Traumatic Childbirth and the Impact on Mother–Child Bonding

Revised August 2023

Doris D'Hooghe
Kerkplein 1
9981 Sint-Margriete
Belgium

Traumacentre Belgium
www.traumacentrum.be
0032472243461
003293790553

Abstract

In the early stages of a child's development, the mother–child relationship is of monumental significance. Providing support and guidance to both mothers and children as they build safe relationships is one of our most important responsibilities as mental health professionals. Clinical observation and research have shown that when this relationship is damaged or in danger, it interferes with the child's developmental trajectory. In the past decade, there has been growing recognition of the trauma that childbirth can cause for a mother and it can lead to serious post-traumatic problems. Both parents and medical specialists can develop long-term difficulties following traumatic childbirth. As described by Aydin and Aktaş (2021), midwives who witness interpersonal birth trauma can themselves become traumatized. As a consequence, some midwives may begin to doubt their professional integrity and consider leaving the profession altogether. Furthermore, one study showed that about 45% of women experience traumatic childbirth (Ayers & Pickering, 2001) and up to 21% develop PTSD

following childbirth (Schwab et al., 2012; Verreault et al., 2012). As a result of PTSD, the mother is unable to establish a safe attachment relationship with her child, which adversely affects the child's development. I categorize developmental domains into the following eight categories: needs development, neurobiological development, somatic development, emotional development, cognitive development, self-actualization, and spiritual development. It is possible for any of these domains to become impaired or interrupted in the absence of a safe attachment relationship.
A parallel approach is to acknowledge the existence of trauma to ensure its prevention, recognition, understanding, and treatment.

Introduction

It becomes clear that a consensus is needed regarding a trauma definition. Trauma can be viewed from two perspectives (Peterson, 2018). Firstly, it can be viewed as the traumatic event itself (e.g., traumatic childbirth). Secondly, it can be viewed as the experience of the trauma (i.e., “I am traumatized”) and refer to the consequences of the experiences (e.g., anxiety). In my view, trauma is a unique and individualized reaction of a person/child/unborn to a traumatic event that produces different dissociative reactions across each of the eight developmental domains in which it occurs. I believe that the person’s individual trauma experience and the derived consequences of trauma are more relevant than the events that caused the trauma.

Traumatic Childbirth

Greenfield et al. (2016) describe traumatic childbirth as follows: “the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but [results] in psychological distress of an enduring nature.” 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.” I consider Reid's definition of traumatic birth the broadest.

Traumatic childbirth can be caused by a variety of factors

<u>Prenatal influences.</u>

Given the existence of a prenatal attachment bond, a woman’s condition during pregnancy, both physically and psychologically, plays a tremendous role in how she interacts with her prenate. According to research by Marquez (2000), the prenate can store traumatic experiences in their “bodymind” (Pert, 1987), manifesting permanently as psychosomatic symptoms. In my opinion, it constitutes psychological violence when a mother rejects or tries

to abort her unborn child. This unnamed murderousness is introjected by the prenate, who experiences it as psychological infanticide (Francis & Silvers, 2013).

It is common for pregnancy to bring mothers' own unresolved attachment histories to the surface.

Similarly, traumatic issues related to the body, such as sexual abuse or incest, can adversely affect an expectant mother's relationship with her unborn child. Such traumas can trigger flashbacks, dissociation, panic, and terror in pregnant women.

Previous loss, stillbirth, miscarriage, and so on also negatively affect the birthing process. Additionally, women who experience unplanned pregnancies are more vulnerable.

It is my clinical observation, as well as one of Emerson's key findings, that prenatal trauma can cause complications at birth. This negatively impacts subsequent delivery processes. Emerson emphasized two outcomes of the birthing process after prenatal trauma: first, it often causes birth to be perceived the same way as prenatal trauma, and second, birth complications are more likely to occur in conditions of high prenatal stress.

Factors underlying traumatic childbirth.

