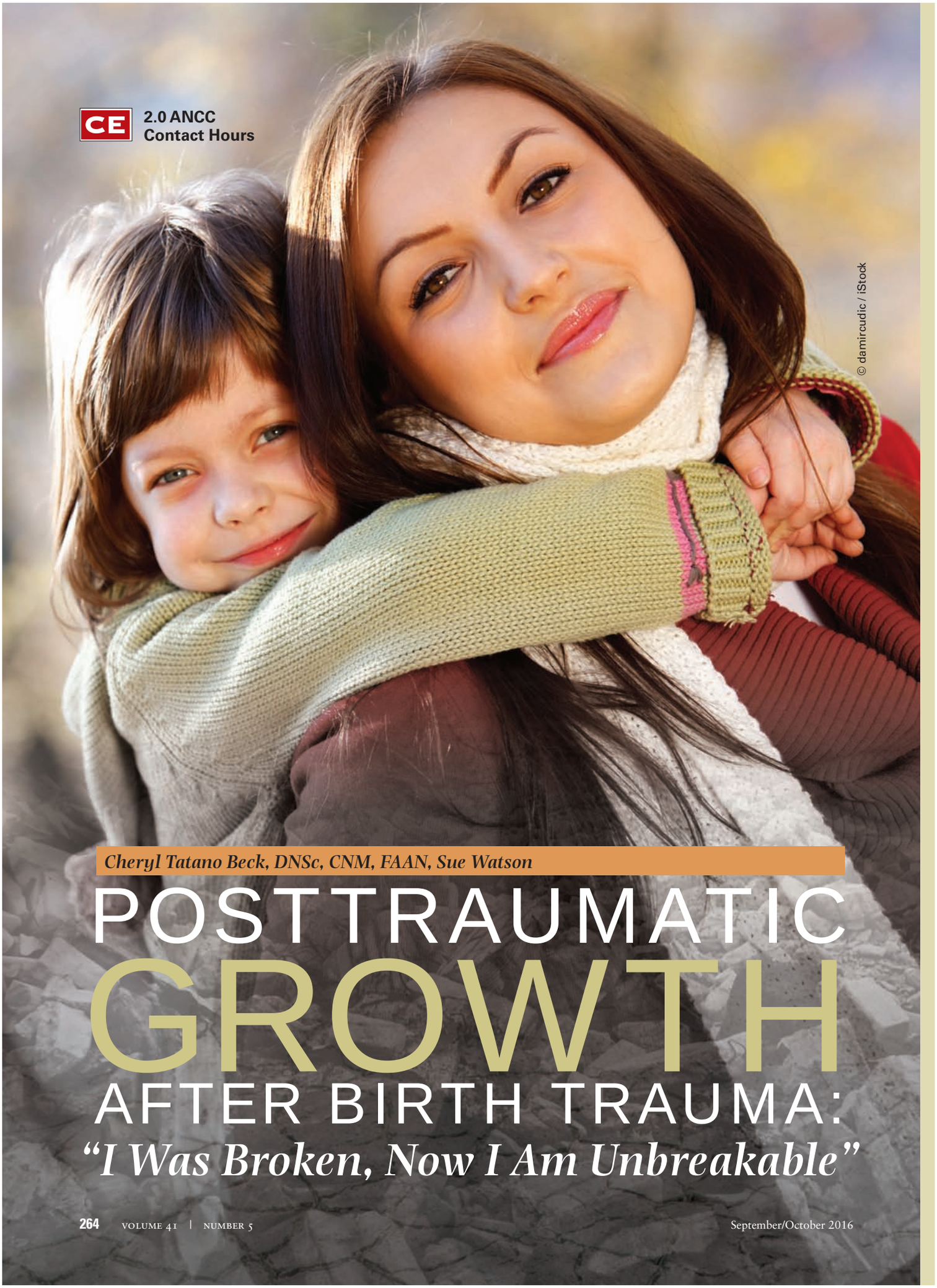

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Cheryl Tatano Beck, DNSc, CNM, FAAN, Sue Watson

POSTTRAUMATIC GROWTH AFTER BIRTH TRAUMA:

"I Was Broken, Now I Am Unbreakable"

Abstract

Purpose: The aim of this study was to investigate women's experiences of posttraumatic growth following traumatic childbirth.

