CE 1.5 ANCC Contact Hours

Abstract
Purpose: The purpose of this study is to describe experiences of mothers interacting with their infants after traumatic childbirth.
Study Design and Methods: A descriptive phenomenological method guided by Dahlberg, Dahlberg, and Nystrom's reflective lifeworld research was used. Women were 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. Data were collected via an electronic survey. Women were asked to describe how their traumatic births affected their caring for and interactions with their infants and any other children they may have.
Results: Eighteen women representing six countries across the globe participated. Four constituents of mothers' experiences interacting with their infants after traumatic births were identified: feelings of numbness and detachment, crying and anger, distressing cognitive changes, and limited outside social interactions.
Clinical Implications: To help women struggling with the aftermath of their traumatic birth, nurses first need to identify them. Clinicians need to be attentive to symptoms such as a withdrawn, dazed look, and appearing distanced from their infants. Prior to hospital discharge after childbirth, women should be given opportunities to share their perceptions of their birth to determine if they view it as traumatic. Interventions should be started as soon as possible in this fragile mother–infant dyad to prevent long-term consequences.
Key words: Mother–infant interactions; Parturition; Posttraumatic; Qualitative research; Stress disorders.

Mothers' Experiences Interacting with Infants after Traumatic Childbirth

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In the postpartum period, the prevalence of posttraumatic stress related to traumatic childbirth ranges from 4% in community samples to 18.5% in high-risk groups (Yildiz, Ayers, & Phillips, 2017). Posttraumatic stress disorder (PTSD) is a trauma- and stressor-related disorder that occurs from exposure to serious injury, threatened or actual death, or sexual violence (American Psychiatric Association, 2013). A person can directly experience the trauma or can witness it. There are four main categories of PTSD symptoms: intrusions, avoidance, arousal, and negative alteration in cognitions and mood related to the traumatic event.

In a metasynthesis of 13 qualitative studies on the psychosocial implications of traumatic childbirth on maternal well-being, Fenech and Thomson (2014) found that ghosts from birth trauma tormented mothers. Women reported intense negative emotions and dysfunctional coping strategies, a sense of loss of self, and shattered relationships. None of these qualitative studies specifically concentrated on mothers' interactions with their infants; however, there were hints that these dyads may be at risk of difficulties in bonding.

Prevalence rates of posttraumatic stress related to traumatic births range from 4.0% in community samples to 18.5% in high-risk groups.

Literature Review

What little research that has been conducted specifically on mothers' interactions with their infants after birth trauma is quantitative. Parfitt and Ayers (2009) investigated the effect of postpartum posttraumatic stress symptoms on parental–baby bonding. In an Internet study, 126 women and 26 men completed the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) and the Postpartum Bonding Questionnaire (PBQ; Brockington, Oates, George, & Turner, 2001). Parents with elevated posttraumatic stress symptoms reported a significantly poorer relationship with their infants than parents without these symptoms.

In Italy, Ionio and DiBlasio (2014) examined if persisting posttraumatic stress symptoms 2 months after birth affected the interactive synchrony in the mother–infant dyad at 3 months postpartum. Nineteen women completed the Perinatal Posttraumatic Stress Disorder Questionnaire (PPQ; DeMier, Hynan, Harris, & Manniello, 1996) at 2 days and 2 months postpartum and the Still Face Paradigm (Tronick, Als, Adamson, Wise, & Brazelton, 1978) at 3 months postpartum. The Still Face Paradigm consists of a mother and her infant being videotaped for three 2-minute long phases. In the first phase, the mother and infant engage in free play. The second phase includes the mother sitting still and watching her baby without smiling or interacting at all. In the third phase, the mother resumes normal interaction with her infant. At 2 days postpartum, 10.5% of mothers had potentially clinically elevated levels of posttraumatic stress symptoms; 21.1% had these symptoms at 2 months postpartum. High numbers of posttraumatic stress symptoms at 2 months after birth influenced mother–infant interactions at 3 months postpartum. Infants whose mothers reported elevated posttraumatic stress symptoms cried more and had more avoidance behaviors, frequently looked away, and physically distanced themselves from the adult than infants of mothers with lower posttraumatic stress scores. Childbirth-related PTSD and its association with low maternal attachment were examined with 685 postpartum women within 6 months of giving birth (Dekel, Thiel, Dishy, & Ashenfarb, 2019). Women completed the PTSD Checklist for DSM-5, the Maternal Attachment Inventory (MAI; Müller, 1994), and the Peritraumatic Distress Inventory. In the sample, 12% of women had postpartum PTSD, 16% general PTSD, and 5% comorbid postpartum PTSD and general PTSD. Analysis of variance revealed women with postpartum PTSD had significantly lower maternal attachment levels than women with no PTSD and even those with general PTSD. Little is also known about the long-term impact of childbirth-related posttraumatic stress symptoms on child development. In the United Kingdom, McDonald, Slade, Spiby, and Iles (2011) examined prevalence of posttraumatic stress symptoms due to childbirth at 2 years postpartum and their relationship to perceptions of the mother–child relationship. At 6 weeks and 3 months after birth, 81 women completed the Posttraumatic Stress Disorder Questionnaire (PTSDQ; Watson, Juba, Manifold, Kucala, & Anderson, 1991), the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979), and the Mother's Object Relation Scale – Short Form (MORS-SF; Oates, & Gervai, 2003). At 2 years postpartum, the women again completed these questionnaires. In this sample, 17.3% of the mothers reported some posttraumatic stress symptoms at a clinically significant level at 2 years after birth. Total PTSDQ scores were significantly correlated with mothers' perceptions of difficulties in interactions with their children.