It is common for women to feel out of control during birth if they experience extreme pain or long labor. Cesarean section and vacuum extraction are also considered uncontrollable processes. There is an additional risk of traumatic childbirth if a mother experiences panic, helplessness, fear of losing her baby, or any other negative emotions during birth. When mothers undergo these intense emotions during childbirth, they may dissociate from the baby and themselves. In other words, the mother is no longer (psychologically) present. The baby consequently experiences abandonment and loss, resulting in annihilation anxiety and a sense of not-being. An infant's attachment to their mother can be greatly affected by their mother's dissociation.

Situations affecting the baby, such as a child born with a disability, a premature baby, a baby in neonatal intensive care units, etc. can influence negatively the mother-child bond.

The absence of support and friendly treatment from medical specialists impacts a mother's sense of being alone and helpless, which affects the bond between the mother and her child.

Unwanted, invasive, and painful medical procedures, together with a perception of indifferent care, are also risk factors for a traumatic birth.

Women are also more likely to experience postpartum trauma when support is lacking from their partner or family or if they live in a violent environment and experience domestic abuse.

The way a mother experiences childbirth can also be (negatively) influenced by an unresolved traumatic personal history. Mothers who have experienced personal attachment trauma and have a history of sexual abuse may be unable to develop safe attachment relationships with their babies. In giving birth to her baby, a mother often reenacts her own unresolved birth trauma.

The unique experiences of women

I want to highlight a revised view of what can be called trauma by clarifying the differences between a traumatic event and its consequences. In the aftermath of a traumatic event, the consequences depend on the experience of the individual. I define trauma as the individual consequences of traumatic events.

In traumatic childbirth, the mother's perception of the trauma is not solely influenced by the birth event. Rather, it is based on the unmet expectations and relational experiences of women giving birth. There are some women who create an idea of how the birth would be or take place. As a result of traumatic incidents, those expectations could not be met. A woman might feel disappointed and failed after such an experience. Their relationship with the child is negatively affected by these factors.

Using Colaizzi's (1977) process for thematic analysis, women's birth trauma experiences are characterized by four themes. According to Beck (2004), in "Theme 1: To Care for Me", women felt vulnerable and alone, and reassurance and a caring attitude was lacking. "Theme 2: To Communicate with Me", in which women felt invisible. "Another theme is the provision of safe care", which indicates that the women were disappointed in the care they received and were in danger as a result. In addition, there is "Theme 4: The End Justifies the Means", in which the outcome of the baby being well is all that matters. The unique experiences of the mother are denied and minimized.

A traumatized birth is often viewed as routine by clinicians who place their own agendas ahead of the needs of their patients. Actions are too practical, resulting in unnecessary interventions (Beck, 2004). Birth trauma often includes violence and physical abuse. This phenomenon resulted in the introduction of the legal term "obstetric violence" (Borges, 2018). Women are traumatized more by the way physical procedures are performed than by the procedures themselves (Reed et al., 2017). A patient is considered a passive agent in the health system, whereas the practitioner has authority and responsibility. Within this paradigm, power dynamics legitimize care providers' control over women, ultimately leading to mistreatment (Beck, 2004). The feelings of being invisible and unheard were very real for many women. This type of ignoring results in out-of-control experiences and causes despair, anxiety, anger, and rage on the part of the mother. As a result of these intense feelings, they are unable to welcome their infant in a peaceful and stress-free manner.

What are the symptoms of traumatic childbirth?

Symptoms of childbirth-related trauma vary and depend on a mother's unique experience. The unique symptoms will also affect the relationship between the mother and her baby as well as the environment in which the mother lives. The following symptoms may result from a traumatic childbirth:

- It is possible for her to undergo recurring birth experiences, which may be accompanied by fear of future labor.
- The mother may avoid intimacy and sex with her partner due to low self-esteem and feelings of helplessness.
- A sense of guilt can lead to feelings of isolation and loneliness, which are compounded by withdrawal from social interactions.
- Mothers who experience intense pain, helplessness, and fear during childbirth may avoid contact with their newborns for a long period of time after the birth. In some cases, the mother may refuse to see or touch her baby in the first few days after birth. She may even develop lasting psychological detachment from the baby.
- Some women no longer recognize themselves and experience dissociation. This numbness and detachment are often confused with post-natal depression.
- Postpartum PTSD can also develop following a traumatic birth.

