Effects of Trauma during the Perinatal Period: Healing Through Eye Movement Desensitization and Reprocessing (EMDR)

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Abstract

This paper examines current literature about using EMDR to treat trauma during the perinatal period. Many women experience trauma before, during, and after childbirth. If left untreated, these women are at higher risk for perinatal mood disorders such as anxiety and depression. Furthermore, unresolved trauma during the perinatal period may have detrimental effects on infant attachment, relationship with spouse or partner, and negative self-perception. EMDR is an integrative psychotherapy that has been effective in the treatment of trauma. In addition to describing the therapeutic process of EMDR, this paper specifically discusses how EMDR is successful at promoting healing in women who have survived a traumatic experience during the perinatal period.
Effects of Trauma during the Perinatal Period: Healing Through Eye Movement Desensitization and Reprocessing (EMDR)

Childbirth represents a natural and positive experience in a woman’s life, but sometimes it is also a stressful event. Recent studies show that not only do negative child birth outcomes or severe pathologies influence mothers’ perceptions and psychological distress, but could also lead to the development of post-traumatic stress disorder (PTSD), which can have negative implications for the mother, father, and infant. Many studies have indicated that women with post-traumatic stress following childbirth usually do not recover spontaneously. Therefore, it is essential to develop more appropriate services and to provide effective treatment for post-partum women. Thus far, there is no standard intervention that has been proven effective for women with post-traumatic stress following childbirth because of insufficient research. However, EMDR has been shown to be an effective treatment for PTSD and thus may be effective for PTSD resulting in childbirth. This literature review examines the prevalence of trauma after child birth, identifies the role and effects of PTSD after childbirth, and presents current available treatment modalities. This paper glances at the Adlerian view of trauma through the lens of Individual Psychology and explains the process of EMDR and how it can helpful in healing trauma after a negative child birth experience. This paper will end with a brief description of how EMDR and Individual Psychology can blend together to create a treatment strategy for resolving child birth trauma.

**Perinatal Trauma**

**Prevalence**

The prevalence rates for posttraumatic stress disorder (PTSD) after childbirth range from approximately 2% to 9% (Beck, Gable, Sakala, & Declercq, 2011, p. 220). In a study by Beck,
Gable, Sakala, and Declercq (2011), it was found that as much as 9% of their sample of 1,373 women, screened positive for PTSD after childbirth. This result was determined by responses given by the PSS-SR. This is a self-reported measure, 4-point rating scale that was designed to assess the presence and severity of PTSD symptoms are present in an individual, as well as the severity of symptoms, if present. This assessment consists of 17 questions that coincide with the DSM-IV (American Psychiatric Association, 1994) diagnostic symptom criteria for PTSD. Three diagnostic categories are represented on the questionnaire: intrusion, avoidance, and arousal. A diagnosis of post-traumatic stress disorder was made when each participant reported they experienced at least one intrusion, three avoidance, and two arousal symptoms, as well as a total PSS-SR score of 12 or higher. This study also discovered that a total of 18 percent of women scored above the cut-off point of 12 or higher on the PSS-SR, which indicated they were experiencing an elevated level of post-traumatic stress symptoms (Beck et al., 2011, p. 222).

Interestingly, women tended to have the highest occurrence of symptoms in the arousal category at 14% (Beck et al., 2011).

Another study by White, Matthew, Boyd, and Barnett (2006) used this same assessment tool in addition to the Edinburgh Postnatal Depression Scale (EPDS). The EPDS on this assessment is a 10-item self-report screening measure for post-natal depression. White et al. (2006) determined the prevalence of PTSD after childbirth was found to be only 2% of all the mothers screened. This study assessed mothers with both questionnaires at multiple post-partum intervals; after birth, at 6 weeks, 6 months, and 12 months. “The prevalence of having a PTSD profile at 6 weeks post-partum was 2%” (White, Matthew, Boyd, & Barnett, 2006, p. 107). In addition, about 10.5%, reported experiencing symptoms of post-traumatic stress. However, these women did not meet the full criteria for PTSD diagnosis. This indicates that even though women
could not be fully diagnosed, trauma after childbirth, and corresponding distressing symptoms, still exists. While this may be true, another interesting outcome of research according to White et al. (2006) the prevalence of a PTSD diagnosis profile remained relatively stable across the first 12 months post-partum, with estimates being 2.6% of women at 6 months and 2.4% of women at 12 months (p. 107).

The aim of the study by White et al. (2006) was to investigate the extent to which symptoms of trauma and depression occur together in the postnatal period. In addition the researchers documented the prevalence and longitudinal development of PTSD after traumatic childbirth. White et al. (2006) reported that often times symptoms of post-partum depression (PPD) and PTSD overlap. This presents an issue when deciding the course of treatment for a woman experiencing distressing symptoms in the post-partum period. Prevalence rates have been significantly higher for PPD than PTSD. According to White et al. (2006):

This is most likely due to the fact that depression is a more common mental health condition, and inclusion of PTSD as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is comparatively recent. Similarly in terms of post-partum mental health issues, the general level of awareness of post-partum depression is much higher than that of post-partum PTSD. (White et al., 2006, p. 109)

From this particular study by White and colleagues, it was concluded that post-partum depression and PTSD often co-occur. This co-occurrence could make diagnosis and accurate prevalence rates of PTSD after childbirth difficult to ascertain. Interestingly, not only do depression and PTSD after childbirth co-occur, a study by Maggioni, Margola, and Filippi (2006) found symptoms of depression and anxiety can be a direct result of either a traumatic birth or an unexpected unmedicated birth.
Childbirth represents a natural and positive experience in a woman’s life, but sometimes it’s also a stressful event. Recent studies show that not only negative outcomes or severe pathologies influence mothers’ perceptions and psychological distress, but also normal delivery could assume a catastrophic trait and lead to post-traumatic stress disorder (PTSD) symptoms. (Maggioni, Margola, & Filippi, 2006, p. 81)

This is a thought-provoking discovery since it is often assumed that only women that experience a painful or control-less labor and birth are subject to PTSD. One can glean from this result that it is truly the perception a woman has of her birth experience that determines whether or not she feels it is traumatic. It is therefore essential to consider both obvious traumatic experiences and less obvious or ambiguous experiences when examining prevalence rates of PTSD after childbirth.

**Risk Factors**

There are many factors to consider that put a woman at risk for PTSD after childbirth. The overwhelming risk factor is subjective distress in labor (Anderson, Melvaer, Videbech, Lamont, & Jorgenson, 2012). “Negative emotions, distress, and a generally negative experience of labor” is often the lead contributing factor to PTSD after childbirth (Anderson et al., 2012, p. 1264). A feeling of loss of control, unexpected pain in labor, fearing for own life or baby’s life during labor, all contribute to a negative perception of the birth experience. These, in turn, put a woman at risk for developing PTSD symptoms. The second most important risk factor according to Anderson et al. (2012) is obstetrical emergencies. An obstetrical emergency includes emergency cesareans and vaginal delivery using vacuum and/or forceps. These emergency deliveries accounted for 9% of the women that developed PTSD in their study alone. Also included in risk factors for PTSD after childbirth include infant complications such as pre-term
labor, oxygen deprivation, and infants with weight and medical complications, as well as mental
difficulties such as depression, anxiety, and PTSD before or during pregnancy, and low support
during birth are also listed as major risk factors to developing PTSD after childbirth (Anderson
et al., 2012).

The results from Anderson et al. (2012) concurred with a previous study by Beck et al.
(2011). Results from Anderson et al. (2012) reported the most frequently reported risk factors for
posttraumatic stress disorder resulting from childbirth were high levels of obstetric intervention,
perception of inadequate support during labor, cesarean birth, prenatal depression, history of
prior counseling, and loss of control in labor (Beck et al., 2011). The outcomes of Beck et al.
(2011) study also supported other risk factors such as no private health insurance, unplanned
pregnancy, pressure to have an induction and epidural analgesia, planned cesarean birth, and not
breastfeeding as long as desired. In contrast to Anderson et al. (2012), Beck et al. (2011)
investigation found that planned cesarean birth, rather than unplanned cesarean birth, was also a
contributing risk factor. Their reasoning for this was that “women who [chose] a planned
cesarean may have issues such as fear of childbirth, a previous traumatic birth, or a high-risk
pregnancy” (Beck et al., 2011, p. 225). Beck et al. (2011) also found elevated postpartum
depression symptoms to be the strongest predictor of PTSD after childbirth.