In Norway, a population-based (N = 1472) 2-year follow-up study was conducted focusing on the impact of postpartum posttraumatic stress symptoms on child development (Garthus-Niegel, Ayers, Martini, von Soest, & Eberhard-Gran, 2017). At 8 weeks postpartum, women completed the IES and at 2 years postpartum, they completed the Ages & Stages Questionnaire and the Ages & Stages Questionnaire-Social-Emotional. At 8 weeks after birth, 6.6% of the sample had clinically significant posttraumatic stress symptoms. Postpartum posttraumatic stress symptoms had a small significant relationship with mothers' perception of poor child social–emotional development 2 years later. This relationship remained significant after adjusting for confounding variables of maternal depression, anxiety, and infant temperament.

In Italy, childbirth-related posttraumatic stress symptoms during the first few days after birth and at 3 months postpartum were measured to determine if they were

associated with children's adjustment at 18 months (DiBlasio, Camisasca, Miragoli, Ionio, & Milani, 2017). Eighty-eight women at 18 months postpartum completed the PPQ (DeMier et al., 1996) and the Child Behavior Checklist (CBCL; Frigerio, 2000). At 18 months after birth, mothers' posttraumatic stress symptoms remained at a high level (18% of the sample). Analysis revealed that elevated posttraumatic stress levels at 3 months were significantly correlated with higher internalizing and externalizing problem behaviors in children. Due to the number of different instruments used to measure posttraumatic stress in these studies, it is difficult to draw any firm conclusions. The limited quantitative research, however, on childbirth-related posttraumatic stress and mothers' interactions with their infants is beginning to shed light on this vulnerable mother–infant dyad. Needed now is qualitative research to provide a more comprehensive picture of women's experiences interacting with their infants after their traumatic births.

Methods

Research Question

For women who have had traumatic births, what is the essence of their experiences interacting with their infants?

Research Design

The qualitative methodology used was Dahlberg, Dahlberg, and Nystrom's (2008) descriptive phenomenological reflective lifeworld research. This approach is not a set of fixed or locked rules. It is an open design. Lifeworld refers to our being in the world. It is based on the phenomenological and hermeneutic philosophies of Husserl (1970), Merleau-Ponty (1996), and Gadamer (2004). A hallmark of reflective lifeworld research is an open attitude to discovering what stands before use, an openness to the meaning of an experience. Phenomenological reduction is a critical first step in the approach of Dahlberg et al., but instead of using that term, which they believed was loaded with philosophical implications, they use the term "bridling," which is derived from Spanish riding school practice that involves disciplined communication with the horses as they dance. In bridling, researchers reflect on their own lifeworld so it does not go unnoticed in the research process. The art of bridling focuses on openness and a respectful attitude that allows the phenomenon under study to present itself. Bridling points forward and not backward, whereas the term bracketing implies that the researcher's energy is concentrated on restraining preunderstanding. A "bridling" researcher is careful not to make something definite when it is indefinite (Dahlberg & Dahlberg, 2003).