Study Design and Methods: A descriptive phenomenological study was conducted using Colaizzi's data analysis method. The Internet sample of 15 mothers was recruited from the Trauma and Birth Stress Web site. Women were asked to describe in as much detail as they could remember, their experiences of any positive changes in their beliefs or life as a result of their traumatic childbirth.

Results: Using Calhoun and Tedeschi's metaphor of an earthquake to help explain posttraumatic growth, the seismic waves of birth trauma had enough power to lead to four themes of posttraumatic growth revealed in this phenomenological study: (1) Opening oneself up to a new present, (2) Achieving a new level of relationship nakedness, (3) Fortifying spiritual-mindedness, and (4) Forging new paths.

Clinical Implications: Mothers' experiences of their personal growth after birth trauma can help inform future research that can promote posttraumatic growth in mothers. Clinicians can share results of this study with their patients to provide some hope to mothers struggling with the aftermath of a traumatic birth that some women have reported positive growth. Healthcare providers need to respect trauma survivors' struggles while at the same time permitting mothers to explore possibilities for growth. Clinicians must not, however, create the false expectation that posttraumatic growth will happen in most trauma survivors.

Key words: Parturition; Posttraumatic stress disorder; Qualitative research.

Posttraumatic growth has been reported among persons who have experienced a wide range of traumas. Examples of these trauma survivors include veterans (Tsai, El-Gabalawy, Sledge, Southwick, & Pietrzak, 2015), childhood cancer survivors (Duran, 2013), survivors of intimate partner violence (Valdez & Lilly, 2015), and women with infertility (Yu et al., 2014).

Up to 34% of new mothers have reported experiencing a traumatic birth (Soet, Brack, & DiIorio, 2003). Traumatic childbirth is an event(s) that occurs during labor and birth and involves a woman's perception of (1) an actual or threatened serious injury or death to herself or her infant and/or (2) being treated in a dehumanizing way that strips the woman of her dignity. In a meta-analysis, Grekin and O'Hara (2014) reported prevalence of posttraumatic stress disorder (PTSD) due to birth trauma in community samples was 3.1%. In at-risk samples it was 15.7%.

Up to 34% of new mothers have reported experiencing a traumatic birth.

Traumatic childbirth has both short term and chronic adverse consequences for mothers such as its impact on breastfeeding and subsequent childbirth (Beck, 2015). Only a handful of studies have been conducted on perinatal posttraumatic growth. Examining their personal growth, which involves positive changes in women's lives following birth trauma, can provide a more complete picture of these psychological reactions which in turn can help inform future research that can promote posttraumatic growth in mothers. Clinicians can share results of this study with their patients to provide some hope to women struggling with the aftermath of a traumatic birth that aspects of positive growth in their lives may be possible.

Posttraumatic Growth

Posttraumatic growth is defined as the "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). In posttraumatic growth a person's development in some areas surpasses what was present prior to occurrence of the struggle with the crisis. This does not happen as a direct result of the trauma but instead as the result of the person's struggle in the aftermath of the trauma as they attempt to cope or survive. Posttraumatic growth can coexist with the distress of the trauma (Calhoun & Tedeschi, 2013).

Calhoun and Tedeschi (1998) used the metaphor of an earthquake to illustrate posttraumatic growth. Key to this development may be the traumatic event's ability to successfully "shake the foundations" of the person's assumptive world (Calhoun & Tedeschi, 1998, p. 216). The trauma experience needs to be seismic, like in an earthquake, to achieve this severe shaking of a person's understanding of the world. These assumptions about the world that can be shaken include beliefs such as the meaning of life; things that happen to people are fair; why persons think and act the way they do; relationships with others; one's abilities, strengths, weaknesses, and expectations for the future; spiritual or religious beliefs; and a person's worth or value as an individual (Cann et al., 2010). Cognitive rebuilding is necessary after a psychological crisis just as physical structures must be rebuilt after an earthquake.