Perhaps the most interesting and important risk factor occurred when a woman
experiences childbirth and perceives it negatively based on her expectations before the event.
Maggioni et al. (2006) assessed women’s expectations and perceptions of their birth experience
and how those expectations and perceptions related to developing PTSD symptoms. Maggioni et
al. (2006) summed the aim of this study by asserting:
Since expectations before an event could modify the perceptions, reactions, and satisfaction afterward, the representations of the idealized delivery were carefully analyzed…. Differences between expectations and the actual experience can affect women’s feelings and can produce adverse emotional outcomes such as disappointment, guilt, depression, and trauma. (pp. 81-82)

Unmet expectations of pain, as well as a woman’s perception of control (degree of how in charge the women felt over their birth experience) contributed greatly to developing PTSD symptoms after childbirth. Maggioni et al. (2006) reported that “women experiencing limited choices and limited control on decisions during labor and delivery have been associated with adverse psychological outcomes, such as PTSD” (p. 82). Feelings of disappointment that result from unmet expectations of support during labor and birth are also a major risk factor for PTSD after childbirth. In addition, Maggioni et al. (2006) expressed the “perception of inadequate support or feeling hurt or neglected by medical staff has emerged to be strong predictors of disappointment with childbirth and the onset of postnatal PTSD” (p. 83). Also, continuous support from partners and health professionals, who provide support, encouragement, help, and empathy, has been associated with higher satisfaction with a woman’s childbirth experience. Finally, this study also found personality and mental factors such as anxiety and depression are reported to influence PTSD (Maggioni et al., 2006). It was discovered that the rates of depression symptoms in women are between 12.5% and 9.7% and significant anxiety levels exist for 19.4% of women and 23.7%. (Maggioni et al., 2006). These women also experience PTSD symptoms (Maggioni et al., 2006).
PTSD after Childbirth

Definition of PTSD

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM V; American Psychiatric Association, 2013) is the most widely accepted nomenclature used by clinicians and researchers for the classification of mental disorders. Posttraumatic Stress Disorder (PTSD) is listed under the Trauma and Stress or Related Disorders in the DSM-5. This is a change from the DSM IV-TR (2000), which listed PTSD as an anxiety disorder. The diagnostic criteria for PTSD are (a) directly experiences the traumatic event, (b) witnesses the traumatic event in person, (c) learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental), and (d) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related) (American Psychiatric Association, 2013, p. 271). In addition,

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual’s social interactions, capacity to work or other important areas of functioning…. [It is] not the physiological result of another medical condition, medication, drugs or alcohol. (American Psychiatric Association, 2013, pp 271-272).

In terms of symptoms, four clusters exist: intrusion, avoidance, negative alterations are cognitions and mood, and alterations in arousal and reactivity (APA, 2013, pp. 271). One symptoms from each of the intrusion and avoidance categories must be present as well as two symptoms from each of the alteration categories. In addition to an individual experiencing symptoms, their symptoms need to be present for at least one month before a diagnosis can be made (American Psychiatric Association, 2013, p. 272).
According to McKenzie-McHarg (2004), “childbirth was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a recognized cause of post-traumatic stress disorder in 1994, and the disorder itself was described by DSM-III in 1980” (p. 219).

Unfortunately, there is no such specifier in the DSM-5. Currently, diagnosis is made based on the above criteria from the DSM-5. However, it is important to note that most of the literature presented in this paper uses the DSM-IV as diagnostic criteria for PTSD. As presented above, prevalence rates of PTSD after childbirth range from approximately 2%-9% at 6 weeks postpartum and rates of as high as 33% for woman that are partially symptomatic and do not meet full criteria for a diagnosis of PTSD. It is essential then, that childbirth should be considered a significant stressor and risk factor for developing PTSD.

**Symptoms of PTSD**

As indicated above, symptoms of PTSD can be grouped into four categories: intrusion, avoidance, cognitive and mood alterations, and hyper-arousal (American Psychiatric Association, 2013, pp 271-272). Intrusion symptoms are typically seen as flashbacks to the event, nightmares, and intrusive thoughts. Avoidance behaviors and changes in cognitions and mood present as staying away from places or activities that trigger reminders of the traumatic event, as well as emotional dissociation, feeling strong guilt, anxiety, depression, and difficulty recalling the event. Hyper-arousal symptoms typically manifest as being easily startled, feeling tense, irritability, and trouble sleeping (American Psychiatric Association, 2013, pp 271-272). All symptoms can impact functioning to the point of being debilitating. Symptoms of PTSD can affect relationships and self-perception as well as damage educational and vocational functioning (National Institute of Mental Health, 2012).
Symptoms of PTSD after childbirth. There are several ways symptoms are expressed in an individual with PTSD. However, some are specific to PTSD after childbirth. An article by Zimmerman (2013) stated there are three symptom categories that are affected dramatically by PTSD after childbirth, although to varying degrees depending on the individual. First, physical symptoms, include long-term pain from the birth itself (Ayers et al., 2006). Episiotomies, caesarean sections, and the need for pelvic reconstructive surgery can cause severe physical pain. Women who had a traumatic vaginal birth also reported to Ayers et al. a lack of vaginal sensation and physical deformation to the vagina. Extreme exhaustion and lack of energy is another common symptom for women with PTSD (Ayers et al., 2006)” (p. 63). Two, psychological symptoms such as depression, suicidal ideation/intentions, anger, fear of having another child, and negative perception of self may appear. Three, social symptoms include conflicted relationships with partner and child. Each woman experiences specific symptoms individually. Clinically, it is important to assess for these categories of symptoms. However, symptoms manifest differently for each woman (Zimmerman, 2013).

Current Approaches to Treatment for Perinatal Trauma

There are several current treatment modalities that could be used for treating PTSD after childbirth. Unfortunately, valid research on this population and effective treatment are relatively limited. In one study by Ponniah and Hollan (2009) considered PTSD as a whole without differentiating specific cause. They discovered evidence that trauma-focused cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) are efficacious and specific for PTSD (Ponniah & Hollan, 2009). However, when looking specifically at PTSD after childbirth, it has been indicated in several studies that CBT, EMDR,
and counseling have been successful treatment modalities. For instance, Lapp, Agbokou, Peretti, and Ferreri (2010) reported that overall, “women in the majority of the studies reported that they positively appreciated…interventions, suggesting that providing an opportunity for women to relate their childbirth experiences is worthwhile” (Lapp et al., 2010, p. 116). It seems from this evidence that giving women a chance to share their birth stories with a trained and competent therapist is therapeutic. In addition, there is evidence that the bi-lateral stimulation of EMDR, whereby the trauma can be desensitized and re-processed, can be helpful in alleviating PTSD symptoms.