Procedure

To practice bridling, the researchers reflected on their own lifeworlds before data collection and analysis began. This was an ongoing process and not accomplished at just one time. The first author reflected on her clinical practice and series of qualitative studies she had conducted on traumatic childbirth and its long-term, chronic impact on women's lives. The second author reflected on starting her charitable trust in New Zealand, Trauma and Birth Stress, to provide support to women who perceived their births had been traumatic.

After approval from the University's Institutional Review Board, women were 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) and second authors' Facebook page with a link to our electronic survey. Once they had read the information sheet, the women's participation in the electronic survey implied their informed consent. All data were anonymous.

Women completed the Participant Profile that asked for demographic and obstetric information. Next, women responded to the following statement: *Please describe for us in as much detail as you can remember and wish to share how your traumatic birth has impacted your caring for and interactions with your infant and any other children you may have. Any specific examples you can share on your experiences will be extremely valuable in helping to educate clinicians so that they can provide better care to mothers who have experienced a traumatic childbirth*. Women participants were not given a definition of traumatic birth. It was the perception of each woman if she believed her birth had been traumatic.

Data Analysis

After reading and rereading the interview transcripts as a whole in reflective lifeworld research, a researcher's attention is then focused on its different parts. The text is divided up into smaller segments called meaning units to assist in achieving a deeper understanding of the data. Dahlberg et al. (2008) described an intermediate step in the process of identifying the essential structure of meaning of the phenomenon under study. In this step, researchers can make clusters of meaning, but these clusters are not part of the findings; but instead they provide only a temporary pattern of meaning that lead to the essential structure or meaning of a phenomenon. The researcher then returns to the entirety of the texts now fortified with a broader understanding than initially thought. The researcher needs to relate clusters of meaning to each other to yield essential meanings and structure of the phenomenon. Dahlberg et al. cautioned researchers that essences are never totally described. Essences are open, infinite, and expandable.

In presenting the findings, Dahlberg et al. (2008) explained that first the essence of the phenomenon is described. After that, the constituents are described, which are the particulars of the structure. Quotes from participants are included here. These constituents provide contextual aspects to the essence. Both the description of the essence and its constituents are to be written in the present tense. Dahlberg et al. called for present tense "because it describes how the phenomenon is, i.e. not what the informants said about it" (p. 255). The essence is written at a more abstract level than its constituents.

Results

Sample

Eighteen women representing six countries across the globe participated. Ages ranged from 27 to 59 years (M = 35). Thirteen women were primiparas and five were multiparas. Sixteen women had experienced one traumatic birth and, for two women, it was their second birth trauma. Length of time since their most recent traumatic birth ranged from 14 days to 24 years (M = 3.83 years). See Table 1 for demographic and obstetric characteristics of the sample.

Essential Structure of Meanings

After a traumatic birth, the essence of mothers' interactions with their infants is understood by the women as an unanticipated disconnect between the mother and her infant. The close ties women envisioned during pregnancy that would happen once they gave birth are missing. Replacing this anticipated warm, loving relationship is a disturbing numbness that leaves women with a deadened feeling. Distressing emotions of irritability, anger, and anxiety now take center stage in their interactions with their infants. Longed for, treasured memories of the joy of having a child are instead replaced with those of crying through a sea of tears. At times, insidious cognitive changes seep into the mother–infant relationship where women's brains confuse ordinary, everyday occurrences as life-threatening to their infants, or mothers constantly worry that their infant will die of sudden infant death syndrome. Questioning whether their baby is actually their own or is another woman's can occur. The already

Table 1. Mothers' Demographic and Obstetric Characteristics

Demographic and Obstetric Characteristics	Variable	Number (M)	Percentage (%)
Race	New Zealand European	12	66
	Hispanic	2	11
	Multiracial	2	11
	White (non-Hispanic)	1	6
	Pacific Island	1	6
Education	Less than high school	2	11
	High school	2	11
	Nondegree tertiary	2	11
	Bachelors	9	50
	Masters	3	17
Marital status	Cohabiting	2	11
	Married	16	89
Country of birth	New Zealand	9	50
	Hong Kong	3	16
	USA	2	11
	Australia	2	11
	Canada	1	1
	Colombia	1	1
Type of birth	Vaginal	10	55
	Cesarean	8	45
PTSD diagnosis	Yes	3	19
	No	13	81
	Missing	2	
History of prior trauma other than birth trauma	Yes	8	47
	No	9	53
	Missing	1	
Currently under care of therapist/ counselor	Yes	3	18
	No	14	82
	Missing	1	

