Many mothers report feeling they had little or no say in what occurred during labour. They speak of procedures being carried out without discussion or consent. They speak of people 'barging in and out of the room' without introduction or comment to the patient and on it goes.*

*The birth process itself may just add to the emotional roller coaster ride these women ride if the pregnancy has been complicated. If they are struggling to deal emotionally with a birth perceived in their eyes as traumatising they are far more likely to drop breastfeeding within a very short time. They have enough to deal with without the worry of establishing breastfeeding and all the conflicting advice that goes with it. It is interesting to note that statistics for duration of breastfeeding multiples are not available. I suspect if they were it would paint a rather gloomy picture. I believe these statistics should be presented separately to better reflect the true situation.*

*For these women to successfully breastfeed, a lot of support is needed in the early days. This support is not always available, either in hospital or at home. Mothers of triplets who wish to breastfeed struggle even more than twin mums to find the right support and encouragement to breastfeed. Most multiple birth clubs have a breastfeeding support person who is usually more than willing to come to the aid of new mums. Clubs also hire breastfeeding pillows which make establishing breastfeeding a little easier. Having the support of a mother who has successfully breastfed her multiples is only part of the answer though. Continuity of care through pregnancy, good care and communication throughout labour and good support postnatally all I believe have a part to play in a woman's ability to successfully breastfeed.*

#### **From a Midwife Member of TABS (in response to questions asked).**

*Women need to understand what has happened to them and why. They need to be able to read the notes and understand them and what they mean. Will this have implications for future births? What were the possible outcomes? Has the LMC reflected on what has happened and what do they think about it - would they have done anything different. The woman will have questions and they may be repeated several times until she is able to process the information. Was the LMC her original or was she a back-up she hadn't met*

*previously - will she get an opportunity to debrief with her. "Will the LMC debrief? Or is the LMC steering clear of that conversation. Sometimes a woman may just want to be heard - acknowledged for the loss they are feeling. Many women will be too numb to even go there and discuss the birth - shellshock and so often it is after the LMC has finished care that questions come up.*

*Skin to skin restores some of the purity that has been stripped away from the birth. It is an emotional and special time of closeness as well as important for breastfeeding success.*

*For the health professional to "back off breastfeeding and just focus on other positive experiences" further reinforces the idea of "was I/am I a failure?" Certainly look at other relaxing experiences as bathing but also use these as an opportunity to establish breastfeeding i.e. it is well researched the effects of deep water bathing together to help with breastfeeding issues. To me, to back off is a cop out which has long lasting effects which is beneficial to no one. Obviously there may be times where babies may need to be cup fed - but it should always be done with the goal of breastfeeding.*

*With regard to the importance of appropriate language, obtaining informed consent, and respect. Ohhhhhh - if this only happened in the first place then there wouldn't be so much PTSD. I find it frustrating that this always comes after the fact. All LMCs should be working in this way and then there wouldn't be a need for the ambulance at the bottom of the cliff. When are we going to understand that this is the woman's experience and she is in control. Let go of our agendas to get along with hospital staff and not to rock the boat - this is too important.*

*(Lactation Consultants) are often working with the mothers of older babies so need to be able to recognise the difference between PTSD and PND. It is imperative if you want women to get well - leave them long enough or misdiagnose them and they eventually will get PND as well.*

*My own experience....*

*An over-medicalised birth - issues of extra fluid on board which is detrimental to establishing your milk supply. Tired midwife who wanted to go home as soon as baby born - when I asked her about breastfeeding she said to just let the baby suck and then she left. So I did let the baby suck which resulted in grazed nipples - bad start.*

*Felt that since I'd failed at birth, breastfeeding was the only original thing left from my birth plan which I could retain/own/control. It was incredibly difficult and it took until 6 weeks for me to be able to breastfeed her successfully - if I hadn't been able to I would have been utterly and completely devastated - add that to a bad birth experience and you can see why this would not be desirable. For me it was stubborn, pig-headedness which made me keep going. It was the only natural thing I had left after a horrendous birth. Also bonding is difficult after a traumatic experience - breastfeeding is a time of closeness, bonding and love. A time to reconnect.*

### **III. TABS AND PTSD**

Following a lengthy process which finally ended in a diagnosis of PTSD, one Auckland mother who found it hard to accept that so little was known about PTSD following childbirth, wrote to a national parenting magazine. From the response, it became apparent that others shared her concerns. In May 1998, five mothers came together because of a shared experience: stressful and traumatic pregnancies or births which had affected their lives negatively for months or years afterwards. To help others similarly affected, they formed TABS, Trauma and Birth Stress, a Charitable Trust, and now a web-based education and support group for mothers and health professionals. Whilst entirely New Zealand based, TABS is now receiving international recognition for members' work in supporting mothers and families; providing information on PTSD and where to get help; and educating health professionals about PTSD around pregnancy and childbirth.