Tedeschi and Calhoun (1996) identified five dimensions of growth: Appreciation of Life, Relating to Others, Personal Strength, New Possibilities, and Spiritual Change. They developed the Posttraumatic Growth

Inventory (PTGI), which is a 21-item Likert scale that measures these five dimensions. Ratings are made on a 6-point scale from 0 to 5 and can yield a range of possible total scores from 0 to 105 with a higher score indicating greater growth. A person can experience growth in some dimensions but not necessarily in all five domains. It is important to note that not all individuals who experience trauma develop posttraumatic growth.

Perinatal Posttraumatic Growth

Only three studies were found that examined perinatal posttraumatic growth after birth trauma. All these studies used Tedeschi and Calhoun's (1996) PTGI in some manner to measure the five dimensions of growth. In their qualitative study Black and Sandelowski (2010) interviewed women who had been told prenatally of the presence of a severe fetal anomaly. They found that, 1 year later, 12 of the 15 women had experienced positive changes in their lives. The five dimensions of the PTGI were used as the categories to code the interview data. The dimension that showed the earliest and most prolonged change was in Relating to Others.

In the next two studies, conducted in the United Kingdom, community samples were used. To be included in the studies women did not have to perceive their births to be traumatic. A convenience sample of 219 women who had given birth within the previous 36 months, with a mean of 10.95 months (SD = 7.20), participated in an Internet study (Sawyer & Ayers, 2009). In this study, 37.2% of the mothers fulfilled the Diagnostic and Statistical Manual of Mental Disorders' (DSM-IV) (American Psychological Association, 2000) criterion for PTSD of experiencing a traumatic event (in this case, childbirth). At least moderate levels of posttraumatic growth were experienced by 50% of mothers. The researchers defined "at least moderate levels" as a total score on the PTGI of more than 62. The mean total PTGI score for the sample was 58.81. There were no significant differences in posttraumatic growth levels between women who fulfilled the PTSD stressor criterion and those who did not. Appreciation of Life was the most endorsed dimension of posttraumatic growth (80%), followed next by Personal Strength (63%), Relating to Others (52%), New Possibilities (48%), and Spiritual Change (16%).

Sawyer, Ayers, Young, Bradley, and Smith (2012) conducted a longitudinal study with 125 women who completed the PTGI during their third trimester of pregnancy and again at 8 weeks postpartum. Twenty-three percent of the mothers' perception of their birth as traumatic fulfilled the DSM-IV's PTSD stressor criterion. In this study, 48% of the women experienced at least a small degree of positive change after birth that was operationalized as a total score in the PTGI of more than 41. The mean total PTGI score was 39.81. Results mirrored Sawyer and Ayers's (2009) earlier study with Appreciation of Life being the most endorsed dimension (68%). Personal Strength was second (52%), followed by Relating to Others (51%), New Possibilities (45%), and lastly Spiritual Change (22%).

Further research is warranted on perinatal posttraumatic growth. In the only two quantitative studies of posttraumatic growth in mothers, community samples were used. These studies did not specifically assess growth in mothers who perceived their childbirth to be traumatic. There had yet to be a phenomenological study conducted that would explore mothers' experiences of posttraumatic growth without using the PTGI dimensions to guide the analysis. Therefore, the purpose of this descriptive phenomenological study was to investigate women's experiences of posttraumatic growth following traumatic childbirth.

Methods

Research Design

Descriptive phenomenology is an inductive method that attempts to uncover and describe the essential structures of the lived experience of a phenomenon. The essence of a phenomenon is grasped through the study of the particulars of experiences. Husserl's (1970) philosophy of phenomenology underpins the descriptive phenomenological method. The two steps of epoché and reduction are essential to Husserl's philosophy. Epoché means abstention and reduction means to lead back. For Husserl the epoché helps suspend our natural attitude of taken-for-granted beliefs of the phenomenon. He used the term "bracketing" for this first step where one puts asides presuppositions that can stand in our way from being open to the phenomenon. Once bracketing is completed and we open ourselves to the world without our presuppositions, it leads to reduction where one can see what is unique in a phenomenon (Husserl). Colaizzi's (1978) phenomenological method was used in this study.

