Nursing Research • July/August 2008 • Vol 57, No 4, 228–236

Impact of Birth Trauma on Breast-feeding

A Tale of Two Pathways

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Editor's Note

Materials documenting the review process for this article are posted at http://www.nursing-research-editor.com.

▶ ***Background:*** Up to 34% of new mothers have reported experiencing a traumatic childbirth. Documented risk factors for delayed or failed lactogenesis include stressful labor and delivery, unscheduled cesarean births, and psychosocial stress and pain related to childbirth.

▶ ***Objective:*** To explore the impact of birth trauma on mothers' breast-feeding experiences.

▶ ***Methods:*** Phenomenology was the qualitative research design used to investigate mothers' breast-feeding experiences after birth trauma. Fifty-two women were recruited over the Internet through the assistance of Trauma and Birth Stress, a charitable trust located in New Zealand. Each mother sent her breast-feeding story to the researchers via the Internet. Colaizzi's (1978) method was used to analyze the data.

▶ ***Results:*** Eight themes emerged about whether mothers' breast-feeding attempts were promoted or impeded. These themes included (a) proving oneself as a mother: sheer determination to succeed, (b) making up for an awful arrival: atonement to the baby, (c) helping to heal mentally: time-out from the pain in one's head, (d) just one more thing to be violated: mothers' breasts, (e) enduring the physical pain: seeming at times an insurmountable ordeal, (f) dangerous mix: birth trauma and insufficient milk supply, (g) intruding flashbacks: stealing anticipated joy, and (h) disturbing detachment: an empty affair.

▶ ***Conclusions:*** The impact of birth trauma on mothers' breast-feeding experiences can lead women down two strikingly different paths. One path can propel women into persevering in breast-feeding, whereas the other path can lead to distressing impediments that curtailed women's breast-feeding attempts.

▶ ***Key Words:*** birth trauma · breast-feeding · phenomenology · PTSD

The World Health Organization (WHO; 2002) recommends exclusive breast-feeding for 6 months. In Healthy People 2010, there are calls for an increase in the proportion of mothers who breast-feed their babies (U.S. Department of Health & Human Services, 2000). The proposed 2010 target is to have 75% of mothers breast-feeding in the early postpartum period, 50% at 6 months, and 25% at 1 year. Listening to the Mothers II survey (Declercq, Sakala, Corry, & Applebaum, 2006) revealed that at 1 week after delivery, 51% of women were breast-feeding exclusively; at 6 months postpartum, 12% of women were breast-feeding exclusively; and at 1 year postpartum, only 3% were breast-feeding exclusively. The New Zealand Ministry of Health (2002) recommended the following breast-feeding targets: to increase exclusive breast-feeding rate at 6 weeks to 90%, at 3 months to 70%, and at 6 months to 27% by the year 2010. Plunket, New Zealand's largest provider of services to support the health and development of children under 5 years old, reported that 52% of New Zealand mothers were breast-feeding exclusively from 2 to 6 weeks, 38% at 10 to 16 weeks, and 14% at 4 to 7 months postpartum (Plunket Client Information System, 2007). In New Zealand, the government funded the Ministry of Health to develop a national breast-feeding campaign. New Zealand also has a National Breast-feeding Advisory Committee.

More work needs to be done to achieve the recommendations of the WHO, Healthy People 2010, and the New Zealand Ministry of Health. To increase the number of infants who are exclusively breast-fed for 6 months, the WHO (2002) calls for addressing the following potential problems: (a) nutritional status of mothers who are breast-feeding; (b) nutrition of infants living in areas with deficiencies, such as in iron, zinc, and vitamin A; and (c) routine primary healthcare of infants. The New Zealand Ministry of Health (2002) noted these barriers to successful breast-feeding: (a) poor initiation of breast-feeding, (b) perceived inadequate breast milk supply, (c) poor

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suckling or attachment, (d) pacifiers, (e) infant formula, (f) early weaning and introduction of solids, and (g) maternal smoking.

Not one of the potential problems or barriers identified by these organizations addresses traumatic childbirth as a possible pivotal factor that can impact breast-feeding. Stressful labor and delivery, emergency cesarean birth, and psychosocial stress or pain due to childbirth are documented risk factors for delayed lactogenesis, which is the initiation of plentiful milk secretion (Dewey, 2001; Hurst, 2007). Examples of reported rates of birth trauma include 34% in the United States (Soet, Brack, & DiIorio, 2003) and 21.4% in The Netherlands (Olde et al., 2005). The percentage of women who go on to develop posttraumatic stress disorder (PTSD) secondary to traumatic childbirth ranges from 1.7% in a sample of 1,640 Swedish women (Wijma, Soderquist, & Wijma, 1997) to 5.9% in a Nigerian sample of 876 mothers (Adewuya, Ologun, & Ibigbami, 2006). One of the cardinal posttraumatic stress symptoms is the avoidance of stimuli or triggers related to the original trauma (American Psychiatric Association, 2000), which can distance mothers from their infants because they are constant reminders of the original trauma the women endured (Ayers, Eagle, & Waring, 2006; Bailham & Joseph, 2003; Beck, 2004a; Nicholls & Ayers, 2007).

The only research located on the impact of any postpartum mood and anxiety disorder on breast-feeding has been focused on postpartum depression (Dennis & McQueen, 2007; McCarter-Spaulding & Horowitz, 2007). The purpose of this qualitative study was to explore the impact of traumatic childbirth on mothers' breast-feeding experiences.

