EMDR Therapy for PTSD Related to Childbirth Trauma

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There is no greater agony than bearing an untold story inside you.

-Maya Angelou-

The very most profound thing we have to offer our children is our own healing.

- Anne Lamott -

Objectives

Identify	Discover	Understand
Identify PTSD secondary to reproductive or childbirth trauma	Discover current research addressing treatment for childbirth trauma and needs for further research	Understand the basics of EMDR therapy and it's application to PTSD related to childbirth trauma.

Posttraumatic Stress Disorder (PTSD)

- **Directly experiences or witnesses the event**
- Presence of one (or more) **intrusion symptoms** associated with the traumatic event(s)
- Persistent **avoidance** of stimuli associated with the traumatic event
- **Negative alterations in cognitions and mood** associated with the traumatic event(s)
- Marked alterations in **arousal and reactivity** associated with the traumatic event(s)
- Can have a delayed onset (over 6 months) and/or a dissociative presentation (APA, 2013)

PTSD Related to Childbirth or Reproductive Trauma

- "Reproductive trauma" or "Perinatal Onset"
  - Fertility treatments, bleeding or other pregnancy complications, breastfeeding difficulty, NICU experience, experiences with hospital staff, postpartum complications, etc.
- Delayed onset (not all report traumatic or difficult childbirth but may go on to have PTSD symptoms later).
- *Trauma is in the eye of the beholder, it is subjective.*
- Independent of outcome *(i.e.* healthy/happy baby = traumatized unhappy mom*)*.

Perinatal Onset PTSD

- **Prevalence** – 12.3% of women in the general population and over 12% of pregnant women and 9% of postpartum women met criteria (Beck, 2013).
  - Upwards of 34% of women report having a traumatic birth (Beck, 2013)
  - As high as 41.2% reported with Latina adolescents (Anderson, 2010)
    - Inconsistency is due to various assessment measures used and timing of screening.
    - IES (Impact of Event Scale), Traumatic Event Scale – B, PCL-5 (PTSD Checklist)
- **Presentation**
  - Negative beliefs about self – powerless, control/safety, being a failure, defectiveness, shame
  - Feelings of being abandoned or neglected by provider, invalidated or unheard, bullied or coerced (into procedures), overpowered, assaulted and "raped" (even without prior sexual assault history).

Perinatal PTSD, continued.

Symptoms –	• Perseveration on baby's health (or own). • Avoidance of situations that serve as reminders of trauma (doctor's office or medical equipment, needles, sometimes breastfeeding or being touched).
General Themes -	• Loss of dignity, helplessness, horror, terror, shame *(Beck, CT. 2004)* • Being dehumanized, overpowered, lack of options/control and autonomy.
Triggers –	• Hospital or doctor's office, medical appointment, previously neutral noises that may approximate sounds in delivery (such as beeping) • Own body can be a trigger (i.e. menstrual cramps, breastfeeding or bleeding)
Impact on parenting, overlap with PMADs-	• Difficulty with attachment / bonding with infant (Arch Ped Adolescent Med, 2006) • Comorbidity with PMADs • Trauma in the partner who witnessed birth – relationship conflict • Delay / avoidance of subsequent pregnancy • Narrative of self-blame, etc. becomes created

Current Research on Treatment for PTSD Secondary to Childbirth Trauma

- **Narrative / Debriefing:**
  - Description of the event, a telling of one's story including the facts, emotions, thoughts, symptoms, etc.
  - Of 7 studies that were identified / reviewed (6 RCT and 1 pilot), Narrative / debriefing are inconclusively effective for PTSD after childbirth
- **CBT (Cognitive Behavioral):**
  - One of the most studied interventions for PTSD in the general population, more limited with this specific population
  - 2 case studies showing improvement in PTSD symptoms following a traumatic childbirth (Ayers et. al, 2007)
- **EMDR (Eye Movement Desensitization and Reprocessing) Therapy**

What is EMDR Therapy?
(Eye Movement Desensitization and Reprocessing Therapy)

- **History:**
  - Developed in 1987 by Francine Shapiro, PhD
  - Helps correct the way the brain stores a traumatic memory so that it is not "stuck in time"
  - Complete psychotherapy that also includes identifying any blocked memory processing
- **Typical memory / information processing:** When an experience is successfully processed, it's adaptively stored in the brain, integrating with other similar experiences about the self and others.
- **Traumatic memories:**
  - During heightened arousal, brain cannot process information as it does ordinarily.
  - Information processing system gets disrupted
  - One moment becomes *inadequately processed* and *maladaptively stored* - "frozen in time," in state specific form: original images, sounds, smells, feelings and thoughts (Shapiro, 2001)

EMDR, continued.