**Counseling**

Professional guidance by a competent counselor in psychotherapy can be a supportive and therapeutic way to heal from trauma after childbirth. Professional counseling gives a woman an opportunity to share her birth experience and process through any traumatic occurrences. According to Lapp et al. (2009), healing from “PTSD rests on four fundamental components: psycho-education, exposure, cognitive restructuring and anxiety management training” (pp.115-116). The process the counselor uses to guide a woman through her experience is important, as some strategies can be unhelpful. McKenzie-McHarg (2004) asserted that welcoming women to tell their birth story soon after birth, as well as experiencing empathy from another person, disclosing feelings, and receiving social support can be helpful if done correctly and in the right time frame (p. 219). In some cases where psychotherapeutic treatment happened too soon after the birth or went too fast, actually caused harm and worsening of symptoms. Proper coping strategies, such as emotion regulation strategies and containment strategies (mentally putting away painful emotions until the woman is ready to deal with them), should be soundly in place before treatment continues. McKenzie-McHarg (2004) also found that for some women,
McKenzie-McHarg (2004) reported immediate counseling (<1 week post-partum) to be unhelpful, and in some cases hurtful, in treating trauma symptoms after childbirth (p. 220). An opposing view can be seen in an interesting study by Gamble, Creed, Moyle, Webster, McAllister, and Dickson (2005). For example, Gamble et.al. (2005) assessed a midwife led brief counseling intervention strategy for postpartum women as risk of developing trauma symptoms and PTSD. In total, 103 women met the criteria to participate in this study and all were randomized into an intervention (n=50) or a control (n=53) group. For the intervention group, each woman received face-to-face counseling within 72 hours after birth and again at 4 weeks and 6 weeks postpartum via a telephone session. The “main outcome measures were posttraumatic stress symptoms, depression, self-blame, and confidence about a future pregnancy” (Gamble et al., 2005, p. 11). Strategies in the intervention group are presented in the following Table 1.

**Table 1 Counseling Overview (p. 13)**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Key Element of Counseling Intervention</th>
</tr>
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<tbody>
<tr>
<td>Therapeutic relationship between midwife and woman</td>
<td>Show kindness; affirm competence of the woman, simple nontthreatening and open questions about the birth, attentive listening, and acceptance of woman’s perspective.</td>
</tr>
<tr>
<td>Accept and work with women’s perceptions</td>
<td>Prompt the woman to tell her own story, listen with encouragement but not interruption.</td>
</tr>
<tr>
<td>Support expression of feelings</td>
<td>Encourage expressions of feelings by open questions, actively listening; reflecting back the woman’s concerns.</td>
</tr>
<tr>
<td>Filling in missing pieces</td>
<td>Ask questions to determine if the woman is connecting current emotions and behaviors with the traumatic event(s). Acknowledge and validate grief and loss. Gently challenge and counter distorted thinking such as self-blame</td>
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and a sense of inadequacy. Encourage the woman to see that inappropriate or hasty decisions may be a reaction to the birth.

**Review labor management**

Ask if the woman thought that anything should have been done differently during labor. Offer new or more generous or accurate perceptions of the event. Realistically postulate how certain courses of action may have resulted in a more positive outcome. Acknowledge uncertainty.

**Enhance social support**

Initiate discussion about existing support networks. Talk about way to receive additional emotional support. Help the woman understand that her usual support people may be struggling with their own issues.

**Reinforce positive approaches to coping**

Reinforce comments by women that reflect a clearer understanding of the situation, plan for the way forward or outline positive action to overcome distress. Counter oblique defeatist statements.

**Explore solutions**

Support women to explore and decide on potential solutions, e.g., support group(s), further one-to-one counseling, seeking specific information, accessing the complaint system.

| The intervention group and control group had differing results. Results were measured at a 3 month postpartum follow up and revealed the women in the intervention group reported decreased trauma symptoms, lower risk of depression, lower risk of stress, and lower feelings of self-blame. Also, confidence about a future pregnancy was higher for these women than for control group women (Gamble et al., 2005). In addition, conclusions from this study confirmed to say that women have an overall positive reaction to brief counseling after their childbirth experience. These women also identified there is a “need for emotional support after a distressing birth experience” (Gamble et al., 2005, p. 17). In summary: |
Brief, midwife-led counseling intervention for women who report a distressing birth experience was effective in reducing symptoms of trauma, depression, stress, and feelings of self-blame. The intervention is within the scope of midwifery practice, caused no harm to participants, [and] was perceived as helpful, and enhanced women’s confidence about a future pregnancy. (Gamble et al., 2005, p. 17)

Alder, Stadlmayr, Tschudin, and Bitzer (2006) also supported a brief counseling intervention strategy for mothers who were at risk for trauma symptoms after childbirth. Their intervention process was similar to that used by Gamble et al. (2005) and consisted of a:

- 40-60 minute counseling intervention three days after birth and a supportive telephone interview 4–6 weeks postpartum. The intervention supported expression of the women’s perceptions and emotions about birth, clarification of misunderstandings and questions, enhancement of social support and coping strategies. (Alder, et al., 2006, p. 110)

The difference in this study was these women were offered counseling by a licensed therapist.

Results of this study found mothers in the intervention group had lower PTSD symptoms at 3 months after birth. Also, women in this group had lower depression scores and self-blame, as well has higher confidence about having children in the future at 3 months postpartum. The control group, however, did not differ in PTSD symptoms and qualified for diagnosis via the DSM-IV criteria. The conclusions were also similar to Gamble et al. (2005) in that there is “a need to process and reconstruct the exact course of the childbirth experience…in the days postpartum and can be considered as an adaptive, normal process” (Alder et al., p. 109).

**Cognitive Behavioral Therapy**

Cognitive Behavioral Therapy (CBT) can be described as a “form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors” (Duckworth &
Freedman, 2012). It is believed that by exploring these patterns of thoughts and corresponding beliefs, emotions, and behaviors, people experiencing mental distress can modify their thought patterns to improve coping and lower their symptoms. In fact, Lapp, Agbokou, Peretti, & Ferreri (2010) reported that CBT can be successful in treating individuals with PTSD. In addition to this, only one study is published to date that observed the effect of CBT on PTSD specifically after childbirth. Lapp et al. (2010) reported that each woman’s treatment involved reliving, exposure and cognitive reevaluation as well as going back to visit the hospital ward in which they experienced the traumatic childbirth. Another study by Ponniah and Hollan (2009) observed the effect of trauma-focused CBT on PTSD in general. In this study, the cause of the trauma was not considered in results. The researchers reported:

Trauma-focused CBT involves repeated exposure to the trauma memory in imagination or through the writing of a narrative, in vivo exposure to situations associated with the traumatic event that are objectively safe yet cause anxiety or are avoided, and/or challenging maladaptive trauma-related appraisals such as “I will never be able to trust anyone again” or “No place is safe” using techniques such as Socratic questioning and behavioral experiments.” (Ponniah & Hollon, 2009, p. 1087)

The results of their study indicated “repeated exposure to the trauma memory and/or in vivo exposure to situations avoided since the traumatic event was shown to lead to markedly greater improvements in PTSD symptoms than no treatment monitoring” (Ponniah & Hollon, 2009, p.1088). The results remained stable at 6-month, 1-year, and 5-year follow up assessments, providing long-term effectiveness of treatment.

In the context of CBT, trauma can be interpreted as the result of a shattered or broken assumption or core belief (Maggioni et al., 2012) “According to this theory, we all have a frame
of conceptions and assumptions concerning ourselves and the world: when these assumptions are shattered by a terrible event, the subjects will develop the symptoms of PTSD” (Maggioni, 2012, p. 86). In terms of the birth experience, many women have preconceived notions about what birth is and what to expect. For example, most women held beliefs about their ability to handle childbirth, which are shaped by their upbringing, the stories they were told about birth, the media, society, and, most importantly, individual perception of self. In CBT, these core about childbirth expectations and how women feel they have been damaged are assessed and healed through Socratic questioning, formulations, cognitive re-structuring/re-appraisal, re-framing, shaping, and exposure (Ponniah & Hollon, 2009).

More specifically, Ayers, McKenzie-McHarg, and Eagle (2007) examined at formulations and employed exposure therapy to heal trauma after childbirth. Ayers et al. (2007) described formulation as a way “to summarize important factors in the development of the problem, and to show how thoughts, emotions, and behavior interact to perpetuate [the] problem” (p. 182). In addition, formulations can also help inform women about the CBT model, understand how their current behavior preserves the problem. Formulations also help guide treatment (Ayers et al., 2007). This study examined two case studies in which both women had postnatal PTSD and used CBT as their treatment model. In addition to formulations, Ayers et al. (2007) used exposure intervention to lessen distress and heal traumatic memories of their birth experience. Exposure therapy involved both women visiting the labor and delivery ward of the hospital, which helped them confront the anxiety associated with the birth and therefore decrease their avoidance of reminders of the birth (Ayers et al., 2007). Furthermore, Ayers et al. (2007) emphasized the importance of sensitivity to each woman’s experience of birth. They state that treatment for each woman should be tailored to fit the needs of the client and proceed at a pace
that is comfortable for the client to avoid re-traumatizing. This study concluded that in the cases reviewed, CBT was an effective treatment. The researchers likened these case studies to postnatal PTSD as a whole and reported CBT to be effective in treating PTSD after childbirth (Ayers et al., 2007).