Sample

Inclusion criteria were that the mother a) perceived her childbirth had been traumatic, (b) experienced some aspect of personal growth after her birth trauma, and (c) was at least 18 years of age. The international Internet sample consisted of 15 mothers who were all married. Six women (40%) were from the United Kingdom, 4 (27%) from New Zealand, 3 (20%) from the United States, and 2 (13%) from Australia. Their ages ranged from 32 to 57. Fourteen women were White and one was Samoan. Eleven mothers (73%) were multiparas, whereas 4 (27%) were primiparas. Ten women had vaginal births and 5 had cesareans. Twelve women reported their education; 1 had a high school diploma, 9 bachelor's degrees, and 2 master's degrees. Examples of types of birth trauma these women experienced included infant death, emergency cesarean, stillborn infant, 4th degree laceration, postpartum hemorrhage, vacuum extraction, and stripped of their dignity. Five women (33%) reported being formally diagnosed with PTSD due to their traumatic births. Length of time since the women's traumatic births ranged from 5 months to 19 years.


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Posttraumatic growth involves positive psychological changes experienced by an individual as a result of struggling with a highly challenging life event.

Procedure

Recruitment began once receiving the University's Institutional Review Board approval. Women were primarily recruited through Trauma and Birth Stress (TABS), a charitable trust in New Zealand whose mission is to provide support for women who have experienced traumatic childbirth. A recruitment notice was posted on TABS' Web site (www.tabs.org.nz). The second author of this study is the Chairperson of TABS who was actively involved in recruiting participants through her connection with this Web site. Two mothers from other Web sites, such as www.birthtraumaaustralia.com, participated in the study.

Women who wanted information about the study emailed the first author at her university address. Two documents were then sent on attachment via email to the potential participants: an information sheet and directions for the study. Participants were asked to respond to the following statement: Please describe for us in as much detail as you can remember your experiences of any positive changes in your beliefs or life as a result of your traumatic childbirth. Mothers sending their narratives to the first author implied informed consent. After receiving the information sheet and directions, the length of time it took for mothers to send their descriptions of their posttraumatic growth to the researchers ranged from 2 days to 4 months. Data collection continued for 18 months until achieving data saturation. Length of mothers' descriptions of their posttraumatic growth ranged from 1 to 7 single-spaced typed written pages. After reading a mother's description of her experiences of posttraumatic growth, the first author emailed the participant if clarification of some part of her narrative was needed.

Colaizzi's (1978) method was used to analyze mothers' written descriptions of their posttraumatic growth. In this method all the significant statements included in the participants' descriptions that pertain directly to the phenomenon were extracted and their meanings formulated. Next the formulated meanings were categorized into themes. The themes were then integrated into an exhaustive description of the phenomenon under study. This exhaustive description was then returned to some of the participants for validation. There were no changes suggested by the participants.

Trustworthiness

Credibility was enhanced by the first author keeping a reflexive journal throughout data collection and data analysis. Thick description provided by rich quotes was included in the description of each theme to bring it to life and increased authenticity of the findings. Confirmability focused on the congruence between two or more persons regarding the data's meaning. One mother who experienced posttraumatic growth reviewed the findings and shared that "this is excellent. There is nothing I can add. Very, very powerful." The second author confirmed the audit trail of the results starting with reading all the data and following Colaizzi's (1978) data analysis steps. A PhD student who has been a labor and delivery nurse with 20 years' experience followed the audit trail and confirmed findings.