Characteristics of postpartum PTSD

As seen previously, “childbirth could be experienced as traumatic for some women. A traumatic childbirth could cause psychological distress, and even post-traumatic stress disorder (PTSD)” (Ertan et al., 2021). According to Bailham & Joseph (2003) besides the features of PTSD, some significant symptoms in the postnatal period including sexual avoidance and parenting problems are particular features of women who suffered traumatic childbirth.

Postpartum PTSD is characterized by intrusive symptoms connected to a traumatic childbirth experience, such as flashbacks to the labor, nightmares, and unpleasant memories of the birth. These intrusive symptoms can lead to sleep disorders and even a fear of sleep, which can cause relationship problems and avoidance of intimacy.

Patients with postpartum PTSD may also experience a denial of – or attempt to avoid – painful memories, thoughts, or feelings related to the traumatic birth. Doctor/hospital visits and thoughts about the birth are often avoided.

Postpartum PTSD can involve negative changes in thought processes and mood – for example, the inability to remember a significant part of the traumatic birth or persistent and extremely negative views/expectations about herself, others, or the world in general.

Recurrent feelings of fear, disgust, anger, guilt, or shame and a clear decline in interest or participation in meaningful activities may also arise. They may also be unable to experience positive emotions.

Patients may have feelings of dissociation and may distance themselves from others.

Changing levels of arousal is another characteristic. This includes irritable behavior, anger outbursts, hypervigilance, excessive panic reactions, concentration problems, sleep disturbances, and so on.

Traumatic childbirth and postnatal mother-child bond

The effects of traumatic childbirth can interfere with the ability to establish a safe attachment relationship with the child. Attachment is described as a deep and enduring emotional bond that connects one person to another across time and space**.** It is directed toward a specific person who is emotionally significant and characterized by seeking security, comfort, and pleasure (Ainsworth, 1974; Bowlby, 1969).

Mother-child relationship

Firstly, I want to make a clear distinction between the care of a child (child rearing) and the development of an attachment relationship with the child. A cornerstone in the attachment and trauma-based approach to child development is the creation of a safe relationship with the mother. Researchers have integrated findings from developmental and attachment theories with neurodevelopmental research to better understand the significance of early relationships and the impact of interactional disturbances.

Attachment

I want to emphasize the importance of attachment relationships that are persistent and ongoing. Every disruption to the mother–child relationship, whether physical or psychological, creates attachment trauma. Because infants are immature and totally dependent on their mothers, interruptions in the bond are perceived as a threat by the child. Attachment is directed toward a specific, emotionally significant person (the “attachment figure”). One cannot form an attachment relationship with a stranger. Furthermore, attachment is characterized by the search for security, comfort, and pleasure. At this stage of development, an infant is highly dependent on its mother to regulate its inner state, as the mother functions as the child's external regulator.

Quality of the attachment relationship

The quality of this attachment relationship is thus highly significant. Bowlby (1982) states that the quality of the relationship depends on the attachment figure. Having the proper parenting skills is essential for the development of a safe attachment relationship between the mother and the child. They are the ability to reflect, mentalize, contain a child's distress, regulate, respond sensitively, share pleasure with the child, and play with the child. The absence of these features causes traumatic stress in the child and impacts their neurobiological, psychosocial, and spiritual development. Overall, it affects the child's attachment capability.

"Invisible Attachment Trauma" (D'Hooghe & Brack, 2018)

As described in D'Hooghe & Brack (2018), three possible events in the mother–child relationship can lead to the absence of necessary parental skills. I first want to note the interruption in the relationship between the mother and her child. This is where she is either physically absent (e.g., the child is in a neonatal intensive care unit), emotionally absent (e.g., due to experiencing unbearable pain during labor, or the mother is rejecting and refusing to see or touch her baby), or psychologically absent (e.g., the mother experiences flashbacks of her own unresolved childhood or is unable to attune sensitively to the baby). Such interruptions preclude a key feature of attachment, namely the direction of the attachment towards a specific individual with emotional significance in a persistent and ongoing relationship. As a result of such an interruption or loss of the mother–child relationship, the child suffers annihilation anxiety and a sense of non-being. The lack of shared pleasure, play, and regulation through interaction is evident. This interruption to the bonding process harms the baby. Among other things, it affects its first anxiety experiences and the development of certain areas of the brain responsible for regulating emotions and stress, socializing, and experiencing empathy. The child experiences a feeling of unwelcomeness and nonexistence.