EMDR

Lapp et al., (2010) describes EMDR as “a multimodal, dual attention task whereby the participant focuses on their traumatic memories, emotions, and thoughts while engaging in bilateral stimulation such as eye movements, hand tapping or tones” (p. 116). The purpose of EMDR is to decrease emotional distress and to change the person’s negative perception and processing of the traumatic event with more positive or less emotionally charged thought processes. Limited studies exist that assess EMDR as effective treatment for PTSD after childbirth. However, there have been many studies that look at the effectiveness of EMDR with PTSD as a whole. A study by Ponniah and Hollan (2009) reported:

At a 6-month follow-up [for mixed-cause PTSD subjects], EMDR had the superior outcome. In studies that had diagnosis as an outcome measure, between 77 and 90% of EMDR patients no longer met diagnostic criteria for PTSD at the end of treatment in the analyses of completers.” (Ponniah & Hollon, 2009, p. 1103)

A research review by McGuire, Lee, and Drummond, (2014) directed their attention to studying the efficacy of EMDR treatment on PTSD specifically after childbirth. They believed that even though EMDR had been shown to be equal in achieving overall symptom reduction, it may be better than other treatment models in terms of treatment efficiency (McGuire et al., 2014). This is due to the fact that EMDR may have more rapid results in achieving intrusive symptom reduction than other treatment models, leading to fewer treatment sessions overall as well as less
time enduring PTSD symptoms. EMDR is has been shown to be effective at reducing intrusive thoughts or images. This in turn lowers distress and increases emotional regulation. A decrease in intrusive symptoms leads to the client feeling a sense of control. A perceived lack of control can cause PTSD in the first place (McGuire, Lee, & Drummond, 2014). As described previously, a perceived lack of control and negative perception of the birth experience, contributed significantly to a PTSD symptoms in women in the postpartum period. McGuire et al. (2014) further discovered that single case traumas (like in childbirth where it is an isolated single event) “have been shown to result in no longer meeting a diagnosis of PTSD after just a few sessions of EMDR” (p. 278). This is important since PTSD can have a negative impact on the mother’s ability to function and take care of her infant. If a mother can receive EMDR treatment and reduce trauma symptoms in less time, she has a better chance in bonding to her child and being an effective parent.

**Effects of Perinatal Trauma**

**Perinatal Mood Disorders**

PTSD after childbirth often co-occurs with other perinatal mood disorders. Most commonly, PTSD is closely tied with post-partum depression; so close in fact, that it can be difficult to discern a primary diagnosis since symptoms of PTSD and depression frequently overlap. According to Zaers, Waschke, and Ehlert (2008):

Depressive disorders are the most frequent psychiatric disorders of women after childbirth. The range of prevalence rates in the different studies on postpartum depression differ between 6% and 22% depending on the diagnostic criteria and the duration of assessment…. Criteria for the diagnosis are depressed mood, diminished interest or pleasure, weight loss or weight gain, appetite disturbance, insomnia or hypersomnia,
fatigue, agitation or retardation, worthlessness or guilt, problems concentrating, and thoughts of death.” (p. 62).

Along with depression; anxiety disorders, obsessive compulsive disorder, as well as alcohol and drug use are also found among women with acute trauma or PTSD after childbirth, especially if PTSD was present before birth.

A study by Onoye, Goebert, Morland, Matsu, and Wright (2009) found that out of 54 Caucasian, Asian, and Pacific Islander women, those with “PTSD and subclinical PTSD were more likely to also experience stress (73%), anxiety (64%), and depression (73%) during the postpartum period compared to those without PTSD” (p. 395). They also discovered that, “the best predictor for postpartum PTSD was prenatal PTSD as assessed in early pregnancy” (Onoye, 2009, p. 398). This particular study investigated the relationship between PTSD and the co-occurring behavioral risk factors of anxiety, depression, and alcohol and substance use. The researcher’s hypothesis, which turned out to be true, was that if PTSD existed at the onset of pregnancy, it was a predictor of increased risk for the aforementioned co-occurring problems.

The results of the research conducted by Onoye et al. (2009) showed that, of the women with PTSD, “…24% of the women screened positive for depression, and approximately 20% for an anxiety disorder” (Onoye et al., 2009, p. 396). In addition, Onoye et al. (2009) revealed, “women with prenatal PTSD at the initial assessment were more than 3 times as likely to have postpartum PTSD” (p. 397). Also, women with unresolved PTSD at the onset of pregnancy participated in binge drinking more often than those that did not have prenatal PTSD. Interestingly, it seems that, of the women with neither prenatal anxiety nor prenatal depression, were not predictive of postpartum PTSD. What can be gleaned from this research is that prenatal PTSD has a positive correlation with depression and anxiety. However, prenatal depression or
anxiety do not necessarily increase the risk for postpartum PTSD. Onoye et al. (2009) stressed the importance of treatment for PTSD either before pregnancy or very quickly after birth because maternal mental health is essential for positive child development.

Interestingly, not only does depression co-occur with PTSD, but the symptoms of these disorders have a lasting effect 6 weeks, and even 6 months postpartum. A study by Zaers et al. (2008), that examined the progression of depression and PTSD symptoms in women from third trimester in pregnancy to 6 months postpartum and established that depressive and post-traumatic stress symptoms were not found to decline significantly after birth. At six weeks postpartum, 22% of the women had depressive symptoms, with this figure remaining fairly stable at 21.3% after 6 months postpartum. In addition, 6% of the women studied reported PTSD symptoms at 6 weeks postpartum, with 14.9% reporting such symptoms at 6 months postpartum (Zaers et al., 2008). A total of 47 women participated in this study. The women completed a myriad of tests including the General Health Questionnaire, the State-Trait Anxiety Inventory, the Edinburgh Postnatal Depression Scale, and the PTSD Symptom Scale. The results of this study revealed the largest predictor of psychiatric symptoms in the postpartum period was anxiety in late pregnancy. Other predictors included psychiatric symptoms in late pregnancy, critical life events, and the experience of delivery. The researchers grouped women together according to depression and PTSD symptoms. They reported that 12% of these women suffered from PTSD and depressive symptoms after 6 weeks postpartum and 14.9% of these women after 6 months (Zaers et al., 2008). This stresses once again the importance for intervention quickly after birth to resolve trauma so symptoms do not persist and increase over time.

The two previous studies by Onoye et al. (2009) and Zaers et al. (2008) address aspects of how various prenatal psychiatric symptoms impact PTSD after childbirth. In the following
study by Ayers (2007), explored how thoughts and emotions during birth, as well as cognitive processing after birth, affect the development of PTSD and co-occurring psychiatric problems. Ayers (2007) observed a total of 50 women (n=25 women with PTSD; n=25 women without PTSD) in a qualitative study. Each woman was matched for obstetric occurrences to investigate nonmedical aspects of birth that made the birth experience traumatic for the mother. Each woman was interviewed 3 months after childbirth. Interesting results emerged from this study in terms of how cognitions played a role in whether the woman viewed her experience as traumatic. Themes that were noticed included “thoughts during birth included mental coping strategies, wanting labor to end, poor understanding of what was going on, and mental defeat” (Ayers, 2007, p. 253). As one can expect, more negative emotions were felt during birth with primary feelings of being “scared, frightened, and upset” (Ayers, 2007, p. 253). Ayers (2007) noted women with PTSD 3 months after childbirth reported feelings of “panic [and] anger,” and reported thoughts of “death, mental defeat, and dissociation during birth” (p. 253). Ayers (2007) concluded from this study that the results proved useful in identifying features of birth and postpartum processing that could lead a woman to develop PTSD after childbirth.