Literature Review

Birth Trauma

Birth trauma is an event that occurs during any phase of the childbearing process that involves actual or threatened serious injury or death to the mother or her infant. The trauma can be classified as a negative outcome, such as postpartum hemorrhage, or psychological distress. Experiencing this extremely traumatic stressor, a woman's response can be intense fear, helplessness, loss of control, and horror (Beck, 2004b). Even though the *Diagnostic and Statistical Manual of Mental Disorders-Text Revision* (*DSM-IV*; American Psychiatric Association, 2000) does not specifically list childbirth as one of its examples of extreme traumatic stressors, childbirth certainly can qualify as one (Beck, 2004b).

In a sample of 40 women from New Zealand, the United States, Australia, and the United Kingdom, mothers' perceptions of the essential components of birth trauma included lack of caring and communication by the labor and delivery staff, provision of unsafe care, and the glossing over of their traumatic experiences as the delivery outcome took center stage (Beck, 2004b). In the United Kingdom, 3 months after delivery, 25 women with severe posttraumatic stress symptoms and 25 women without such symptoms participated in a qualitative study about their birth experiences (Ayers, 2007). Mothers with posttraumatic stress symptoms reported that during their childbirth, they experienced more anger, panic, feelings of being overwhelmed and of giving up, dissociation, and thoughts of death as compared with the mothers without such symptoms.

Reported risk factors for perceiving labor and delivery as traumatic include a high level of obstetric intervention, dissatisfaction with labor and delivery care, loss of control, and a history of psychiatric counseling (Adewuya et al., 2006; Cigoli, Gilli, & Saita, 2006; Nicholls & Ayers, 2007; Soet et al., 2003). For instance, in a sample of 122 Swedish mothers who had emergency cesarean births, Tham, Christensson, and Ryding (2007) reported that 25% of these mothers had moderate posttraumatic stress symptoms and another 9% had a high level of these symptoms at 3 months postpartum. Two factors were associated significantly with these posttraumatic stress symptoms: fetal asphyxia as the reason for the emergency cesarean birth and women with a low sense of coherence or coping style.

Impact of Birthing Practices on Breast-feeding

Delivery type In investigating early cessation of breast-feeding by 7 to 10 days postpartum, Hall et al. (2002) reported that 113 women out of 1,108 had stopped breast-feeding. Vaginal delivery by vacuum extraction was a significant predictor of early cessation of breast-feeding in this sample. Nissen et al. (1996) found in Sweden that compared with women who had vaginal births (n = 20), mothers who had cesarean deliveries (n = 17) had a less pulsatile oxytocin release pattern and lower levels of prolactin. Both of these are critical hormones needed for successful lactation. With a sample of 280 mothers, Dewey (2001) reported that a delay in lactogenesis was related to prolonged duration of labor and emergency cesarean delivery. In New Zealand, 153 mothers participated in semistructured interviews regarding their breast-feeding experiences (Manhire, Hagan, & Floyd, 2007). These interviews revealed that cesarean births had a negative physical effect on breast-feeding but that mothers' persistence and commitment helped sustain their breast-feeding efforts.

Labor stress Chen, Nommsen-Rivers, Dewey, and Lonnerdal (1998) investigated the relationships among labor and delivery, stress hormones, and lactation outcomes in 40 women. At delivery, women who had experienced longer labors had elevated stress hormone levels in their blood and lower breast-feeding frequency on the first day postpartum. On Day 5 after delivery, primiparas who had a long duration of labor had lower milk volume. Grajeda and Perez-Escamilla (2002) reported that stress during labor and delivery, as reflected by cortisol levels, was a significant risk factor for delayed onset of lactation in a sample of 136 mothers in Guatemala.

Researchers are beginning to study the links between breast-feeding outcomes and birthing practices such as type of delivery, length of labor, and labor stress (Kroeger, 2004). These studies have tended to be focused on physiological measures such as cortisol and prolactin levels. The gap in the knowledge base that this qualitative study was designed to fill was mothers' descriptions of how their traumatic childbirth impacted their breast-feeding.

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Methods

Research Question

What is the essence of women's breast-feeding experiences after a traumatic childbirth?

Sample

This Internet sample consisted of 52 mothers. Inclusion criteria were as follows: (a) the mother perceived her childbirth to be traumatic; (b) her birth trauma in some way had impacted her decision to breast-feed, her breast-feeding experience, or both; (c) her age was at least 18 years; and (d) she could articulate her breast-feeding experience.

The obstetric and demographic characteristics of the sample are listed in Table 1. In this sample, the birth trauma was emotional trauma, physical trauma, or a combination. The most frequently reported types of birth trauma included emergency cesarean delivery, postpartum hemorrhage, premature birth, infant in a neonatal intensive care unit, forceps or vacuum extraction, severe preeclampsia, and third- or fourth-degree lacerations. An example of birth trauma that was only reported once in this study was necrotizing fasciitis after cesarean delivery. Nineteen (37%) of the women reported having been diagnosed with PTSD due to childbirth. Three of these 19 women at first had been given an incorrect diagnosis of postpartum depression. At the time of their participation in the study, 16 mothers (31%) were currently under the care of a therapist or counselor. Time to diagnosis ranged from as short as 2 weeks after delivery to as long as 18.5 years.