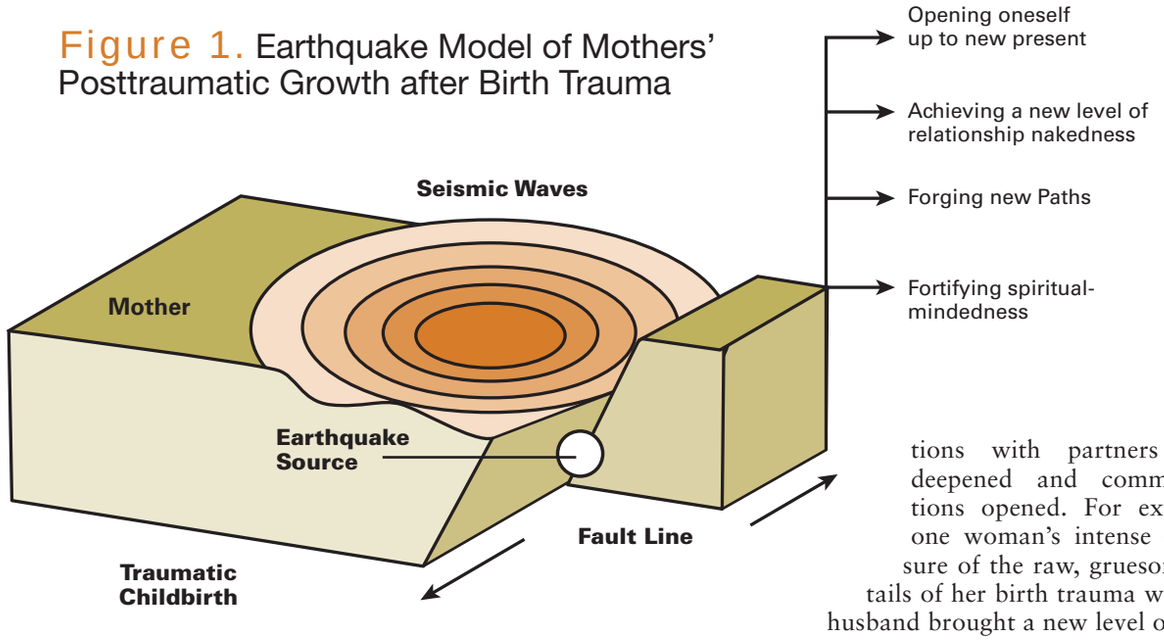
Results

Analysis of the 15 descriptions of posttraumatic growth following birth trauma yielded four themes. Figure 1 uses the metaphor of an earthquake to illustrate the seismic power of a traumatic childbirth that can lead to posttraumatic growth. Though women in this study experienced different types of birth trauma, themes of their personal growth in their lives were all similar. The country where the posttraumatic growth took place did not seem to be a factor in the patterns of positive changes.

Theme 1. Opening Oneself Up to a New Present

Achieving posttraumatic growth was a process. The following quote provides one mother's insight into this process: "At first, the very fabric of your being is shattered, destroyed. Nothing makes sense. The pieces do not go back together again. Rather, it is a gradual, new, very different kind of becoming." A mother's opening herself up to this new present can be "much like the agony a butterfly suffers as it fights through its chrysalis." The

Figure 1. Earthquake Model of Mothers' Posttraumatic Growth after Birth Trauma



personal rewards can be immense for some women as illustrated by this woman's quote: "I was broken. Now I am unbreakable."

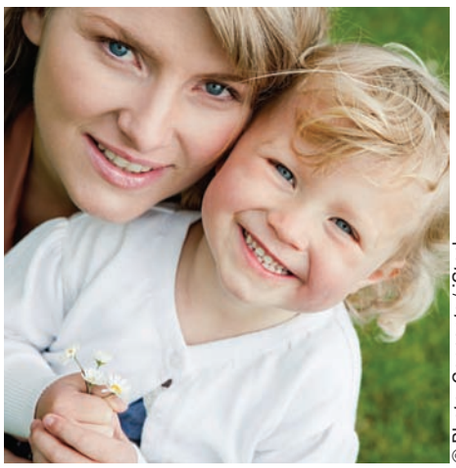
Mothers experiencing positive changes in their lives felt that their surviving birth trauma made them a stronger person. There is an inner knowing now that they can survive anything. One mother shared that "no one would wish trauma or subsequent PTSD upon anyone, yet when having had this, one knows you have become CHANGED FOREVER yet a better person for it all. Better and stronger and very self-aware undergirds your new daily life."