TABS offers information and support. The organisation does not provide professional treatment of PTSD, however it does provide a list of professionals who may be able to help. This is important for women trying to locate professional counsellors who are skilled in providing treatment for PTSD. Lactation Consultants should be aware of the potential value of a self-help group in conjunction with professional treatment. What else should Lactation Consultants be aware of? Much of the information contained in this section is reprinted with TABS permission. It is more detailed and readily available on the TABS website [www.tabs.org.nz](http://www.tabs.org.nz) <<http://www.tabs.org.nz>>. A resource manual for health professionals is also available for purchase from TABS.

In the DVSM-IV listings, PTSD and Acute Distress Disorder are the only diagnoses that:

- Place the origin of the symptoms on external events rather than on individual personality;
- Recognise that, subject to enough stress, any human being has the potential for developing mental health problems.

Where there is sufficient stress, other factors such as an individual's previous mental stability and psychological state, are irrelevant in predicting the development of PTSD. The development of PTSD symptoms, and the severity of those symptoms, has more to do with the intensity and duration of the stressful event than any pre-existing personality patterns. In short, although the "pre-trauma" personality, belief system, and values do affect reactions to and interpretations of the traumatic event, PTSD does not develop because of some inherent inferiority or weakness in the personality. Trauma changes personality, not the other way around. A single

incident perceived as a life-or-death situation, lasting as little as a few seconds can be enough to traumatise an individual.

### **PTSD Diagnostic Criteria**

In order to diagnose PTSD, the sufferer must fit the following criteria (DSM-IV):

1. The person has experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others AND the person's response involved fear, helplessness or horror.
2. The traumatic event is persistently re-experienced in at least one of the following ways:
  - Recurrent and intrusive distressing recollections of the event.
  - Recurrent distressing dreams of the event.
  - Acting or feeling as though the event were recurring (including flashbacks when waking or intoxicated).
  - Intense psychological stress at exposure to events that symbolise or resemble an aspect of the event.
3. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the event) as indicated by at least three of the following:
  - Effort to avoid thoughts or feelings associated with the event.
  - Efforts to avoid activities or situations which arouse recollections of the event.
  - Inability to recall an important aspect of the event (psychogenic amnesia).
  - Markedly diminished interest in significant activities, such as hobby or leisure time activity.
  - Feeling of detachment or estrangement from others.
  - Restricted range of affect; eg, inability to experience emotions such as feelings of love.
  - Sense of a foreshortened future such as not expecting to have a career, more children or a long life.
4. Persistent symptoms of increased arousal (not present before the event) as indicated by at least two of the following:
  - Difficulty in falling or staying asleep.
  - Irritability or outbursts of anger.
  - Difficulty concentrating.
  - Hypervigilance.
  - Exaggerated startle response.
  - Physiological reactivity on exposure to events that resemble an aspect of the event, eg breaking into a sweat or palpitations.
5. B, C, and D must be present for at least one month after the traumatic event.
6. The traumatic event caused clinically significant distress or dysfunction in the individual's social, occupational, and family functioning or in other important areas of functioning.

Accurate diagnosis of PTSD is often difficult due to the number of characteristics of the illness. The sufferer may not want to think or talk about the trauma because this means reliving it. Sometimes the mother may not know that her negative feelings, thoughts, and problematic behaviour are linked to the trauma. The longer the person has suffered from untreated PTSD, and the more severe the trauma, the more likely the PTSD will be hidden by Cover-Up Symptoms. This is especially so in the numbing stages of PTSD.

### **Cover-Up Symptoms**

- Alcohol and drug abuse
- Eating disorders: bulimia nervosa, anorexia nervosa, compulsive eating
- Compulsive gambling or compulsive spending
- Psychosomatic problems
- Homicidal, suicidal or self-mutilating behaviour
- Phobias
- Panic disorders
- Depression or depressive symptoms
- Dissociation symptoms
- Fainting spells

### **Risk Factors for PTSD**

A Risk Factor is an event(s) that can contribute to the occurrence of PTSD. It can happen any time during the pregnancy, labour, delivery and/or postnatal periods. The number of Risk Factors present may vary greatly. Some Risk Factors affect some women, but not others. Each risk factor can increase the chances of PTSD occurring. Most can be avoided or lessened considerably by those looking after the woman, by simple measures such as giving the woman respect, treating her with dignity, acknowledging her needs and communicating effectively at all times.

- Managed labour
- Induction

- Poor pain relief
- Feelings of loss of control
- Unnecessary trauma
- Traumatic delivery
- Impersonal treatment, overly professional, stand-offish or judgemental attitude of staff
- Multi handling
- Shift changes
- Lack of explanations
- Feelings of loss of control
- Not being believed or listened to
- Lack of attention to dignity, e.g. no coverings
- True obstetric emergencies
- Invasive procedures without explanations or consent
- Forceps, suturing without adequate analgesia
- Prolonged latent phase - resulting in demoralisation
- Conflicting advice
- Having baby(ies) admitted to SCBU (Special Care Baby or Unit) or NICU (Neonatal Intensive Care Unit)
- Severe postnatal anaemia
- Post Partum Haemorrhage
- Poor postnatal care
- Old trauma
- Unmet need to debrief, review, or to understand what happened
- Emergency Caesarean Section
- Shoulder dystocia
- Poor Postnatal Care
- Postnatal problems

### How is PTSD different from Postnatal Depression?

#### PTSD

May start soon after birth or months or even years later. If left untreated, PTSD does not go away. Usually starts soon after birth or usually within the first six months. If left untreated, some women might get better within about 2 years, though for others it may be a life-time experience.