For Internet samples, Hamilton and Bowers (2006) suggest that the response rate be computed. The response rate for this study was based on the number of women who initially made contact with the researchers for additional information about the study and then went on to participate in the research. In the current study, 129 women initially responded to the Internet recruitment notice and requested more detailed information about the research. Out of these 129 women, 75 participated in the study, for a 58% response rate. Twenty-three of the 75 women who did send their breast-feeding experiences on an attachment to the researchers did not meet all of the sample criteria and consequently were not included in the sample. The reason for not including these 23 mothers was that they had not experienced a traumatic birth. These women wanted to share their difficulties with breast-feeding. The following is an illustration of this:

> I think I made a mistake as the birth of my daughter was not traumatic but we had problems with breast-feeding. You may not want to use my story. I don't want to jeopardize your study at all since the birth was fine.

TABLE 1. Demographic and Obstetric Characteristics of Internet Sample (*n* = 52)

Characteristic	*n*	%
Country		
New Zealand	28	54
United States	11	21
Australia	6	12
United Kingdom	4	7
Canada	3	6
Parity		
Primipara	31	60
Multipara	21	40
Delivery		
Vaginal	26	50
Cesarean	25	48
Both	1	2
Marital status		
Married	46	88
Living with partner	5	10
Separated	1	2
Education		
Graduate school	8	15
College	34	65
Partial college	4	8
High school	3	6
Partial high school	1	2
Missing	2	4

Phenomenology

Colaizzi's (1973; 1978) phenomenological research method was chosen to guide the discovery of the essence of women's breast-feeding experiences after a traumatic childbirth. Colaizzi's (1973; 1978) method includes elements of both interpretive and descriptive phenomenology. Because he was "in full accord with Merleau-Ponty" (Colaizzi, 1973, p. 4), he labeled his phenomenological method as existential phenomenology. Merleau-Ponty (1956) stressed that, "our relation to the world is so profound that the only way for us to notice it is to suspend its movement, to refuse it our complicity or to render it inoperative" (p. 64). Unlike Husserl, who emphasized the need for complete reduction (bracketing of one's natural attitude so that one can allow the phenomenon to show itself), Merleau-Ponty (1956) stated that "the greatest lesson of reduction is the impossibility of a complete reduction" (p. 64). Consciousness for Merleau-Ponty (1962) was viewed as awareness and existence in and toward the world through one's body.

Colaizzi's (1978) method also includes components of Husserlian phenomenology as it places emphasis on description over explanation. Colaizzi (1978) called for phenomenologists to begin their research by uncovering their presuppositions about the phenomenon under study. Individuals must interrogate their presuppositions about the phenomenon under study to discover their beliefs and attitudes. Colaizzi falls short of having the researcher bracket or hold in abeyance these presuppositions as one would do using a pure descriptive phenomenological method. Colaizzi instead directs researchers to use these discovered presuppositions to help formulate research questions.

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Data Analysis

Written descriptions were the source of data in this study of the impact of birth trauma on breast-feeding. When the source of the data comes from written descriptions, Colaizzi (1978) calls for protocol analysis to be used to analyze the data. His procedural steps for this type of analysis are illustrated in Figure 1. There is overlapping among the steps, and the sequence of steps is flexible. This protocol analysis helps to achieve objectivity from the phenomenological perspective. According to Colaizzi (1978, p. 52), "objectivity is fidelity to phenomena. It is a refusal to tell the phenomenon what it is, but a respectful listening to what the phenomenon speaks of itself."

Procedure

Approval from the university's institutional review board was obtained. A recruitment notice was placed on the Web site of Trauma and Birth Stress (TABS), a charitable trust located in New Zealand. The second author was one of the five women who founded TABS. She was instrumental in the recruitment of participants for this study. The mission of TABS (www.tabs.org.nz) is to provide support to mothers who have suffered through traumatic childbirths and to educate healthcare professionals and the lay public on PTSD due to birth trauma. For the 11-month data collection period, the average number of hits to the Web site was 13,264 per month.

An information sheet and directions for the study were sent as an attachment via e-mail by the first author to interested participants. After reading these two documents, prospective participants had the opportunity to e-mail the first author to ask questions about the study. Participation in the research required the mother to write her story of the impact her traumatic childbirth had on her breast-feeding experiences in as much detail as she wished to share. Participants sent their stories to the researchers over the Internet as an e-mail attachment. Sending their stories implied informed consent. Follow-up e-mails to participants were made at times to ask women to clarify a point they had made or to provide a specific example. The length of time it took for mothers to send their stories after they had received the information sheet and directions ranged from 1 to 10 weeks.

Methodological Congruence

In qualitative research, methodological congruence consists of four components: rigor in documentation, procedural rigor, ethical rigor, and auditability (Burns, 1988). These criteria were used to address the rigor of this study on the impact of birth trauma on breast-feeding. The essential elements of this research, such as the research question, purpose, sampling, and data analysis, have all been addressed, as is called for in documentation rigor. Regarding procedural rigor, the researchers included women of all levels of education, from lower than a high school diploma to doctoral degrees, to eliminate the potential for "elite bias." The first author kept a journal where she recorded her reactions, thoughts, and feelings during the data collection and analysis phases of the study. A sufficient amount of time (11 months) was spent gathering data. Sufficient data were gathered. Fifty-two women participated in this Internet study. This number exceeded what was necessary to achieve saturation of data. Because the women had e-mailed their stories, the researchers felt obligated to include their data in the study findings.