Furthermore, there can be "ghosts in the nursery" (Fraiberg, 1975) which represent the mother's unprocessed attachment and trauma history. Her unresolved trauma history negatively impacts her ability to relate to her children. As a result of these "ghosts," the mother is unable to reflect and mentalize properly. Reflection refers to the ability of caregivers to reflect on their own pasts and to understand how these past experiences may be re-triggered by the child. I consider "ghosts in the nursery" to be a psychological interruption in the attachment relationship. It is also important that the mother is capable of mentalizing, which involves thinking about and analyzing the child's verbal and non-verbal communication and reflecting back to them so they can understand and feel their internal experiences. Children develop their core self through being seen and understood by their mothers. Mothers' feelings of numbness or dissociation will lead to dysfunction in their mentalizing capacities.

Lastly is the mother's inability to serve as the external regulator of the child's internal world. A mother's unresolved childbirth trauma may cause her to be dysregulated, both emotionally and neurobiologically. In such cases, she is often unaware that she has been traumatized

since her experiences are not acknowledged. Safe attachment is also based on containment, which is an important aspect of regulation. Containment (Bion, 1959) is the situation in which “a person can recognize and understand an emotional connection without feeling overwhelmed. The person can also react and communicate with the other.” By not being able to contain the child's internal content, the mother cannot respond sensitively to the child's signals. The mother is thus emotionally incapable of reacting appropriately and adequately to the child's emotions and stress. It is impossible for a mother to respond sensitively to her child's needs when she suffers from trauma symptoms or is affected by persistently negative moods. In the absence of an appropriate reaction from the mother, the child will be unable to manage their own inner life and cannot learn to regulate their emotions, which is normally a cornerstone of a healthy, well-functioning psyche.

The child

If traumatic childbirth experiences and their consequences (as described above) impact this first relationship between mother and child, a relational dissociative reaction occurs in the form of an unsafe attachment style. This is the first developmental domain to be compromised. Ainsworth (1974) categorizes three unsafe attachment styles: ambivalent attachment, avoidant attachment, and disorganized attachment. My goal is to complete Ainsworth’s classification by adding the infanticidal attachment style (Kahr, 2007). As mentioned previously, due to attachment trauma the child's development is impaired in all eight developmental domains: needs development, neurobiological development, somatic development, emotional development, cognitive development, self-actualization, and spiritual development.

Prevention

Providing maternity healthcare services that are respectful, competent, and caring is a goal of prevention. The result of such healthcare provision is reduced postpartum PTSD and improved experiences for women during childbirth.

In order to provide adequate care, women need sufficient information about rights, procedures, and birth processes, as well as discussion, respect for the individual, confidentiality, privacy, informed choice, interest, presence, and reassurance (Beck, 2004).

Informed consent for medical treatment in the sphere of reproductive health services and childbirth is a fundamental human right (Šimonović, 2018). Women and their partners should be informed before birth about specific treatments that may be used during childbirth. Thus, they should be able to make well-considered decisions in advance rather than making unsuitable decisions during a traumatizing experience.

Taking a comprehensive history of previous birth experiences as well as specific fears or difficulties is essential to providing quality care. Such information will help clinicians identify and adapt to traumatic signals. Furthermore, it will help prepare the team to address certain factors with special care (Beck, 2004).

A crucial first step is to inform clinicians about the proactive role they can play in preventing PTSD after childbirth. Mental health workers need to be trained in psychological/trauma education. Clinicians' interactions may seem routine to patients. Therefore, medical care providers need to understand how their practice impacts the psychological and emotional experience of birth (Beck, 2004). Women can experience a sense of lost control during labor, so clinicians can offer them options when possible to enhance their sense of control.

Establishing a hospital environment that provides birthing women with a sense of security, safety, and intimacy should also be a priority. As a result, their anxiety and perceived insecurity will be dampened. This makes them more relaxed, thereby reducing complications during birth.