Heightened empathy was another important area of personal growth for women following birth trauma. Women also learned to become more assertive as part of their personal growth in the aftermath of their traumatic childbirth. Learned was a willingness to use their voice and personal power to fight back both emotionally and physically for themselves and others.

Theme 2. Achieving a New Level of Relationship Nakedness

Posttraumatic growth infused the relationships a woman had on multiple levels: with her husband, her friends, her children, and even sometimes with her patients if she happened to have a career in healthcare. Connections with partners were deepened and communications opened. For example, one woman's intense disclosure of the raw, gruesome details of her birth trauma with her husband brought a new level of what she described as "relationship nakedness." By relationship nakedness is meant that women no longer covered up what they were thinking or feeling but now felt secure enough in their relationships with their partners to be totally open and "naked" in front of them not hiding behind anything. A deeper level of understanding and a new tenderness between women and their partners developed through their growth after birth trauma.

Though the women in this study experienced different types of birth trauma, themes of their personal growth in their lives were similar.



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Posttraumatic growth also involved deeper and closer relationships with longtime girlfriends and also with new friends. Being able to talk intimately with friends about their traumatic births was hugely important to mothers in their growth. New, invaluable friendships began as mothers reached out to other women on traumatic childbirth Web sites.

Relationships with their infants and older children took on an even deeper meaning. Some mothers experienced a heightened need for their children "to know love, to know they are delighted in, to feel safe, to feel empowered and supported, and to feel nurtured." Mothers' relationships with their children involved a new focused meaning on being role models, especially for their daughters.

Theme 3. Fortifying Spiritual-Mindedness

For some mothers their faith became stronger and they developed a better understanding of spiritual and

religious matters in their everyday lives. One mother disclosed "I used to feel that my traumatic birth was something I wanted to take back (to somehow reverse time and change it so I could be 'ME' again) but over time I have learnt to embrace it as it keeps me connected to God and has also been one of the biggest catalysts for positive change in my life."

Another mother shared that "I can honestly say that overall, the most significant thing in my growth has been prayer and my personal relationship with the creator of this universe. I now believe that I was made for a purpose. Not only has He opened the right doors for me to gain healing and growth I specifically needed, but He has also given me huge insight into birth trauma which I hope to use for His glory in helping others with similar experiences." The lyrics from an old hymn were shared by one participant as she introduced them by saying: "These words often bring me to tears when I sing them because I know just how much God had done in my life and just how grateful I am." Here is the verse: "Something beautiful, something good, All my confusion, He understood, All I had to offer Him was brokenness and strife, but He made something beautiful out of my life."

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Clinicians need to respect mothers' struggles with traumatic childbirth and help them explore possibilities for growth.

Theme 4. Forging New Paths

New professional and personal goals were established as part of posttraumatic growth following birth trauma. There were two main paths that women followed. One path led to enrolling in and completing university degrees and the second path led to volunteer work. Women reported studying at universities in the fields of nursing, midwifery, and child and family health. As one mother explained, "I then went to the university to complete a nursing degree. I faced a number of fears in my nursing placements. As I did this I became stronger and stronger and after a lot of hard work I achieved my Bachelor of Health Science in Nursing."

Volunteering was another important aspect of positive life changes for some mothers. These women had never volunteered before but now felt the need to not only help other women who have experienced traumatic childbirth but also to try and prevent this from happening to other women. In one mother's narrative she explained, "I need to stress my overwhelming desire to talk about my experience and prevent it from happening again led me to volunteering for the Birth Trauma Association. This in itself was a big area of growth for me." In another woman's narrative she shared that her PTSD due to her traumatic pregnancy and birth "catapulted me into action and that this should not be happening to others." As one of her positive life changes, one woman formed a local International Cesarean Awareness Network chapter and actively volunteered there. Lastly one participant who is a midwife now volunteers at a crisis pregnancy center to help support women and families in crisis.