**Infant Attachment**

Psychiatric symptoms of PTSD after childbirth include hyper-arousal, dissociation, and flashbacks of the traumatic event (Ayers, 2007). If a woman develops PTSD after child birth, these symptoms can severely impact the mother’s daily functioning and ability to parent or have a relationship with her infant. Infant attachment to the mother is a major concern because the infant develops his or her sense of safety and belonging. With the mother being the primary caregiver in most cases, it is important to consider how PTSD that develops from a traumatic pregnancy or child birth experience affects infant attachment.
To date, there have been only a handful of studies that specifically look at the relationship between PTSD and infant attachment. One such study by McDonald, Slade, Spiby, and Iles (2011) examined how child birth related PTSD symptoms at 2 years postpartum correlated with self-reported parenting stress and the mother-baby bond. Eighty-one women were observed and measurements of PTSD symptoms were taken at 6 weeks and 3 months postpartum. These measurements were used as predictive associations with parenting stress and mother-infant relationship at 2 years postpartum. Since PTSD is highly correlated with depression, the authors predicted a negative impact on infant attachment since there are also indications that childbirth-related PTSD symptoms are associated with mothers having more negative perceptions of their children (McDonald et al., 2011). However, their research yielded only neutral results.

McDonald et al. (2011) stated that of all the research participants, 17.3% respondents reported some PTSD symptoms at a clinically significant level at 2 years postpartum. Yet, these symptoms were only ineffectually linked to parenting stress and were not related to mothers’ perceptions of their children. Earlier PTSD symptoms within 3 months of childbirth did “show limited associations with parenting stress at 2 years but no association with child relationship outcomes once current depression was taken into account” (McDonald, Slade, Spiby, & Iles, 2011, p. 140). An important association found in this study was, PTSD symptoms on both measures were related to the child being perceived as more difficult, but evidence for associations between PTSD symptoms and perceptions of the child as less warm or more invasive was unclear (McDonald et al., 2011). If a child is perceived as being more difficult, a negative perception of a child could possibly develop. This negative perception can lead to poor infant attachment if the mother is neglectful or abusive. Infants are completely dependent on an understanding and responsive caregiver to read their behavioral signals. Thus, the presence of
maternal postpartum psychological distress can exert a harmful effect on infant development, and may increase the potential for developmental, emotional, and behavioral difficulties in later childhood (Davies, Slade, Wright, & Stewart, 2008).

How mothers perceived their infants after a traumatic childbirth experience was the aim of a research study done by Davies et al. (2008). The authors hypothesized that psychological distress in the postpartum period could adversely affect the mother-baby relationship. Their goal was to explore whether or not PTSD symptoms related to labor and delivery were associated either positively or negatively with the mothers’ perception of her infant. The Davies et al. (2008) study was larger than the McDonald et al. (2011) study and involved 211 women who were assessed at 6 weeks postpartum for PTSD symptoms of hyper-arousal, avoidance, and intrusions, as well as mother’s perceptions of her infant. The women who met full or partial criteria for PTSD diagnosis perceived their attachment relationships to be “significantly less optimal and also reported more negative maternal representations in terms of their infants being less warm and more invasive. They also rated them as being temperamentally more difficult, prone to distress, and less easy to soothe (Davies et al., 2008, p. 536). If a woman concludes that the cause of her trauma during childbirth, and the subsequent emotional distress and detachment, was the child itself, she may feel resentment toward her infant. This plays a crucial role in early attachment of the mother-infant bond. This study found that a perceived negative experience whereby the child is the culprit to the trauma results in significant difficulties in attachment (Davies et al., 2008).

Nicholls and Ayers, (2007) predicted from previous research that postnatal psychopathology, such as depression or psychosis, results in poor mother–baby attachment in up to 25% of women with these disorders” (Nicholls & Ayers, 2007). These authors expanded their
research more than McDonald et al. (2011) and Davies et al. (2008) and included infant attachment with the father as well as the mother after a traumatic child birth experience. Each couple was interviewed as a unit and both partners were able to express their personal experience and their perception of their partner’s experience. They were asked to describe various facets of the relationship with their infant as well as discuss their birth experience. Nicholls and Ayers (2007) reported at least some aspect of the infant parent relationship was affected by those parents that perceived their birth experience as traumatic. Most qualitative comments made were typically spilt between positive and negative statements in regard to the perceived effect of the birth experience (Nicholls & Ayers, 2007). Also, Nicholls et al. (2007) reported differing attachment styles related to the parent-child bond by categorizing bonding styles of overprotective/anxious and avoidant/rejecting. An interesting side note of mothers that reported overprotective/anxious bonds and avoidant/rejecting bonds is that of these women, all commented on excluding their partners from sharing childcare responsibilities. From this research, one can conclude that a traumatic childbirth experience, especially if perceived as traumatic by both partners, can negatively impact the parent-infant attachment. It is clear, however, that more research needs to be done regarding the long-term effects of parent-infant attachment after a traumatic child birth experience.

**Couple Relationship**

Postpartum PTSD not only affects the mother, it affects the whole family. The mother’s birth experience and subsequent psychological problems from unresolved trauma can have an impact on how her partner feels as well. In fact, a number of studies suggest that postnatal co-morbidity exists in couples. For example, Ayers, Wright, & Wells (2007) found that, while mothers had a higher prevalence of depression than fathers, a father was significantly more likely
to experience depression if his partner experienced depression. The manner in which traumatic child birth affects the family as a unit is an important point to consider because it could have possible negative effects on the couple relationship as well as infant attachment.

Nicholls and Ayers (2007) researched the experience and impact of childbirth-related PTSD on women and their partners. In this study, six couples were interviewed where one partner had clinically significant symptoms of child birth-related PTSD. After interviews were conducted, four central themes contributed to a perceived traumatic birth experience and corresponding marital issues. These identified themes were (a) birth factors, such as negative emotions in labor and lack of control or choice; (b) quality of care, such as birth environment and staff; (c) effects on relationship with partner, including physical relationship, communication, and support; and (d) effects on parent-infant relationship (Nicholls and Ayers, 2007). Women reported that PTSD “affects their sense of self, that they have less patience, have feelings of anger, anxiety, depression, find it hard to sympathize with others’ problems, feel isolated from their infant, fear future pregnancy and report that it affects social relationships” (Nicholls & Ayers, 2007, p. 492). The authors speculated these symptoms, as well as avoidance, “may lead to the mother not bonding with the infant or, conversely, that hyper-arousal and vigilance may lead to an over-anxious or protective parenting style” (Nicholls & Ayers, 2007, p. 492). Nicholls and Ayers (2007) wanted to invite the perspective of the partner (father) in their research. Interestingly, their case studies that suggest male partners can be impacted by a negative birth experience, particularly subsequent postpartum anxiety (Nicholls & Ayers, 2007).

Nicholls and Ayers (2007) stated that the main effects on the couple relationship were the physical relationship, communication within the relationship, conflict, emotions within the relationship, support from partner, coping together as a couple and overall effects on the
relationship (Nicholls & Ayers, 2007). Effects on the physical relationship included avoiding sex because it was a reminder of the childbirth event. Sexual intimacy often triggered flashbacks or traumatic memories and also motivated a need to protect a “battered and bashed” body and avoid pregnancy (Nicholls & Ayers, 2007, p. 499). Communication issues included avoidance of talking about the birth and associated challenges. The authors reported that, even when couples did discuss the traumatic event, the problems were not necessarily resolved. Coping strategies for couples were also mentioned.

Women talked about barriers to coping together, such as a lack of time together as a couple resulting from childcare demands, balancing work and home life and/or having little social support, meaning that couples had little time to talk to one another or take time out. (Nicholls & Ayers, 2007, p. 501)

Intriguingly, if partners shared their experience and each person helped the other in coping, a more positive outcome was observed with less damage to the marital relationship. Perhaps what can be surmised from this research has positive implications for couples and family therapy. If the couple is given a safe space to express their thoughts and feelings related to their birth experience and changing relationship, perhaps these couples would experience a more positive outcome whereby communication and closeness are increased.