Ethical rigor was maintained. The research was approved by the university's institutional review board. Each participant was sent via e-mail attachment an information sheet regarding the particulars of the study. Prospective participants could e-mail questions to the first author. Auditability, which is the fourth dimension of Burns' (1988) methodological congruence, addressed the decision trail

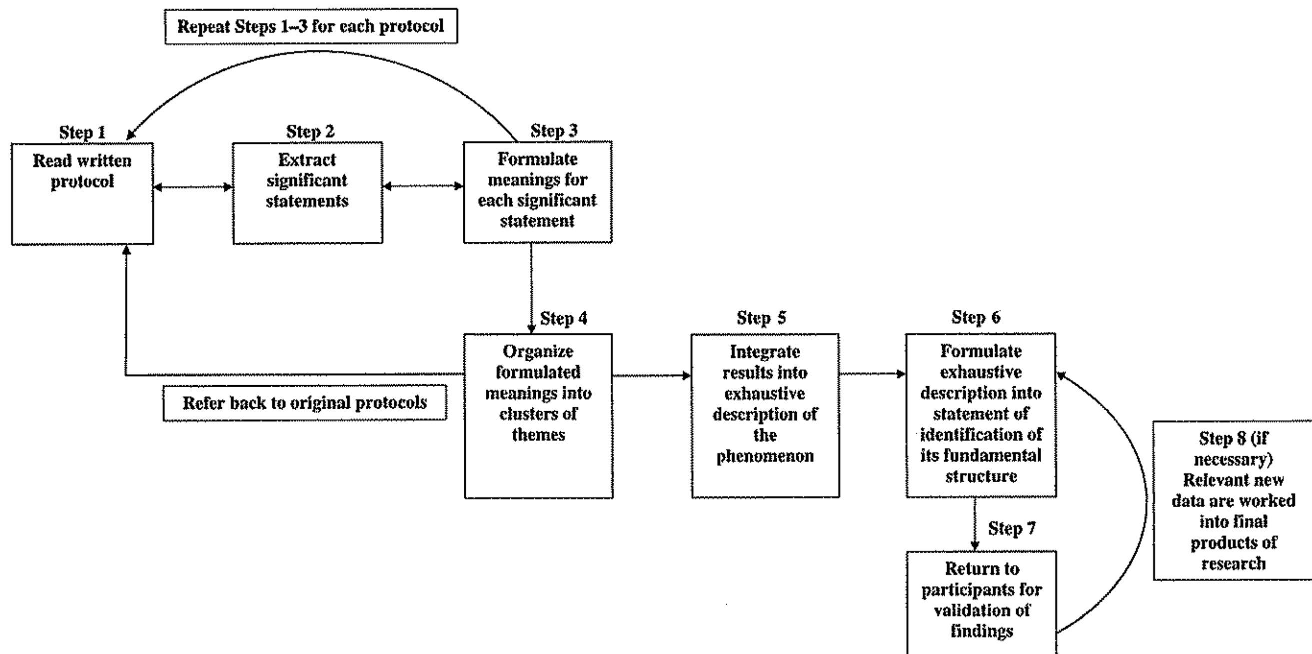

FIGURE 1. Colaizzi's procedural steps for analyzing data phenomenologically.

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used by the researchers to arrive at their findings from the original data. The second author followed the decision trail of the first author and confirmed the themes that emerged from Colaizzi's (1978) method of data analysis. Two other mothers who had experienced birth trauma and breast-fed their infants reviewed the findings and did not make any suggestions for change. They both said not to change a thing. Table 2 provides a partial audit trail of specific examples for how meanings were formulated from mothers' significant statements.

Results

Analysis of the 52 stories of the impact of birth trauma on breast-feeding produced 249 significant statements, which yielded eight themes. Three of the women in the study chose not to initiate breast-feeding. These mothers had experienced postpartum depression or PTSD with previous births. These women knew their limits and wanted to protect their mental health so that they could be the mothers they wanted themselves to be for their newborn infants. One mother revealed, "I clung dearly to my emotional equilibrium, rather than allowing what I had heard too clearly of the emotional difficulties of breastfeeding to be my downfall."

Forty-nine mothers who had experienced traumatic births chose to breast-feed. The duration of breast-feeding for this sample ranged from 48 hours to 27 months. Each of the eight themes describes aspects of birth trauma that promoted or impeded breast-feeding. These themes are portrayed as weights on a scale that, depending on the number of these weights a woman experienced, could tip the breast-feeding scale in one direction or another (Figure 2). The first three themes helped to facilitate breast-feeding, whereas last five themes hampered or disrupted mothers' experiences related to breast-feeding. The use of the weights on a scale to illustrate the themes does not mean to imply at all that the themes are divided into opposing categories. Rather,

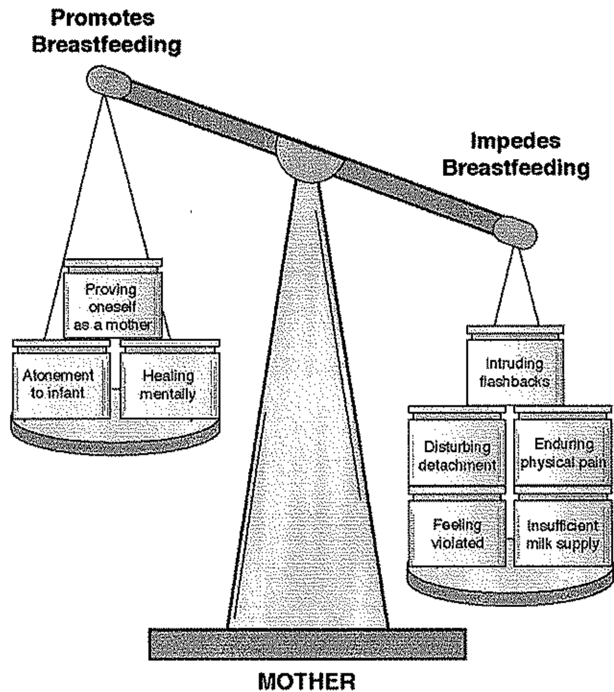

FIGURE 2. Breast-feeding scale.