vulnerable mother–infant dyad experiences another issue that hinders their developing relationship. Due to either emotional or physical birth trauma, women limit outside interactions with other mothers or even just time spent outside their homes, so preventing further external stimulation for their infants and themselves. A cloistered life can ensue. When mothers perceive their births to have been traumatic, the meaning of their experiences interacting with their infants can be further understood by its constituents or components described as follows.

Constituent 1: Interacting with their Infants Includes Feelings of Numbness and Detachment

Mothers repeatedly share how the aftermath of their traumatic births leaves them feeling numb and detached from their infants. *Mechanical mother*, *robot*, *zombie*, and *empty shell* are terms women often use to describe how they interact with their infants. One woman admits that she was afraid to look herself in the eye. She felt like her soul had died. Another mother reveals that she'd *wake up numb unable to feel a thing and drag myself through the day and work myself to the point of exhaustion*. One woman explains that when her infant cried and needed her, she would just react blankly and spin out internally.

For some mothers, this detachment from their infants is not just during the first weeks after giving birth. It can take months for some women to bond with their babies. For months, as this mother describes it, she was emotionally flat. *I was numb toward my son but still going through the emotions of hugs and kisses but felt detached the whole time until he was about 6 months old. That was when I started to allow myself to enjoy him*. Even after women start to bond with their infants, some mothers share that at times they find themselves becoming detached randomly from their babies.

When women are multiparas, their traumatic births also may negatively affect their interactions with their toddlers. The following excerpt from this mother's narrative illustrates this: *When I came home from the hospital, I could not bear to have my then 18-month-old son near me. It took nearly a month before I could cuddle him*

The numbness and detachment that hinder mother–infant bonding spill over into their breastfeeding experiences. As this mother reveals *breastfeeding was just one of the many things that I did while remaining totally detached from it while I was doing it*.

Constituent 2: Interacting with their Infants Encompasses Crying and Anger

In place of the attachment to their infants that they report no longer feeling, the women's lives are now filled with crying, anger, and anxiety. One mother shares that she used to just sit there and cry while feeding her baby. Another woman admits sometimes she cries in front of her son and she thinks it scares him. She tells her son that she is okay, just a bit sad and that everyone cries but she wishes she didn't need to. Mothers struggle not to let their traumatic births affect their infants as this woman explains: *I feel like I succeeded in showing my son my love and giving him all I had, as my natural self knew none of this was his fault but sometimes caring for him was through lots of tears*. Irritability and anger also consume a part of mothers' lives. Participants explain that prior to their birth trauma, they would not consider themselves as angry persons. Their emotions changed after the birth as this quote reveals, *In the first couple of weeks after the birth I started getting irritated at everyone including my baby*. Another woman reveals that she would get irritable every time she needed to feed her son. She had trouble sleeping for months after he was born due to flashbacks of the birth which made her feel resentful and irritated with her son even though she knew it wasn't his fault. Irritability at times turns to anger as this excerpt from a mother's narrative illustrates: *I've never experienced strong feelings of anger before, but sometimes I feel so much rage, anger, and frustration I need to leave my daughter somewhere safe like her bedroom so I can cool off. I'd never hurt her, but I can see how other people with less self-control might*.

Constituent 3: Interacting with their Infants Includes Distressing Cognitive Changes

Traumatic childbirth affects mother–infant interactions in yet another way. At times it can affect women's mental capacity. This mother describes *I felt distanced from reality, unable to focus and concentrate. It felt like having to try and learn to knit while still trapped inside the wreckage of a car accident. This is how I felt when I tried to breastfeed*. Another mother explains her world seemed warped about birth trauma. She would look at her hands and wonder if they were a part of her. Some women even question whether the infant is actually their baby or is someone else's as this quote helps to illustrate: *The way my traumatic experience has impacted the interaction with my baby was that I used to think he was not my baby. I thought he might have been changed in the delivery room. I used to take good care of him, but I didn't feel he was my son*.