#### PND

### What PTSD Symptoms are also common to PND?

- Persistent weepiness
- Lack of concentration
- Loss of confidence
- Anxiety
- Eating too much or too little
- Difficulty falling or staying asleep, sleeping too much
- Constant tiredness
- Guilt
- Lack of bonding with baby
- Feeling “emotionally numb”
- Loss of enjoyment of life
- Inability to cope with baby(ies) or activities of daily living
- Isolating oneself from family, friends, and avoiding social situations
- Feeling extremely moody, irritable, angry, suspicious or frightened
- Lack of motivation
- Feelings of self-harm
- Feeling fear and sense of doom about the future

### What symptoms should alert you to possible PTSD?

- The person has experienced an event which they perceive as traumatic
- Flashbacks of the event, vivid & sudden memories
- Nightmares of the event
- Inability to recall an important aspect of the event - psychogenic amnesia
- Exaggerated startle response, constantly living on edge
- Hyper-arousal, always on guard
- Hyper-vigilant, constantly looking around for trouble or stressors
- Avoidance of all reminders of the traumatic event
- Intense psychological stress at exposure to events that resemble the traumatic event

- Physiological reactivity on exposure to events resembling the traumatic event- panic attacks, sweating, palpitations
- Fantasies of retaliation
- Cynicism and distrust of authority figures and public institutions
- Hypersensitivity to injustice

### **Recommendations for Prevention or Treatment of PTSD**

The TABS website and manual provide information on topics such as multiple births, the importance of birth plans and treatment options. Antenatal recommendations include respect, dignity, continuity of care, acknowledgement, and the opportunity for debriefing, defusing, and reviewing. Postnatal recommendations include suggestions to look, ask, listen, be supportive and non-judgmental, have information available, and again the opportunity for debriefing, defusing, and reviewing. Health professionals should know where to direct mothers and their families for professional help and self-help.

### **CONCLUSION**

This article aims to alert Lactation Consultants to a disorder which occurs as a result of trauma around the time of childbirth. Hopefully this will assist Lactation Consultants in their understanding of why trauma prevention is the key; why it is so essential to be caring, respectful, and to communicate effectively; how PTSD (and Lactation Consultants) might affect breastfeeding; what factors we need to recognise; and where we can refer mothers and their families for further help. The material and assistance of TABS, specifically the personal contributions of the mothers is gratefully acknowledged.

### **REFERENCES**

Allen, S. (1998). A qualitative analysis of the process, mediating variables, and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, 16, 107-131.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (4<sup>th</sup> ed.). Washington, DC: Author.

Ballard, C.G., Stanley, A.K., Brockington, I.F. (1995). Post-traumatic stress disorder (PTSD) after childbirth. *British Journal of Psychiatry*, 166, 525-528.

Beck, C.T. (2004a). Birth trauma: In the Eye of the Beholder. *Nursing Journal*, 53 (1), 28-35.

Beck, C.T. (2004b). Post-Traumatic Stress Disorder Due to Childbirth: The Aftermath. *Nursing Journal*, 53 (4), 216-224.

Bremner, J., Randall, P., Scott, T., Bronen, R., Seibyl, J., Southwick, S., Delaney, R., McCarthy, G., Charney, D., and Innis, R. (1995). MRI based measures of hippocampal volume in patients with PTSD. *American Journal of Psychiatry*, 142 (4), 973-981.

Coleman, D. (1992). Wounds that never heal. *Psychology Today*, Jan/Feb, 62-67.

Crompton, J. (2002). Post-traumatic stress disorder and childbirth. *NZCOM Journal*, 26, 17-19.

Crompton, J. (2003). Post-traumatic stress disorder and childbirth. *Childbirth Educators New Zealand Education Effects*, Summer, 25-31.

Gamble (2002). J.A., Creedy, D.K., Webster, J., and Moyle, W. (2002). A review of the literature on debriefing or non-directive counselling to prevent postpartum emotional distress. *Midwifery*, 18, 72-79.

Reynolds, J.L. (1997). Post-traumatic stress disorder after childbirth: The phenomenon of traumatic birth. *Canadian Medical Association Journal*, 156, 831-835.

Strutman, R., and Bliss, E. (1985). Post-traumatic stress disorder, hypnotisability and imagery. *American Journal of Psychiatry*, 142 (6), 741-743.

Watson, S. (2004). TABS. Personal email correspondence, 22 March, 2004.

Weaver, J. (1997). Childbirth: Preventing post-traumatic stress disorder. *Professional Care of Mother and Child*, 7, 2-3.