mothers' breast-feeding experiences were so complex that each woman experienced a different constellation and weighting of these themes, which inevitably led them down a path that facilitated breast-feeding or another path that hindered their breast-feeding attempts.

Theme 1: Proving Oneself as a Mother: Sheer Determination to Succeed

Repeatedly, mothers shared that after "failing" at giving birth, they wanted to do something "right." Words such as *determined*, *resoluteness*, *unfaltering*, *steadfastness*, and

TABLE 2. Selected Examples of a Partial Audit Trail in Data Analysis for Theme 7 and Theme 3

Theme 7: Intruding flashbacks: stealing anticipated joy

Significant statements	Formulated meanings
"I didn't understand that the continuing flashbacks and unresolved anxiety from the trauma could have had any connection with my poor milk production."	The mother did not understand that her insufficient milk production could be connected to her flashbacks and unresolved anxiety from her traumatic birth.
"I started having flashbacks about the birth in which she would be born disfigured or in which I was covered in blood with no baby. This affected my breastfeeding as it would happen directly after a let down."	Flashbacks of the traumatic birth of her daughter would occur after let down and affect the mother's breast-feeding.

Theme 3: Helping to heal mentally: Time out from the pain in one's head

Selected Subsumed Formulated Meanings
1. Women looked forward to breast-feeding, which had a calming effect and provided a physical bond with their infants.
2. Breast-feeding was like a beacon of light, which gave mothers hope that they would recover from their birth trauma.
3. Mothers' level of guilt decreased due to breast-feeding.

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strength of purpose all described these women. Part of the tenacity to succeed at breast-feeding after experiencing birth trauma was the need for women to "prove" themselves as mothers. One woman who had an emergency cesarean birth revealed,

> Breastfeeding became my focus for overcoming the birth and proving to everyone else and mostly to myself that there was something that I could do right. It was part of my crusade, so to speak, to prove myself as a mother.

A primipara who had a prolonged labor which ended with a vacuum extraction of her infant recalled "a sense of failure at not having the birth I expected, and guilt at feeling that it was just a horrible, painful, bloody experience. In my mind, I think being able to breastfeed successfully was the only and last chance I had to 'normalize' my horrible experience with giving birth so I was bloody determined to do it."

After delivering her premature infant at 32 weeks' gestation via emergency cesarean delivery due to severe preeclampsia, this mother felt the following:

> I had failed in my first task as a mother, to carry her to term. I had lost so much because of her premature birth that I was going to be damned to hell before I was going to give up on nursing her, especially before it even started.

Theme 2: Making Up for an Awful Arrival: Atonement to the Baby

Women repeatedly explained that their decision to breast-feed was driven by their need to make amends to the infants for the traumatic way they had arrived into the world, for example, by emergency cesarean delivery or failed vacuum extraction followed by forceps. Mothers were unyielding in their resolve to make atonement to their infants for their "sin" of the traumatic birth. As one primipara admitted, "Breastfeeding became a form of forgiveness for me. Giving my daughter the best possible start, I breastfed her for 27 months." A multipara who had an emergency cesarean birth revealed, "Breastfeeding became almost an act of vindication. I had to make up for failing to provide my daughter with a normal birth, so I sure wasn't going to fail again."

After experiencing the trauma of an emergency cesarean under general anesthesia, this multipara described,

> I have very sensitive breasts and never had any intent of breastfeeding throughout my whole pregnancy. I changed my mind after I had the traumatic birth because I wanted to make my baby feel more secure after I wasn't there for him straight away. I didn't care anymore about the privacy of my breasts. They had a greater purpose.

Theme 3: Helping to Heal Mentally: Time-out From the Pain in One's Head

After experiencing traumatic childbirth, some mothers disclosed that breast-feeding was soothing. As one multipara who had suffered through postpartum hemorrhage explained,

> Breastfeeding was a time-out from the pain in my head. It was a 'current reality'—a way to cling onto some 'real life.' Whereas all the trauma that continued to live on in my head belonged to the past even though I couldn't seem to keep it there.

Breast-feeding helped to heal women and restore their self-esteem and faith in their bodies. One woman who had delivered prematurely by emergency cesarean birth revealed,

> My body's ability to produce milk, and so the sustenance to keep my baby alive also helped to restore my faith in my body, which at some core level, I felt had really let me down, due to a terrible pregnancy, labor and birth. It helped to build my confidence in my body and as a mother. It helped me heal and feel connected to my baby.

A mother who had been diagnosed with PTSD due to childbirth successfully breast-fed her preterm daughter for over 2 years. As she shared, when she breast-fed,

> I would cover her up to feed her and hide her little head in the clothing. Not because of dignity, but because I did not want anyone else to see the magic and healing that was happening between us. Being able to breastfeed my daughter, despite all the odds, is my proudest achievement in life. I wear it in my soul as a badge of honor.

