Medications and More Newsletter

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Notes from the Editor:

Are you planning a conference? Do need a speaker who will wow your audience? Check out LactSpeak at www.lactspeak.com.

LactSpeak offers a variety of lactation experts who speak on various topics. Their canned presentations are listed, along with the time of each session. Many will prepare presentations to your specifications.

In addion, LactSpeak offers event planning forms, an event planning timeline, how to find a speaker, how to promote your speaker, speaker tips, and facility tips. They also have a listing of upcoming conferences featuring LactSpeak speakers.

The Hartmann/Hale Human Lactation Research Conference starts on Monday, Oct. 1. We hope to see you at the conference. If you attend the conference, please stop by the bookstore booth and tell us hello. We look forward to meeting all of you. If you are not able to attend, check our website (www.ibreastfeeding.com) after the conference for highlights.

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Guest Author

Diagnosis and Treatment of Posttraumatic Stress Disorder (PTSD): Compatibility of Treatment Choices with Breastfeeding

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Traumatic events are relatively common in the lives of childbearing women. According to the U.S. National Center for PTSD, 51% of American women have been exposed to at least one trauma-producing event in their lifetimes, and 6% have been exposed to four or more. Fortunately, exposure to traumatic events does not automatically lead to a diagnosis of PTSD (American Psychiatric Association, 2004). But women are twice as likely as men to meet full diagnostic criteria (10.4% of women vs. 5% of men). And even when they don't, up to one third can have symptoms of trauma that impair their physical and mental health (Kendall-Tackett, 2003; Kendall-Tackett, 2005a).

The National Center for PTSD lists the most common traumatic experiences for women as rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse (www.ncptsd.va.gov). Trauma in the perinatal period can also be caused by previous pregnancy loss, preterm birth, neonatal death, or a frightening or life-threatening birth experience (Kendall-Tackett, 2005a & b).

Diagnostic Criteria for PTSD

Screening questions can indicate whether patients have experienced traumatic events. However, a formal diagnosis of PTSD is more exacting. According to Diagnostic and Statistical Manual IV TR Criteria (American Psychiatric Association, 2000) and the American Psychiatric Association's Practice Guidelines for PTSD (2004), a diagnosis of PTSD requires a discernible traumatic event, one that victims perceive as life-threatening for themselves or a

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loved one. The victim must have responded with fear, helplessness, or horror. In addition, there must be symptoms in each of three clusters: 1) Re-experiencing, 2) Avoidance/numbing, and 3) Hyperarousal.

Re-experiencing includes frequent intrusive thoughts of the event via nightmares or repetitive daytime thoughts. Avoidance includes numbing, avoiding situations that remind them of the traumatic event, and even amnesia about all or part of the event. Hyperarousal includes persistent jumpiness, sleep disturbances, poor concentration, and chronic activation of the sympathetic nervous system. Depression, another manifestation of chronic hyperarousal, is a common co-occurring symptom that must be addressed as well.

Treatments for PTSD and Trauma Symptoms

Comprehensive trauma treatment involves a wide range of activities including patient education, peer support, and trauma-focused psychotherapy--all of which are compatible with breastfeeding. There are also medications that can be added to the treatment regimen. While medications are useful adjuncts, they are not the primary treatments for PTSD. But they can reduce symptomatology and possibly halt the chemical cascade that occurs in the wake of traumatic events.

Psychoeducation and Peer Counseling

The role of both psychoeducation and peer counseling is to help clients understand their experiences and their reactions in the wake of traumatic events. Clients are given information on how to avoid secondary exposure to the event, how to reduce stress responses, and where to go if they need ongoing support. By understanding that their reactions are predictable after traumatic events, clients are less likely to blame themselves and are more likely to comply with treatment.

Trauma-focused Psychotherapy

The two most effective therapies for PTSD and trauma symptoms are cognitive behavioral therapy and EMDR. Both are completely compatible with breastfeeding.

Cognitive-Behavioral Therapy. The focus of cognitive therapy, in general, is to help clients identify faulty ways of thinking that increase the risk of depression and challenging those beliefs with more accurate cognitions. In trauma treatment, this same approach targets distortions in clients' threat appraisal processes and helps to desensitize them to trauma-related triggers (i.e., events that remind them of the traumatic event; American Psychiatric Association, 2004). CBT is a highly effective approach and variants to this approach include exposure therapy and stress-inoculation training (Friedman, 2001; Kendall-Tackett, 2003).

Eye Movement Desensitization and Reprocessing (EMDR). In EMDR the client is instructed to focus on the image, negative thought, and body sensations while simultaneously moving his/her eyes back and forth following the therapist's fingers as they briefly move across his/her field of vision. Eye movements are the most commonly used external stimulus. But therapists often use auditory tones, tapping, or other types of tactile stimulation. Clients can simply think about their traumatic experiences, rather than having to verbalize them. This technique has proven highly effective in reducing symptoms after a few sessions and has been approved by the American Psychiatric Association and the U.S. Veterans Administration for treating PTSD. Certified practitioners of EMDR are available in many parts of the world, including, for example, Amarillo, Texas. An international list of practitioners can be found at the EMDR Institute (www.emdr.com) or the EMDR International Association (www.emdria.com).

Medications

There are several classes of medications that can be used to treat PTSD. Medications are not the central treatment for PTSD. However, they can be useful adjuncts, ameliorating the physical symptoms that impact patients on a daily basis (American Psychiatric Association, 2004; National Institute for Clinical Excellence, 2005; PTSD Support Services, 2004). SSRIs are frontline medication choices in that they reduce symptoms in all three clusters and treat co-morbid depression. Other medications that may be added to the regimen include SARIs, adrenergic agents, anticonvulsants, and antipsychotics (American Psychiatric Association, 2004). I briefly summarize each of these types of medications and their compatibility with breastfeeding in the table on page 3.

Summary

Although medications are not the central treatment modality for PTSD, they can be helpful in women's recovery. Medications can be used safely in breastfeeding mothers with trauma symptoms and there are safer choices within each medication category. Medications can also be used in addition to traditional trauma treatments, such as psychotherapy, peer support, and psychoeducation.

Medication Classification	Medication Names	Lactation Safety Rating	Symptoms Addressed
Serotonin-2 Antagonists/ Reuptake Inhibitors (SARIs)	Trazodone	L2	Lowers incidence of nightmares by reducing REM sleep. Sedating, don't co-sleep while on this medication.
Adrenergic agents	α-2 adrenergic antagonists (Prazosin, Clonidine)	L4 L3	Blocks norepinephrine, decreases nightmares and intrusive thoughts.
	β-adrenergic blockers (Propranolol)	L2	Acute administration may prevent long-term symptoms. Some concern about this medication when there is comorbid depression.
Anticonvulsants	Carbamazepine	L2	Carbamazepine addresses intrusive memories and hyperarousal.
	Valproic acid	L2	Valproic acid helps with avoidance, numbing, and hyperarousal.
Antipsychotics	Olanzapine	L2	Careful differential diagnosis of possible co-morbid psychosis needs to be made before prescribing these. But these can be useful adjuncts for co-occurring psychotic symptoms or when first-line medications have failed.
	Quetiapine	L2	
	Risperidone	L3	

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