Discussion

Traumatic childbirth can certainly be viewed as a psychologically seismic event of a magnitude that can severely shake the foundations of a woman's assumptive world (Beck, 2015). The seismic waves had enough power to lead to the four themes of posttraumatic growth revealed in this phenomenological study. The themes that emerged from mothers' descriptions of their experiences of positive life changes in the aftermath of a traumatic childbirth confirmed earlier findings from the qualitative study of growth after severe fetal anomaly diagnosis (Black & Sandelowski, 2010) where increased emotional closeness with partners (Theme 2), recognizing new possibilities such as attending nursing school (Theme 4), and increased spirituality (Theme 3) were reported.

In two quantitative studies measuring perinatal posttraumatic growth using the PTGI the most endorsed domain was Appreciation of Life (Sawyer & Ayers, 2009; Sawyer et al., 2012). The voices of the mothers in this current phenomenological study did express appreciation of life but it was not the strongest essential component of their posttraumatic growth. Personal Strength (Theme 1) and Relating to Others (Theme 2) emerged as the loudest themes that women voiced in their descriptions of positive life changes following birth trauma. In both of Sawyer et al.'s studies Personal Strength and Relating to Others were the second and third most endorsed dimensions. One possible explanation for the differences in the magnitude of the various dimensions experienced by mothers of posttraumatic growth in the Sawyer et al. studies and this current phenomenological study is the differing samples. In both of Sawyer et al.'s quantitative studies community samples were recruited. In this current qualitative study, however, only women who perceived

they had experienced birth trauma followed by positive changes in their lives were included.

Limitations

Only women who had access to the Internet participated in this study. These women used the resources of TABS and other Web sites for traumatic childbirth. It is not known whether mothers who have neither Internet access nor support from online support groups would describe their experiences of posttraumatic growth differently than what emerged for the current study. Because the length of time since participants self-identified their birth trauma ranged for 5 months to 19 years, the potential of recall bias needs to be noted. None of the participants, however, shared any difficulty in remembering the positive changes in their lives following their traumatic births. Literature supports the accuracy of long-term recollections about the birthing experience (Takehara, Noguchi, Shimane, & Misago, 2014).

Implications for Practice

Clinicians can share with mothers struggling with posttraumatic stress some of the results of this qualitative study to alert their patients that some women have reported positive growth. Healthcare providers are in an important position to promote and encourage a focus on potentially positive aspects in mothers' lives in the aftermath of traumatic childbirth.

Calhoun and Tedeschi (2013) proposed that in working with survivors of trauma, clinicians take on the role of an "expert companion." They chose this term to convey a sense of humility that healthcare providers need to have to provide an environment where personal exploration can help occur to promote the survivor's experience of posttraumatic growth. Healthcare providers need to respect the trauma survivor's struggles and difficulties while at the same time permitting the person to explore the possibilities for growth. Calhoun and Tedeschi stressed, however, not to create the false expectation that posttraumatic growth will happen in most trauma survivors. In conclusion, sage advice from an amazingly strong mother who participated in this study is included so that it can be used by clinicians who are helping women currently struggling with the devastating aftermath of their traumatic childbirth: "LOVE+STRENGTH+HOPE = Our yellow brick road. This was written in the hope that all survivors will find the path to their own road, with love xxx." ✣

Clinical Nursing Implications

- Clinicians can share with women struggling with posttraumatic stress that some mothers have reported positive changes in their lives.
- While respecting women's struggles with traumatic childbirth, healthcare providers can encourage mothers to explore possibilities for growth.
- In working with trauma survivors, clinicians can take on the role of an "expert companion."
- Healthcare providers must not, however, create false hopes in mothers that posttraumatic growth occurs in most trauma survivors.

Achieving posttraumatic growth in mothers' personal lives was a process.