In support of Ayers and Nicholl’s (2007) research, another study by Ayers, Wright, and Wells (2007) highlighted how the couple relationship is affected by a traumatic child birth experience, especially if PTSD is present. Sixty-four couples participated in this study and completed questionnaires about birth, symptoms of PTSD, the couple’s relationship, and the bond between parent and infant at 9 weeks postpartum. Out of the 64 couples, 5% of the men and women reported severe symptoms of PTSD. Ayers et al. (2007) hypothesized that postpartum
PTSD would negatively impact the couple relationship. Their reasoning for this hypothesis was born out of research indicating a strong link between postpartum depression and anxiety. Both diagnoses are both highly correlated with PTSD and associated with poor marital relationships.

Importantly, Ayers et al. (2007) reported the couple’s communication and sexual function may be the most impacted. The researchers claimed a traumatic pregnancy or childbirth experience may trigger a fear of sex and subsequent pregnancies and childbirth. Interestingly, the researcher’s findings showed a null association between PTSD and the couple relationship. This is in contrast to their hypothesis and previous research findings that postpartum psychopathology could be harmful to the couple relationship. Nonetheless, it is still essential to consider how PTSD after childbirth affects the whole family unit rather than just the mother (Ayers et al., 2007).

**Adlerian Perspective of Trauma**

**PTSD and the Lifestyle**

Alfred Adler (1870-1937), a medical doctor turned psychiatrist in the late 1800s, developed the theory of individual psychology in the early 1900s. In his theory, individual means indivisible or undivided rather than single or one-of. This means that all aspects of a person are considered and are then conceptualized into a *lifestyle*. Adler also emphasized nurturing feelings of significance, belonging, and safety as well as improving the human experience through social interest. Inevitably then, the individual feels a part of society and contributes to the common welfare of others.

PTSD can have serious consequences for both the individual and society. If a woman or her partner suffers from unresolved trauma from childbirth, it can negatively impact her relationship with her infant, possibly leading to insecure attachment. Insecure attachment on the
part of the infant will undoubtedly affect the relationships he or she has as they grow and become members of society. Insecure attachment to a primary caregiver can lead to feelings of low self-esteem and dysfunctional attitudes toward others. Both low self-confidence and dysfunctional attitudes become part of the lifestyle of that individual and can result in maladaptive behavior and self-interest rather than social interest. Only the good of the individual is considered, rather than a collaboration with the needs of others. If even a small portion of caregivers with PTSD go untreated, it can have severe consequences for their lives, the lives of their infants. These problems can ripple out into society as a whole.

Individual psychology considers all behavior, and thus all mental health symptoms, as purpose driven and goal directed (Hjertaas, 2013). This teleological movement, as well as the individual’s perception of life events to fit into their lifestyle, is central to the Adlerian view of trauma. In a pathological interpretation, symptoms are understood as being caused directly from an external event. To individual psychology, the truth is more complex than that. Hjertaas (2013) states, “Adler seemed to wonder less about the disturbing event itself and more about why a particular, unique human being becomes fixated on a disturbing experience while another does not” (p. 187). Furthermore, Adler said:

No experience is a [direct] cause of success or failure. We do not suffer from the shock of our experiences—the so-called trauma—but we make out of them just what suits our purposes….There is probably always something of a mistake involved when we take particular experiences as the basis for our future life. (Hjertaas, 2013, p. 187)

Adler developed the opinion that a neurosis (symptom) develops not because an individual experienced something but because of a failure in the style of life and the meaning the person ascribes to the traumatic event (Hjertaas, 2013). The attributed meaning of the trauma to the
individual is born out of the mistaken convictions (beliefs) about themselves, others, and the world. These mistaken convictions, or core beliefs, seem to directly affect the development of PTSD. A Hjertaas (2013) points out that a traumatic event can destroy a person’s optimistic core beliefs about self, others, and life. This shattering of beliefs inevitably makes the person confront a reality that was previously denied or unavailable for the person to recognize.

Understood teleologically, the symptoms of PTSD (such as heightened anxiousness and physiological hyper-arousal; flashbacks; and, in part, nightmares) could be viewed as the individual’s neurologically linked “alarm system” signaling (incessantly) that life is more dangerous than first thought and that one might not be able to effectively meet such a threat” (Hjertaas, 2013, p. 192).

Another concept important for understanding trauma are feelings of inferiority. The helplessness often associated with experiencing the trauma can increase or activate feelings of inferiority or inadequacy. This sense of helplessness and feeling less than is key to developing PTSD (Hjertaas, 2013). Along with a sense of helplessness, an intense fear of witnessing or re-living the traumatic event exists. According to Adler, “the moment of a major traumatic event is perhaps the ultimate experience of inferiority from which individuals attempt to maintain well-being through "an oversized safeguarding component" (Ansbacher & Ansbacher, 1956, p. 263). Hjertaas (2013) points out that PTSD can be both devastating to the life of the individual and those close to him or her. PTSD can also negatively impact many areas of functioning, such as having a sense of safety, self-efficacy, and self-worth, as well as trusting other people, and being able to be intimate (Hjertaas, 2013).

A woman with PTSD after childbirth often experiences a loss of sexual desire or a fear of intimacy because this could lead to a pregnancy. Therefore her birth experience is where the
origin of her fears exist. Also, how a woman perceives herself and her own empowerment can be severely affected by a traumatic child birth experience. This lack of empowerment may cause her to question her own physical and emotional strength and her adequacy as a woman. Furthermore, the impact may be greater if her lifestyle revolved around perfection, control, or power.

**Treating Trauma from an Adlerian Perspective**

Millar (2013) stated that central to Adlerian theory, control, connection, meaning, and a sense of worth and belonging are essential to all humans for their survival. The Crucial Cs model (connect, capability, and count or to matter) was developed to describe the essential needs each individual must possess in order to feel emotionally healthy and whole (Millar, 2013). A fourth ‘C,’ Courage, was added and lends the individual the ability to handle challenges in a positive and socially useful manner (Millar, 2013, p. 246). All four Crucial C’s are essential for treatment of PTSD. In his article, Millar (2013) emphasizes a bio-psycho-social approach to treating PTSD through the lens of individual psychology.

In the process of therapy, a few Adlerian concepts frame the course of treatment. These concepts include: holism, social embeddedness, which refers to the person’s feeling of belonging to a group or community, and purposive behavior. In individual psychology, the person is always viewed as an indivisible unit (Millar 2013). The individual needs to be understood holistically because every biological, psychological, and social aspect is animatedly connected (Millar, 2013). Individual psychology also takes the optimistic view that the potential for community feeling (Gemeinschaftsgefühl) is within each individual and that it forms the foundation for mental health. Social embeddedness or social interest is dependent on the person’s experiencing of a sense of belonging as a social equal, as well as the ability to find ways to contribute usefully to their community (Millar, 2013). A positive sense of belonging is correlated with a greater
ability to handle stress. Since processing trauma can be stressful, a strong communal bond should be in place for therapy to continue. According to Millar (2013), a central aspect of trauma therapy should revolve around building on a person's experience of social connection and feeling bonded to their community.

Millar (2013) quoted Adler as saying, "No experience is a cause of success or failure. We do not suffer from the shock of our experiences—the so-called trauma—but we make out of them just what suits our purposes" (p. 208). A pillar of individual psychology is the concept of goal-directed or purpose driven behavior. These goals of behavior are not always conscious. Rather, they are often embedded deep in the person’s subconscious and directed by the person’s lifestyle. Millar (2013) developed an approach to treating trauma that considers the notion that:

We are not pushed by causes, but [rather] pulled by our self-created goals and dynamic striving. Adler's view of goal-directed behavior invites the practitioner to understand the person's behavior holistically in terms of his or her lifestyle, rather than perceiving a childhood abuse history or traumatic events as causal to the person's behavior. (Millar, 2013, p. 253)

According to Adler, if the traumatic event remains “un-integrated with the lifestyle, it will be re-enacted in various situations, and it will affect a person's psychological movement and interactions, essentially becoming a psychological tumor” (Millar, 2013, p. 252). This psychological tumor will divert the person’s purpose of their behavior, typically toward maladaptive or dysfunctional actions. In addition to goal-directed behavior, Millar (2013) considered the person’s subjective experience and creative interpretation assigned to the event. Adlerian psychology accentuates the theory that it is not the traumatic event that is important. Rather, it is the creative meaning or creative perception the person devotes to the event.
According to Millar (2013), “[individual psychology] provides an optimistic view of therapy, where the client is not a helpless victim but an individual with a considerable capacity for adaptation and a wish to overcome and survive (p. 253).