Theme 4: Just One More Thing to be Violated: Mothers' Breasts

Often, women who were traumatized, either physically or emotionally during childbirth, felt violated and stripped of their dignity. As a result, some mothers became vigilant about protecting their bodies from being violated again; specifically, their vigilance was aimed at their breasts. Feeling violated during childbirth weighed in heavily on the scale, tipping it toward impeding breast-feeding. Mothers wanted control of their bodies so that they could not be violated yet again.

One woman who had given birth to a 33-week premature infant by an emergency cesarean delivery found it hard, while her baby was in the neonatal intensive care unit, to have other people handling her breasts as they tried to get her baby to latch on: "I was sick of everyone grabbing my breasts like they didn't even belong to me. My breasts were just another thing to be taken away and violated."

A primipara, who had an induction followed by a failed vacuum extraction and a cesarean delivery, divulged,

> When I breastfed my baby, I felt like it was one more invasion up on my body and I couldn't handle that after the labor I had suffered. Whenever I put her to breast, I wanted to scream and vomit at the same time. After a horrible 8 weeks, I made the decision to stop breastfeeding. It was crucial in me reclaiming some power for myself, in taking back control of my life, my body and my right to choose what kind of care was best for my child.

A mother, who had endured the loss of her longed-for baby with her first pregnancy, developed PTSD due to her traumatic experiences during that childbirth. After her

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second pregnancy, her response to breast-feeding her newborn reflected the long-term effects of her previous birth trauma. She wrote,

> The body anger. How was I to know if I could succeed at breastfeeding. So why do it when to learn and to do it, invites assistance from health professionals, and if you even touch my body again, or touch me like that, I am going to kick you. I already knew too well the invasion of the privates of one's body.

Theme 5: Enduring the Physical Pain: Seeming at Times an Insurmountable Ordeal

Mothers' pain from the physical trauma that occurred during their deliveries took a toll on breast-feeding. Just as the psychological trauma weighed in on breast-feeding experiences, so did the physical trauma. After suffering severe physical trauma during a vaginal delivery and postpartum hemorrhage, a primipara recounted her painful attempts at initiating breast-feeding,

> Nursing required sitting up, putting pressure on my pointless episiotomy. When the nurses would check my bottom, they would visibly wince before pulling the blanket back up. I snuck a peak myself at one point and was appalled to see that my labia were so swollen that they looked like testicles. I hated breastfeeding because it hurt to try and sit to do it. I couldn't seem to manage lying down. I was cheated out of breastfeeding. I feel I have been cheated out of something exceptional.

For some women whose physical trauma tipped the scale into deciding to stop breast-feeding early on, their decision still haunts them. This is illustrated by the following passage:

> For me I've gotten over the fact that I nearly died having my baby, that I was pretty well ripped and stretched and re-stitched and couldn't breastfeed her. But I hurt for her pain. Somehow I have to forgive myself for stopping breastfeeding after only a short time and not giving her something I couldn't possibly have given her in the state that I was in. Physically I've gotten over her birth, the scars have healed and my iron count has returned to normal, but emotionally I'm still torn. I can't turn back the clock, somehow I'm just going to have to count my blessings and dismiss my failure to breastfeed.

Theme 6: Dangerous Mix: Birth Trauma and Insufficient Milk Supply

Women repeatedly shared their belief that one of the repercussions of their traumatic childbirth was an inadequate milk supply. "My meager milk supply," was recounted frequently by the women. In the end, this resulted in some mothers calling it quits regarding breast-feeding. After experiencing severe postpartum hemorrhage where the mother went into shock and then 3 weeks later had a uterine infection, this multipara disclosed, "I think the trauma definitely affected my milk supply. It wasn't an easy decision but a continuing inadequate milk supply and a desperate need to reduce the pressure, I was forced to 'call it quits.'" Another woman, who suffered a torn pelvic ligament and had a severe reaction to drugs given for her high blood pressure, revealed, "My body was so traumatized by the delivery and days after it that it never fully recovered from it. My milk never really came in well."

For some women, their birth trauma delayed their milk coming in. A woman who had a forceps delivery without any pain medication and whose baby was not breathing at first recalled that having this traumatic birth "had a large impact on my breast-feeding experience. I was in a lot of shock and my milk did not come in for quite a while. My baby was starting to become dehydrated."

Theme 7: Intruding Flashbacks: Stealing Anticipated Joy

Uncontrollable flashbacks from traumatic births had a detrimental domino effect on women's breast-feeding experiences. While trying to breast-feed, these intrusive, unwelcome flashbacks caused women great distress, leading not only to the mothers crying but also at times their infants becoming upset.

With her first delivery, one woman endured a long, painful labor in which her epidural had not been working. She ended up with a forceps delivery and stated,

> I had flashbacks to the birth every time I would feed him. When he was put on me in the hospital, he wasn't breathing and he was blue. I kept picturing this; and could still feel what it was like. Breastfeeding him was a similar position as to the way he was put on me. I would get really upset and cry when I fed him which would cause my baby to cry.

Another primipara shared,

> Probably the worst time was breastfeeding at night. I would be half awake, half dreaming, and I would have flashbacks and dream (or hallucinate?) that my breast would turn into the face of a witch and cackle and laugh menacingly at me. Other times, my daughter's head would turn into the witch and try to eat my breast off.