Acknowledgment

Words do not seem enough to thank the mothers from around the world who so willingly shared their stories of birth trauma and their resulting posttraumatic growth in the hopes of helping other women who have experienced birth trauma. Thank you also to Carrie Eaton, MSN, RNC-OB, for reviewing the data analysis process.

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The authors declare no conflict of interest.

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References

American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders-Text revision* (4th ed.). Washington, DC: Author.

Beck, C. T. (2015). Middle range theory of traumatic childbirth: The ever-widening ripple effect. *Global Qualitative Nursing Research*, 2, 1-13. doi:10.1177/2333393615575313

Black, B., & Sandelowski, M. (2010). Personal growth after severe fetal diagnosis. *Western Journal of Nursing Research, 32*(8), 1011-1030. doi:10.1177/0193945910371215

Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Positive change in the aftermath of crisis* (pp. 215-238). Mahwah, NJ: Lawrence Erlbaum Associates.

Calhoun, L. G., & Tedeschi, R. G. (2013). *Posttraumatic growth in clinical practice*. New York: Routledge.

Cann, A., Calhoun, L. G., Tedeschi, R. G., Kilmer, R. P., Gil-Rivas, V., Vishnevsky, T., & Danhauer, S. C. (2010). The Core Beliefs Inventory: A brief measure of disruption in the assumptive world. *Anxiety, Stress, and Coping, 23*(1), 19-34. doi:10.1080/10615800802573013

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.). *Existential phenomenological alternatives for psychology* (pp. 48-71). New York: Oxford University Press.

Duran, B. (2013). Posttraumatic growth as experienced by childhood cancer survivors and their families: A narrative synthesis of qualitative and quantitative research. *Journal of Pediatric Oncology Nursing, 30*(4), 179-197. doi:10.1177/1043454213487433

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review, 34*(5), 389-401. doi:10.1016/j.cpr.2014.05.003

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenology*. Evanston, IL: Northwestern University Press.
Sawyer, A., & Ayers, S. (2009). Post-traumatic growth in women after childbirth. *Psychology and Health, 24*(4), 457-471. doi:10.1080/08870440701864520
Sawyer, A., Ayers, S., Young, D., Bradley, R., & Smith, H. (2012). Post-traumatic growth after childbirth: A prospective study. *Psychology and Health, 27*(3), 362-377. doi:10.1080/08870446.2011.578745
Soet, J. E., Brack, G. A., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth, 30*(1), 36-46.
Takehara, K., Noguchi, M., Shimane, T., & Misago, C. (2014). A longitudinal study of women's memories of their childbirth experiences at five years postpartum. *BMC Pregnancy and Childbirth, 14*, 221-227. doi:10.1186/1471-2393-14-221
Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-472.
Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1-18.
Tsai, J., El-Gabalawy, R., Sledge, W. H., Southwick, S. M., & Pietrzak, R. H. (2015). Post-traumatic growth among veterans in the USA: Results from the National Health and Resilience in Veterans Study. *Psychological Medicine, 45*(1), 165-179. doi:10.1017/S0033291714001202
Valdez, C. E., & Lilly, M. M. (2015). Posttraumatic growth in survivors of intimate partner violence: An assumptive world process. *Journal of Interpersonal Violence, 30*(2), 215-231. doi:10.1177/0886260514533154
Yu, Y., Peng, L., Chen, L., Long, L., He, W., Li, M., & Wang, T. (2014). Resilience and social support promote posttraumatic growth of women with infertility: The mediating role of positive coping. *Psychiatry Research, 215*(2), 401-405. doi:10.1016/j.psychres.2013.10.032

Trauma and Birth Stress
www.tabs.org.nz

Postpartum Support International
www.postpartum.net

Birth Trauma Association of United Kingdom
www.birthtraumaassociation.org.uk

The Australian Birth Trauma and PTSD Treatment Centre
www.birthtraumaaustralia.com

Birth Trauma of Canada
www.birthtraumacanada.org

Solace for Mothers Healing after Traumatic Childbirth
www.solaceformothers.org

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