Four pillars of treatment exist in Millar’s approach. These include (a) safety and stabilization, (b) dual awareness, (c) remembering and processing through trauma memories, and (d) integration with family and daily life. The first crucial phase in treating PTSD is safety and stabilization whereby the therapist and client build a strong, trusting relationship and coping strategies are established. Since a traumatic event destroys the persons feeling of personal safety, this first phase of therapy is essential so re-traumatization does not occur. The therapist should not only maintain a safe environment for therapy to unfold, but should also make sure supports outside the therapy office are established and social connection utilized. In addition, the therapist and client should establish and practice coping strategies to lower emotional flooding. These processes could include grounding and anchoring strategies such as identifying the locations where each body part is touching, deep breathing, or guided visualization exercises (Millar, 2013).

Dual awareness refers to the person’s capacity to “integrate both internal and external sensory stimuli” or “integrating the experiencing self with the observing self” (Millar, 2013, p. 251). Fascinatingly, Millar (2013) described the neurobiological perspective of trauma by explaining when a trauma occurs, the body’s alarm systems are activated leading to a shift from the frontal regions of the brain that are responsible for logic, reason, and advanced motor function to the ‘survival’ or “nonverbal subcortical regions (p. 251). The non-verbal subcortical regions include the amygdala, thalamus, hippocampus, hypothalamus, and brainstem (Millar 2013). When the brain shifts into survival mode, it is almost impossible to process and integrate
the traumatic event and subsequent memories into conscious and logical mental frameworks. The event then lives in these nonverbal areas of the brain. The individual cannot make sense of the trauma. People often feel “stuck” and unable to effectively process what happened to them. They are left with only emotions, images, and bodily sensations. To help move the client from the survival brain back to the logical brain, Millar (2013) emphasized the importance of helping the client find adequate vocabulary for overwhelming body sensations and emotions occurring at moments of severe disturbance of the trauma.

This involves rebuilding the normal skill of dual awareness described to clients as building a bridge in the brain. The integration of body sensations, thinking, and feeling helps the client develop a greater ability to self-regulate intrusive thoughts, images, or sensations, which may be expressed in the form of sudden panic, flashbacks, and dissociative states. (Millar, 2013, p. 252)

Millar (2013) reported he would facilitate dual awareness by grounding or anchoring strategies. Examples include “enabling clients to focus on the therapist or specific items in the therapy room; asking clients to describe what they are experiencing in their bodies; and confirming for clients where they are right now and that they are safe” (Millar, 2013, p. 252). In essence, the process of dual awareness requires the person to actively identify physical sensations and emotional responses and, at the same time, connect to what they are observing around them.

Remembering and processing trauma memories is the third pillar of treatment according to Millar’s model of trauma therapy. Interestingly, the goal of this process is not working through or desensitizing trauma memories. Rather, assessing and connecting the person’s lifestyle and core beliefs to heal trauma is emphasized. As stated previously, Adlerian psychology does not believe that the traumatic event caused the person to develop PTSD. It is
the meaning the person gives to the event that dictates their subsequent thoughts, emotions, and behaviors. To facilitate finding the attributed meaning the client bestowed on the traumatic event, the therapist and client should first identify strengths and resources that are unique to the client. These strengths and resources can be found by client self-report and non-traumatic *early recollections* (a specific memory that is recalled before the age of 8). Once these are established and dual awareness is assimilated, the client is stable enough to begin work on his or her memories. According to Miller (2013) “the therapist should encourage [the client] to keep within a ‘window of tolerance.’ This is about finding the right balance between some heightened arousal as he or she recalls the memory and a sense of safety” (p. 256). As the client processes traumatic memories, he or she is constantly reminded of his or her strengths and resources. Therefore, using the client’s strengths and resources, provides encouragement and a sense of empowerment and healthy control.

The fourth and final of Millar’s model is integration with family and normal daily life is stage. This process involves the “rebuilding [of] personal and community connection, regaining a sense of capability, experiencing making a difference, and facing obstacles with courage” (Miller, 2013, p. 258). All of these aspects are essential to working through and healing from traumatic experiences and reorienting back to a sense of belonging, safety, and significance. These are the three universal goals all people strive toward. Attaining belonging, safety, and significance can result in positive change and a new optimistic outlook on life.

**Eye Movement Desensitization and Reprocessing (EMDR)**

**History**

Eye-movement desensitization and reprocessing (EMDR) was developed by Francine Shapiro in 1987. The goal of EMDR therapy is to desensitize patients to anxiety and other
intense emotions and integrate information processing. Chen et al. (2014) stated, “Adaptive information processing is the theoretical framework for EMDR, because it addresses factors related to both pathology and personality development” (Chen et al., 2014, p. 1). Moreover, adaptive information is responsible for repossessing information from previous traumatic experiences and integrating them into a positive emotional and cognitive schema (Chen et al. 2014). When a person experiences a traumatic event, which is highly emotionally charged, the information processing system of the brain is overwhelmed. The brain has a difficult time integrating traumatic memories and storing them in an adaptive way. Instead, they are stored in the ‘reptilian’ or ‘survival’ part of the brain, the limbic system. Therefore, dysfunctionally stored traumatic memories may lead to maladaptive coping strategies. These strategies are what manifest as symptoms of PTSD; nightmares, hypervigilance, avoidance, etc. EMDR is used to correct this broken process. EMDR helps trauma survivors access and process traumatic memories so they can be brought to an adaptive resolution (Solomon, Solomon, & Heide, 2009).

An integral aspect of EMDR therapy is a dual-attention stimulus such as eye movement or use tapping one’s legs on the right then left in tempo. The purpose of the dual-attention stimulus is to activate adaptive information processing and induce physiological responses. According to Chen et al. (2014):

Eye movements may unblock the information-processing centers of the brain, creating a connection between stored information on previous events and adverse outcomes that is used to generate a response to a current stimulus. Subsequently aroused relaxation responses or a new series of physiological responses reconnect to the stored information on previous adverse experiences, and the new information is reintegrated. (p. 1)
It is thought that the sensory information given by bilateral stimulation, “alternately stimulates the right and left sides of the brain, forcing a shift of attention across the midline” (Solomon et al., 2014, p. 395). This shift allows for a correction in the information integration process. Thus, what was once a disturbing and emotionally charged memory becomes a properly adapted story. Solomon et al. (2009) explained this phenomenon:

Disturbing memories are usually processed by thinking, talking, and sometimes dreaming about the experience. As the brain slowly processes the memory, it is transferred to the left cerebral cortex where it is filed away along with other memories and becomes part of one’s life story. As with neutral memories, the stored information can be retrieved when needed to understand new experiences (p. 393).

