# Traumatic childbirth and the impact on mother-child bonding

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Recognition is growing for the fact that childbirth can be a traumatic experience for a mother and lead to serious post-traumatic problems.

Both parents and medical specialists can develop long-term problems following such a negative experience.

A traumatic childbirth occurs in 25 to 34 per cent of all births. Approximately one third of women affected will develop a Post-Traumatic Stress Disorder (PTSD).

PTSD affects the mother's ability to develop a safe bonding relationship with her child.

This, in turn, has a negative impact on the psychological and emotional development of the child.

Parallel to this, is the importance of acknowledgingthe trauma in order to ensure recognition, prevention and treatment.

Today trauma is viewed from two perspectives (NCTSN: The national child traumatic stress network.)

Firstly, as the traumatic experience: "I have suffered a trauma" and referring to the event itself(e.g. a traumatic childbirth).
Secondly, as the consequences of the trauma, in other words: "I am traumatised" and referring to the consequences of the experiences (e.g. childbirth trauma).

Reid (2011) identifies traumatic childbirth as "any birth that the mother identifies as distressing to the point of considering it a trauma and includes trepidation surrounding future births." As such, Reid's definition of traumatic childbirth is the most detailed we have.

## Various reasons can be at the basis of a traumatic labour

The prenatal condition of the mother, both physical and psychological, including – for example – unwanted pregnancy, extensive fertility treatment, relationship problems etc.

Situations that occur during the birth itself, such as a prolonged and painful labour, Caesarean section, vacuum extraction, a mother's fear of losing the baby or of dying herself etc.

The intense feelings experienced during the birth, such as dissociation, extreme fear, panic or other negative emotions, can also be predictors for Postpartum PTSD.

Situations affecting the baby, such as a child born with a disability, a baby in neonatology etc.

Situations related to the medical specialists, being - for example - neither supportive nor friendly, providing insufficient or no information etc.

The way in which a mother experiences childbirth can also be (negatively) influenced by a traumatic personal history. Here we can consider an attachment trauma of her own, sexual abuse, anxiety problems, depression etc.

## What are the symptoms of "Birth trauma"?

Symptoms vary and depend very much on a mother's own, unique experience. They will affect both the mother herself and her relationship with others.

She can experience recurring experiences of the birth, sometimes accompanied by fear of a subsequent labour.

Low self-esteem and a feeling of helplessness can lead to relationship problems and even to avoidance of intimacy and sex with her partner.

Feelings of guilt can result in isolation and loneliness, compounded by a withdrawal from contact with others.

There are problems bonding with the child and some mothers completely avoid this bonding.

Postpartum PTSD can also develop following a traumatic birth.

## The following characteristics are present by Postpartum PTSD:

There are intrusive symptoms that are connected to this traumatic event, such as flashbacks to the labour, nightmares, unpleasant memories of the birth …

There is a denial of – or attempts to avoid – painful memories, thoughts or feelings related to the traumatic birth. Doctors and hospital visits, contact with the baby and thoughts about the birth are often avoided.

The occurrence of negative changes in the thought process and mood, for example the inability toremember an important part of the traumatic birth, persistent and extremely negative views or expectations about herself, others or the world in general.

Recurrent feelings of fear, disgust, anger, guilt or shame and a clear decline of interest, or participation, inimportant activities.

The presence of feelings of dissociation or distancing from others, and the inability to experience positive emotions.

Another characteristic is a clear change in arousal and reaction, such as irritable behaviour and fits of anger, hypervigilance, excessive panic reactions, concentration problems, sleep disturbances etc.

## It is clear that the effects of a traumatic labour can interfere with the ability to establish a safe bonding with the child.

The quality of the attachment relationship is of importance for a safe attachment relationship.

As stated by Bowlby (1982), the quality of the relationship mainly depends on the attachment figure.

## What are the core factors that are essential in a parent-child relationship in order to establish a safe attachment?

A safe attachment  relationship ensures the child is seen, understood and supported so it can develop into an emotional and psychological human being.

Here we should make a clear distinction between the care for a child (parenting) and the development of an attachment with the child.

A child's experiences of fear are totally different from those of an adult. This is due to the child's extreme dependence on the primary carer to regulate his inner being and the fact that he is insufficiently developed to solve his own problems.

The attachment must be continuous and correct, which is why a child will experience any disruption to a bonding relationship, be it physical or psychological, as a threat.

## What qualities are vital in an attachment figure?

It is important that the attachment figure responds sensitively to the child. In other words, they are emotionally receptive and able to react immediately in an appropriate and adequate manner to the child's emotions and stress.

Another important part of attachment is a well-developed capacity for reflection. This is the ability of the carer to reflect on his/her own past and understand how these experiences from the past may be (re)triggered by the child.

The parent should also possess sufficient mentalising  capability; ability to think  and analyse the child's verbal and non-verbal communication, and mirror this back so that the child can feel and understand its internal experiences. The experience of being " seen" and " understood" by the parent is the basis for the development of "the core self" in the child.

Another key factor that forms the basis for safe attachment is containment. Containment (Bion, 1959) is the situation in which: “A person is able to recognise and understand an emotional connection, without feeling overwhelmed. The person is also able to react and communicate with the other.”

Play and “shared fun” between a mother and child helps reduce stress and heightens a feeling of safety and connection.

When a mother is suffering from symptoms of trauma or is affected by persistently negative moods, she will be unable to respond to her child in a sensitive manner. In the absence of an appropriate reaction from the mother, the child will be unable to manage its own inner self and the baby will not learn how to regulate its emotions. The ability to regulate emotionsforms a cornerstone for a healthy, well-functioning psyche.

Intense experiences of pain, helplessness and fear during childbirth can lead to the mother later avoiding contact with the baby.

In extreme cases the mother will refuse to see or touch the baby in the days following the birth. She may even develop a lasting psychological detachment from the baby.

This interruption to the bonding process is damaging to the baby, affecting its first experiences of anxiety and the development of certain areas of the brain that are responsible for regulation, social interaction, empathy etc.

Recurring flashbacks of a traumatic labour and nightmares can lead to sleep disorders and even a fear of going to sleep, which can cause relationship problems and an avoidance of intimacy.

Some women no longer recognise themselves and experience a form of dissociation. This numbness and detachment is often confused with Post-Natal Depression.

It goes without saying that a mother’s feeling of numbness and/or dissociation will lead to a dysfunction in her mentalising capacity. Consequently, the child will be unable to develop its own “inner self”.

A traumatic labour can result in two insecure attachment styles: a Preoccupied attachment style, with the emphasis on overprotection and fear, and a Reserved attachment style with the emphasis on avoidance and negation.

A preoccupied attachment style will lead to a child that is angry because his needs are not met, is dependent on his mother, fearful and wary.

With a reserved attachment style, the child denies its roots, rebels against the parent and blocks emotions.

## Prevention

Good care is essential, with sufficient information, discussion, respect for the individual, interest, presence, reassurance.

Good communication to ensure the parents feel they are being “seen”.

Appreciation of the mother’s experience and not ignoring or minimalising this, because – after all - the baby is fine.

## Treatment

First and foremost (as is normal with treatment in the first phase of any trauma) we concentrate on reducing the symptoms, in particular:

- Reduction of stress
    - Establishing day-to-day functioning
    - Physical treatment, e.g. relaxation, medication, yoga
- Regulation of emotions
- Relationship therapy
- Establishing safe bonding between parent and child.

In the second phase we will confront and work through the traumatic experience itself, using - for example - EMDR.