For some women, the anguish of these troubling flashbacks caused them to make a decision to stop breast-feeding early in an attempt to find some comfort and solace. As one mother divulged, "The flashbacks to the birth were terrible. I wanted to forget about it and the pain so stopping breastfeeding would get me a bit closer to my 'normal' self again." One mother who had been sexually abused as a child disclosed, "When I placed my baby to the breast, it triggered flashbacks of my abuse as a child."

Theme 8: Disturbing Detachment: An Empty Affair

Feeling distanced and detached from their infants was yet another way in which birth trauma tipped the scale toward impeding breast-feeding. One wrote,

> Breastfeeding my son in the first few months, certainly the first 6 but possibly as much as 9 months was an empty affair. I felt nothing at all. Breastfeeding was just one of the many things I did while remaining totally detached from my baby.

Another mother admitted, "I hated having to offer my body to my child who felt like a stranger."

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After surviving a postpartum hemorrhage, this multipara shared,

> The first 5 months of my baby's life (before I got help) are a virtual blank. I dutifully nursed him every 2 to 3 hours on demand, but I rarely made any eye contact with him and dumped him in his crib as soon as he was done. I thought that if it were not for the breastfeeding, I could go the whole day without interacting with him at all.

One woman had an emergency cesarean birth under general anesthesia. On contemplating how her birth trauma affected her breast-feeding, she disclosed,

> I didn't feel like a real mother as I was unable to give my daughter a normal birth. I felt very disconnected from this baby as I breastfed her. I felt she could be anyone's baby as I hadn't seen her being 'removed' from me and because I didn't see anything that was going on.

Limitations

Although Internet recruitment enabled women from the United States, New Zealand, Australia, the United Kingdom, and Canada to participate in the study, this sampling method also has some drawbacks. Hamilton and Bowers (2006) warn that Internet samples usually are more highly educated and have higher incomes than non-Internet samples. Transferability of the study findings may also be limited due to the women who participated used TABS, the charitable trust in New Zealand, for support via the Internet. Traumatized mothers who do not have Internet support may describe the impact of their birth trauma differently than the women in this sample.

Discussion

All the women in the sample were similar in the fact that they perceived that they had suffered through a traumatic childbirth, but the impact this trauma had on their breast-feeding was a tale of two strikingly different experiences. The two main clusters of themes that emerged from women's stories illustrate this division of paths, one facilitating and the other hampering breast-feeding attempts. The three themes that promoted breast-feeding and the five themes that hindered it addressed a range of possible aspects of birth trauma that can impact mothers' breast-feeding experiences. Not every mother experienced all of these components. In addition, some women experienced similar effects of their birth trauma, such as feeling violated, but the weight of these specific aspects was different for each woman. Mothers presented with a different constellation of weights, which resulted in the breast-feeding scale tipping in either a positive or negative direction.

Intensive one-on-one support for traumatized mothers as they establish breast-feeding may be necessary. Strategies to approach breast-feeding support can be gleaned from the results of this study. For example, some traumatized women felt like their breasts were just one more thing to be violated. Respect needs to be given to each mother. It is suggested that clinicians always ask permission before touching a woman's breasts to assist with breast-feeding.

During the postpartum period, it is suggested that healthcare providers be attentive to symptoms that may be indicative of a mother having experienced a traumatic birth such as being withdrawn, having a dazed look, or having temporary amnesia (Church & Scanlan, 2002). When observing a woman breast-feeding, it should be noted if she seems distanced and detached from her infant. Clinicians need to remember that birth trauma not only can affect the mother but can also affect her developing a relationship with her infant. The theme of disturbing detachment to the infants confirms the findings of previous research (Ayers et al., 2006; Nicholls & Ayers, 2007).

Prior to discharge from the hospital, it is suggested that clinicians explore with mothers whether or not they perceive their labor and delivery traumatic. Clinicians can screen women for posttraumatic stress symptoms using instruments such as the Perinatal PTSD Questionnaire (Callahan, Borja, & Hynan, 2006). Depending on the severity of symptoms, women may need to be referred to a mental healthcare provider and be followed more closely once they are home.

Providing mothers with support, information, and encouragement to continue breast-feeding is just half of the clinicians' responsibility. Letting women know that they have the right to choose not to breast-feed without guilt or judgment is the other equally important half. Pressure to continue to breast-feed no matter what obstacles mothers are facing can compound their feelings of shame and inadequacy.

Future Research

Additional research is needed to delve further into the complex dynamics of birth trauma on mothers' breast-feeding experiences, that is, what are significant predictors of how a woman who has experienced a traumatic birth will react to breast-feeding? The impact of birth trauma on mother–infant interaction certainly needs investigation. The efficacy of interventions for mothers with posttraumatic stress symptoms due to birth trauma is yet another area that researchers can address. The psychometrics of various instruments to screen for posttraumatic stress symptoms in new mothers need to be assessed. Future research on birth trauma can take multiple directions because there is such a paucity of knowledge on its effects.

Accepted for publication February 26, 2008.

This manuscript is dedicated to the women whose courage and profound generosity made it possible for all of us to learn about the impact of a traumatic childbirth on breast-feeding.

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References

Adewuya, A. O., Ologun, Y. A., & Ibigbami, O. S. (2006). Posttraumatic stress disorder after childbirth in Nigerian women: Prevalence and risk factors. *BJOG, 113*(3), 284–288.