Another aspect of the aftermath of their traumatic births is as this participant describes, *My brain confuses mundane things with life threatening things all the time*. Some women experience panic on a daily basis: *Every time my baby cried I'd fly into a panic. My brain couldn't tell the difference between him being in danger and just being hungry*. Other woman constantly worry about sudden infant death syndrome, and this mother explained that her baby slept with her for the first 5 months of life as a result. Her birthing experience kept reminding her how fragile her baby was.

Constituent 4: Interacting with their Infants Involves Limited Outside Social Interactions

Not only does traumatic birth affect mother–infant interactions, but it also spreads to limiting outside social interactions for this vulnerable dyad. The impaired mental capacity leads to some women overcompensating. Some women never go anywhere apart from their home or their mother's house. As women struggle with flashbacks of their birth trauma, they avoid any reminders of motherhood. As this quote illustrates, *I avoided thinking about*

Suggested Clinical Implications

- The first step in helping women who are struggling with the aftermath of their traumatic birth is to identify who they are.
- Before discharge from the hospital, each mother should be given the opportunity to share her perception of her labor and birth.
- A referral to a mental healthcare professional may be necessary if nurses suspect posttraumatic stress related to traumatic childbirth.
- Maternity and pediatric healthcare providers need to be vigilant in observing mothers' interactions with their infants to identify struggling dyads.

my birth which meant it was hard to join the mothers' groups to which I was invited so my daughter missed out on a lot of social interaction and so did I. Another woman who suffered a severe postpartum hemorrhage was not able to establish a sufficient milk supply. After 4 weeks of lots of tears and stress, she stopped breastfeeding, which had a huge impact on her. She had a lot of anxiety about giving formula, so she spent the first 6 to 8 weeks of her daughter's life at home.

Other results of physical birth trauma, such as severe uterine prolapse, rectocele and cystocele, limit mothers' and their infants' interactions inside and outside their home. One mother shares that for the first 2 months after birth, she rarely held her son close to her in a front/back pack or was even able to carry him. *We stayed home mostly. He was always put in a push chair.*

Discussion

Quantitative data from four studies corroborated constituent 1 that focused on mothers' detachment from their infants (Dekel et al., 2019; Ionio & DiBlasio, 2014; McDonald et al., 2011; Parfitt & Ayers, 2009). However, what was revealed in our phenomenological study that was not identified in the quantitative research were constituents 2, 3, and 4 which dealt with mothers' anger, crying, distressing cognitive changes, and limited outside interactions that the quantitative instruments did not measure.

Qualitative findings of our phenomenological study can help paint a more complete picture of the impact of traumatic birth on mother–infant interaction. Selikoff (1991) noted, "Statistics are human beings with the tears wiped away" (p. 126). The four constituents identified in our study add the mothers' tears to the statistics reported in quantitative studies. Interventions can be designed based on these findings to improve mother–infant bonding and child development.

Limitations

One of the limitations of this study was that it used electronic data collection where data were anonymous and consequently the researchers were not able to follow up on any of the participants' statements to clarify or to give a richer understanding of their experiences. Another limitation was the very wide range in length of time since participants had given birth.

Clinical Nursing Implications

To help women struggling with posttraumatic stress due to childbirth, nurses first need to identify who they are. During the postpartum period, nurses and other clinicians need to be attentive for any symptoms that may indicate a woman had a traumatic birth. Examples of these symptoms can include a withdrawn, dazed look and mothers appearing distanced and detached from their infants. Before a mother is discharged from the hospital after childbirth, she should be given the opportunity to share her perception of her labor and birth to determine if she views it as traumatic. Simpson, Schmied, Dickson, and Dahlen's (2018) integrative review identified the most significant predictors of posttraumatic stress in new mothers as being a history of prior trauma, a cesarean or instrumental birth, and low social support. Continuing education of the entire healthcare team on traumatic birth, posttraumatic stress, and its predictors will help to identify women who may be at risk for developing posttraumatic stress due to birth trauma.

Maternity and pediatric healthcare providers need to be vigilant in observing mothers' interactions with their infants to identify struggling dyads. Women with elevated posttraumatic stress may benefit from specific interventions to help develop positive mother–infant interactions. An example of one such intervention can be teaching mothers infant massage to increase the stimulation they provide to their infants. Interventions need to be started as soon as possible with this fragile mother–infant dyad to prevent long-term consequences.

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