In the aftermath of witnessing a traumatic childbirth, midwives and other medical health professionals need peer support, supervision, psychological guidance, and support.

References

Aydin, R., & Aktaş, S. (2021). Midwives' experiences of traumatic births: A systematic review and meta-synthesis. *European Journal of Midwifery*, *5*(July), 1–10. https://doi.org/10.18332/ejm/138197

Ayers, S., & Pickering, A. D. (2001). Do Women Get Posttraumatic Stress Disorder as a Result of Childbirth? A Prospective Study of Incidence. *Birth-issues in Perinatal Care*, *28*(2), 111–118. https://doi.org/10.1046/j.1523-536x.2001.00111.x

Baez, S. (2023). *The Perceived Impact of Childbirth Related PTSD and Maternal Bonding* [Walden Dissertations and Doctoral Studies]. Walden University.

Bailham, D., & Joseph, S. (2003). Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice. *Psychology Health & Medicine*, *8*(2), 159–168. https://doi.org/10.1080/1354850031000087537

Beck, C. T. (2004). Birth Trauma. In the Eye of the Beholder. *Nursing Research*, *53*(1), 28–35. https://doi.org/10.1097/00006199-200401000-00005

Borges, M. T. (2018). A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence. *PubMed*, *67*(4), 827–862. https://pubmed.ncbi.nlm.nih.gov/29469554

Colaizzi, P. F. (1977). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential phenomenologist alternatives for psycholgy* (pp. 48–71). New York: Oxford University Press.

D'Hooghe, D., & Brack, L. (2018). 'Invisible Attachment Trauma' by Doris D'Hooghe. A brief review. *academia.edu*. https://www.academia.edu/

Ertan, D., Hingray, C., Burlacu, E., Sterlé, A., & El-Hage, W. (2021). Post-traumatic stress disorder following childbirth. *BMC Psychiatry*, *21*(1). https://doi.org/10.1186/s12888-021-03158-6

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the Nursery. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421. https://doi.org/10.1016/s0002-7138(09)61442-4

Greenfield, M., Jomeen, J., & Glover, L. (2016). What is traumatic birth? A concept analysis and literature review. *Britisch Journal of Midwifery*, *24*(4), 254–267. https://doi.org/10.12968/bjom.2016.24.4.254

Marquez, A. (2000). Healing through Prenatal and Perinatal Memory Recall: A Phenomenological Investigation. *Journal of Prenatal and Perinatal Psychology and Health*, *15*(2), 146. https://www.questia.com/library/journal/1P3-1373443731/healing-through-prenatal-and-perinatal-memory-recall

Peterson, S. (2018, November 5). *About Child Trauma*. The National Child Traumatic Stress Network. https://www.nctsn.org/what-is-child-trauma/about-child-trauma

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-016-1197-0

Reid, M. (2011). The impact of traumatic delivery on the mother–infant relationship. *Infant Observation*, *14*(2), 117–128. https://doi.org/10.1080/13698036.2011.583424

Schwab, W., Marth, C., & Bergant, A. (2012). Post-traumatic Stress Disorder Post Partum. *Geburtshilfe Und Frauenheilkunde*, *72*(01), 56–63. https://doi.org/10.1055/s-0031-1280408

Šimonović, D. (2018). *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence* (A/74/137). United Nations. https://eipmh.com/wp-content/uploads/2019/09/UN_Res.71170..pdf

Trombetta, T., Giordano, M., Santoniccolo, F., Vismara, L., Della Vedova, A. M., & Rolle, L. G. C. (2021). Pre-natal Attachment and Parent-To-Infant attachment: A Systematic Review. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.620942

Verreault, N., Da Costa, D., Marchand, A., Ireland, K., Banack, H. R., Dritsa, M., & Khalifé, S. (2012). PTSD following childbirth: A prospective study of incidence and risk factors in Canadian women. *Journal of Psychosomatic Research*, *73*(4), 257–263. https://doi.org/10.1016/j.jpsychores.2012.07.010

Ward, S. (2006). Anger Related to Pre-Conception, Conception, and the Pre- and Perinatal Period. *Journal of Prenatal & Perinatal Psychology & Health; Forestville*, *Vol. 21, Iss. 1*, 57–74.