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

Ayers, S. (2007). Thoughts and emotions during traumatic birth: A qualitative study. *Birth, 34*(3), 253–263.

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Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health & Medicine, 11*(4), 389–398.

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.

Beck, C. T. (2004a). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research, 53*(4), 216–224.

Beck, C. T. (2004b). Birth trauma: In the eye of the beholder. *Nursing Research, 53*(1), 28–35.

Burns, N. (1988). Standards for qualitative research. *Nursing Science Quarterly, 2*(1), 44–52.

Callahan, J. L., Borja, S. E., & Hynan, M. T. (2006). Modification of the Perinatal PTSD Questionnaire to enhance clinical utility. *Journal of Perinatology, 26*(9), 533–539.

Chen, D. C., Nommsen-Rivers, L., Dewey, K. G., & Lonnerdal, B. (1998). Stress during labor and delivery and early lactation performance. *American Journal of Clinical Nutrition, 68*(2), 335–344.

Church, S., & Scanlan, M. (2002). Post-traumatic stress disorder after childbirth: Do midwives have a preventative role? *Practising Midwife, 5*(6), 10–13.

Cigoli, V., Gilli, G., & Saita, E. (2006). Relational factors in psychopathological responses to childbirth. *Journal of Psychosomatic Obstetrics and Gynaecology, 27*(2), 91–97.

Colaizzi, P. (1973). *Reflection and research in psychology: A phenomenological study of learning.* Dubuque, IA: Kendall/Hunt Publishing Company.

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.

Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to mothers II: Report of the second national survey of women's childbearing experiences.* New York: Childbirth Connection.

Dennis, C. L., & McQueen, K. (2007). Does maternal postpartum depressive symptomatology influence infant feeding outcomes? *Acta Paediatrica, 96*(4), 590–594.

Dewey, K. G. (2001). Maternal and fetal stress are associated with impaired lactogenesis in humans. *Journal of Nutrition, 131*(11), 3012s–3015s.

Grajeda, R., & Perez-Escamilla, R. (2002). Stress during labor and delivery is associated with delayed onset of lactation among urban Guatemalan women. *Journal of Nutrition, 132*(10), 3055–3060.

Hall, R. T., Mercer, A. M., Teasley, S. L., McPherson, D. M., Simon, S. D., Santos, S. R., et al. (2002). A breast-feeding assessment score to evaluate the risk for cessation of breast-feeding by 7 to 10 days of age. *Journal of Pediatrics, 141*(5), 659–664.

Hamilton, R. J., & Bowers, B. J. (2006). Internet recruitment and e-mail interviews in qualitative studies. *Qualitative Health Research, 16*(6), 821–835.

Hurst, N. M. (2007). Recognizing and treating delayed or failed lactogenesis II. *Journal of Midwifery & Women's Health, 52*(6), 588–594.

Kroeger, M. (2004). *Impact of birthing practices on breastfeeding.* Sudbury, MA: Jones & Bartlett.

Manhire, K. M., Hagan, A. E., & Floyd, S. A. (2007). A descriptive account of New Zealand mothers' responses to open-ended questions on their breast feeding experiences. *Midwifery, 23*(4), 372–381.

McCarter-Spaulding, D., & Horowitz, J. A. (2007). How does postpartum depression affect breastfeeding? *American Journal of Maternal Child Nursing, 32*(1), 10–17.

Merleau-Ponty, M. (1956). What is phenomenology? *Cross Currents, 6*, 59–70.

Merleau-Ponty, M. (1962). *Phenomenology of perception.* London: Routledge & Paul.

New Zealand Ministry of Health, (2002). *Breastfeeding: A guide to action* [Fact sheet]. Retrieved December 17, 2007, from http://www.moh.govt.nz/moh.nsf/pagesmh/2006

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*(Pt. 4), 491–509.

Nissen, E., Uvnas-Moberg, K., Svensson, K., Stock, S., Widstrom, A.-M., & Winberg, J. (1996). Different patterns of oxytocin, prolactin but not cortisol release during breastfeeding in women delivered by caesarean section or by the vaginal route. *Early Human Development, 45*(1–2), 103–118.

Olde, E., van der Hart, O., Kleber, R. J., van Son, M. J. M., Wijnen, H. A. A., & Pop, V. J. M. (2005). Peritraumatic dissociation and emotions as predictors of PTSD symptoms following childbirth. *Journal of Trauma & Dissociation, 6*(3), 125–142.

Plunket Client Information System, (2007). *Plunket breastfeeding statistics: Summary data 2000–2007.* Wellington, New Zealand: Royal New Zealand Plunket Society.

Rossman, B. (2007). Breastfeeding peer counselors in the United States: Helping to build a culture and tradition of breastfeeding. *Journal of Midwifery & Women's Health, 52*(6), 631–637.

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth, 30*(1), 36–46.

Tham, V., Christensson, K., & Ryding, E. L. (2007). Sense of coherence and symptoms of post-traumatic stress after emergency caesarean section. *Acta Obstetricia et Gynecologica Scandinavica, 86*(9), 1090–1096.

U.S. Department of Health & Human Services, (2000). *Healthy people 2010: With understanding and improving health and objectives for improving health.* Washington, DC: United States Government Printing Office.

Wijma, K., Soderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: A cross sectional study. *Journal of Anxiety Disorders, 11*(6), 587–597.

World Health Organization. (2002). *The optimal duration of exclusive breastfeeding: Report of an expert consultation.* Geneva, Switzerland: Author.

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