Solomon et al. (2009) further researched the effectiveness of EMDR and found EMDR was a superior treatment for trauma. In the study, EMDR was measured against behavior therapy and medication. The results indicated that EMDR was more effective than medication or placebo in achieving sustained decreases in the symptoms of PTSD and depression (Solomon et al., 2009). Interestingly, at a 6-month follow up, researchers found 75% of the trauma survivors were not experiencing symptoms of PTSD and depression compared to 100% of the medication group who experienced PTSD and depression symptoms. Also, it was reported that EMDR was a more efficient treatment compared to behavior therapy with satisfactory results obtained more than 30% of the time (Solomon et al., 2009). In other words, EMDR worked faster and just as well as behavior therapy. If EMDR was done in conjunction with behavior therapy, the outcomes improved with longer remission of symptoms (Solomon et al., 2009).
Process

The EMDR treatment process is unique in that it uses a phase-structure and combines an external stimulus to accompany the processing of internal perceptions of the trauma. This external stimulus, also called bi-lateral stimulation, is usually in the form of tapping of therapist’s hands on client’s knees or ankles, audible tones in the right and left ear, or hand movements back and forth in front of the client’s eyes. EMDR treatment progresses through chains of associations that are tied to co-occurring sensory, cognitive, and emotional states. McGuire, Lee, & Drummond (2014) stated, “The individual is encouraged to ‘let whatever happens happen and just notice’ when freely associated memories enter into the mind though imaginal exposure in short bursts” of 20-50 seconds (p. 274). After 20-50 seconds of free-association, the bi-lateral stimulation is paused and the client is asked to process through any changes of cognitive, emotional, or sensory perception. Over time, the perception of the event changes and emotional ties are removed. Therefore, the treatment process reduces the emotional attachment the client has toward the traumatic event and decreases symptoms of PTSD.

Consistent with McGuire et al. (2014), EMDR utilizes an eight-phase treatment protocol that addresses past, present, and future experiences and behaviors. In addition to a standard treatment protocol, specific protocols exist to treat certain types of trauma. For example, there is a treatment protocol for early childhood trauma as opposed to trauma that happened later in life. Table 1.2 lists the standard protocol for EMDR (McGuire et al., 2014).
Table 1.2 Standard Treatment Protocol for EMDR

<table>
<thead>
<tr>
<th>Phase #</th>
<th>Phase Title</th>
<th>Description of Phase</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>History</td>
<td>Obtain client history and identify if client is a good candidate for EMDR.</td>
</tr>
<tr>
<td>2</td>
<td>Preparation</td>
<td>EMDR process is explained; containment strategies are taught.</td>
</tr>
<tr>
<td>3</td>
<td>Assessment</td>
<td>Target memory identified; identify negative beliefs rooted in the experience; baseline reactivity assessed.</td>
</tr>
<tr>
<td>4</td>
<td>Desensitization</td>
<td>The disturbing experience and present stimuli that trigger the past experience are processed. Client holds traumatic memory in their mind with the associated negative belief, feelings, and sensations in the body while focusing on an external stimulus (tracking therapist’s fingers back and forth, listening to tones on right and left ear, and/or tapping on client’s legs/feet), for 20-50 seconds of bi-lateral stimulation. Client is then asked to process the changes the client is experiencing. This begins the process of adaptive information processing and thus adaptive resolution as the client experiences changes in emotions, cognitions, and bodily sensations.</td>
</tr>
<tr>
<td>5</td>
<td>Installation</td>
<td>Identifies the most desired positive belief about self. Using the same bilateral stimulation as the desensitization phase, the therapist helps the client increase the connection of the new positive cognition with existing positive cognitive networks.</td>
</tr>
<tr>
<td>6</td>
<td>Body Scan</td>
<td>Focus on any residual sensory perceptions. Therapist will ask the client to focus on the original trauma memory while scanning the body from head to toe, looking for any lingering tension or resistance in the body. Any tension is targeted with bilateral stimulation until it is resolved. This phase is essential to truly resolve trauma.</td>
</tr>
<tr>
<td>7</td>
<td>Closure</td>
<td>Brings client back to emotional equilibrium. Relaxation and containment techniques are practiced.</td>
</tr>
<tr>
<td>8</td>
<td>Re-evaluation</td>
<td>Check to see if client has maintained positive results. Based on re-assessment, the trauma memory from the past session may be targeted again until resolution is reached, or therapist and client will move onto a new target memory.</td>
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Effects of EMDR on Treatment of Perinatal Trauma

Limited research has been done on the efficacy of EMDR treatment for PTSD resulting from childbirth. Two articles were found that studied the effects of EMDR treatment on women who developed a PTSD diagnosis after childbirth. Both studies yielded similar results and had relatively small pools of participants. The first study by Stramrood, van der Velde, Doornbos, Marieke-Paarlberg, Weijmar-Schultz, and van Pampus, (2012) included three women who each carried a PTSD diagnosis that resulted from a traumatic childbirth experience. Patients A, B, and C had differing experiences and perceptions of their birth experience. However, each woman
experienced varying degrees of PTSD symptoms including avoidance, hyper-arousal, and intrusion. Stramrod et al. (2012) wrote:

Patient A developed posttraumatic stress symptoms following the lengthy labor of her first child that ended in an emergency cesarean section after unsuccessful vacuum extraction. Patient B suffered a second degree vaginal rupture, resulting in pain and inability to engage in sexual intercourse for years. Patient C developed severe preeclampsia postpartum requiring intravenous treatment. (p. 70)

All three women underwent EMDR treatment during their second pregnancy using the standard EMDR treatment protocol. Results indicated a reduction in stress symptoms and increased confidence about their current pregnancy and upcoming delivery. Additionally, these women looked back at their second birth experience with less distress despite complications. The authors concluded that all three women felt more confident to ask for a vaginal birth rather than demand an elective cesarean. Based on the results of this study, Stramrod et al. (2012) also recommended a large scale randomized controlled clinical trial to examine the effects of EMDR treatment with this population.

The second study by Sandstrom, Wiberg, Wikman, Willman, and Hogberg (2008) observed a slightly larger participant sample. Four women with a PTSD diagnosis that resulted from childbirth were given EMDR treatment during the post-partum period. One of the women was pregnant and three were not pregnant at the time of the study. All four women were given follow-up assessments at 1 and 3 years after EMDR treatment. The authors alleged that all participants reported reduction of post-traumatic stress after treatment. After 1–3 years, the beneficial effects of EMDR treatment remained for three of the four women. Symptoms of intrusive thoughts and avoidance seemed most responsive to treatment (Sandstrom, et al., 2008).
These authors also recommended a larger scale study to look at the efficacy of EMDR treatment for this population.

**Integrating EMDR and Individual Psychology into Therapeutic Practice**

EMDR is a complimentary therapy tool that can be used in addition to individual psychology in the treatment of healing trauma after child birth. One of the largest contributing risk factors in the development of PTSD after childbirth is a negative perception of the event. In Adlerian theory, less interest is given to the diagnosis and emphasis is placed on the client’s perception, negative beliefs, and emotional attachment the client places on the traumatic event. In this way, individual psychology may be helpful in identifying and assessing the client’s core issues related to the traumatic experience. EMDR also assesses for and helps to correct these negative beliefs or error messages by allowing the client to process the memory of the trauma with the goal of turning a negative perception into a positive or neutral one.

Both EMDR and individual psychology emphasize a holistic view of the client and thus takes into consideration not only what the client thinks about the event, but also the emotional attachment and physical sensations that accompany the traumatic memory. Individual psychology takes the holistic outlook one step further and assesses how the person’s lifestyle affects their perception of the trauma. Both treatments also emphasize and teach dual awareness and containment strategies to help keep the client within a tolerant range of emotions or sensations during sessions (Millar, 2013). This helps the client with self-awareness and increases insight.

In the various studies presented, women commented on how the opportunity to share their experience was helpful in healing from their experience, especially in the presence of other women with similar experiences and with a competent counselor or therapist. Both treatment
modalities allow for reflection about the traumatic event and give the client the opportunity to process through the experience at their own pace. This writer plans to implement both treatment modalities within practice when working with this population.

**Conclusion**

It is clear from this literature review that more research is needed regarding the impact of PTSD after child birth, as well as the efficacy of EMDR treatment for this population. However, one can also glean from this review that a negative child birth experience, whereby the mother perceives the event as traumatic, can have detrimental influences on mother’s psychological distress, her ability to cope with motherhood, and the family unit as a whole. In addition, PTSD after child birth is often left only partially or completely untreated. A combination of individual psychology and EMDR therapy could possibly lead to a reduction or remission of PTSD symptoms and allow the woman and family to heal from a traumatic child birth experience, if done properly. Women of this population need and deserve effective treatment so they can live their lives fully and enjoy raising their children.
References