- **Modality:**
  - EMDR therapy uses standardized clinical protocols including alternating bilateral stimulation to aid in memory reprocessing (similar to REM sleep)
  - Normal information processing is resumed, and the memories become "unfrozen".
  - The memory is stored the way other memories have been stored in the brain.
  - Following a successful EMDR therapy session, a person no longer relives the images, sounds, and feelings when the event is brought to mind. You still remember what happened, but it is less upsetting.
- **EMDR reprocessing:** dual attention on a past and the present situation, combined with bilateral stimulation activates a process that allows connections to be made. Past disturbing memories are thereby neutralized and integrated with adaptive experiences

EMDR research on PTSD related to childbirth

- **Research findings:**
  - Successful psychotherapy for women suffering from a traumatic birth experience (George et al., 2013)
  - Reduction in PTSD symptoms, confidence in subsequent pregnancy (Stramrood, 2013)
- **Case Studies**:
  - 4 client case study: (Sandstrom, et al, 2004)
  - 2 client case study: (Stramrood, 2011)
  - 3 client case study following traumatic birth experiences: (Stramrood, 2012)
- **Post-treatment questionnaires:**
  - 26 women treated with EMDR for traumatic obstetric experiences were given questionnaires measuring PTSD, depression, anxiety, and quality of life. (van Deursen-Gelderloos & Bakker, 2015)

Where are we headed?

- **Current research:** OptiMUM study in Amsterdam - RCT providing EMDR therapy to pregnant women with PTSD diagnoses related to prior childbirth trauma (Baas, et al. 2017)
- **Limitations:**
  - Pilot studies, clinical experience, case studies
  - Need for more RCTs (randomized controlled trials) for this specific population

EMDR efficacy for PTSD (non-perinatal onset)

More than 30 RCT studies have been done on EMDR therapy, showing that 84-90% of single-trauma victims no longer have PTSD after treatment(Marcus, 1997), etc.

Preferable to CBT as PTSD symptom nonresponse to CBT is as high as 50% (Karr, 2011)

EMDR therapy is experienced as less intensive than prolonged exposure therapy by the patients; and that there is a faster reduction in symptoms compared to other treatments (Ho & Lee, 2012).

The following have endorsed EMDR therapy as an effective treatment for PTSD:

- International Society for Traumatic Stress Studies
- National Institute for Health and Clinical Excellence (NICE)
- U.S. Department of Veterans Affairs
- Department of Defense
- United Kingdom Department of Health
- World Health Organization (WHO)
- Israeli National Council for Mental Health
- U.S. Department of Health and Human Services (HHS)
- And many other international health and governmental agencies.

Clinical Cases

Case #1

- Client presenting with PTSD after c/s experienced the full pain (resistant to anesthesia). Feelings of powerlessness tied to cultural issues and prior memories of interactions with law enforcement
- Presenting issues:
  - Powerless, authority figures "I'm crazy, I have no voice / no agency"
  - Cultural issues, WOC
- Contributing factors:
  - Family of origin communication patterns
  - Workplace dynamics
- Improvement:
  - Primary: Reduction of PTSD symptoms related to her c/s
  - Family of origin and workplace underlying associations are continuing

Case #2

- Client presenting with PTSD after emergent c/s with good outcome. Thoughts of defectiveness and failure tied to memories from childhood and perfectionism.
- Presenting Issues:
  - Defectiveness, perfectionism "I have to succeed"
- Contributing Factors:
  - Workplace themes
  - Family of origin memories
- Improvement:
  - PTSD symptoms resolved
  - Subsequent pregnancy preparation

Case #3

- Client presenting with PTSD after difficult SVD, NICU involvement, pre-existing vaginismus. Significant conflict with husband / anger towards him presenting with lack of sexual intimacy and difficulty with communication. Started in treatment at 5 months PP - adjunct participation in PP support group and Zoloft.
- Presenting Issues:
  - Powerlessness, not in control, lack of trust, safety
- Contributing Factors:
  - Relationship with husband, communication and sexual intimacy
- Improvement:
  - Anxiety and PTSD symptoms have improved
  - Relationship improvements: reports significant "softening" towards husband after sessions recognizing anger and resentment throughout delivery process.

Resources

- http://www.birthtraumaassociation.org.uk/ Birth Trauma Association
- http://www.emdria.org/EMDR International Association
- http://pattch.org/ Prevention and Treatment of Traumatic Birth
- http://www.solaceformothers.org/ Solace for Mothers after traumatic birth
- http://www.tabs.org.nz/ Trauma and birth stress – PTSD after childbirth
- https://improvingbirth.org Improving Birth

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