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Title: Impact of Birth Trauma on Breastfeeding: A Tale of Two Pathways

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Abstract: Abstract

Background: Thirty-two to 55% of new mothers have reported experiencing birth trauma. Up to 6% of these women develop post-traumatic stress disorder secondary to traumatic childbirth.

Objective: The purpose of this qualitative study was to explore the impact of birth trauma on mothers' breastfeeding experiences.

Methods: Descriptive phenomenology was the qualitative research design used to investigate mothers' breastfeeding experiences following birth trauma. Fifty-two women were recruited over the Internet through the assistance of Trauma and Birth Stress (TABS), a charitable trust located in New Zealand. Each mother sent her breastfeeding story to the researcher via the Internet. Colaizzi's method was used to analyze the data.

Results: Eight themes emerged that are portrayed as factors that weighed in on whether mothers' breastfeeding attempts were promoted or impeded. These themes included Proving oneself as a mother: sheer determination to succeed, Making up for an awful arrival: atonement to the baby, Helping to heal mentally: time out from the pain in one's head, Just one more thing to be violated: mothers' breasts, Enduring the physical pain: seeming at times an insurmountable ordeal, Dangerous mix: birth trauma and insufficient milk supply, Intruding flashbacks: stealing anticipated joy, and Disturbing detachment: an empty affair.

Conclusions: The impact of birth trauma on mothers' breastfeeding experiences can lead women down two strikingly different paths. One path can propel women into persevering in breastfeeding while the other path can lead to distressing impediments that painfully curtailed women's breastfeeding attempts.

Key Words: birth trauma, breastfeeding, PTSD, phenomenology

August 20, 2007

Molly C. Dougherty, PhD, RN, FAAN
Editor, *Nursing Research*
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Dear Dr. Dougherty:

Attached is my manuscript entitled, *Impact of Birth Trauma on Breastfeeding: A Tale of Two Pathways*. It is the latest study in my research program on birth trauma and its resulting PTSD. This study has received approval by the Institutional Review Board of the University of Connecticut. I am the first author and Sue Watson is the second author. We have adhered to all the ethical guidelines put forth by this IRB. We have no conflict of interest to declare.

Thank you in advance for all the time and effort that will be required in this review process.

Sincerely,

Cheryl Tatano Beck, DNSc, CNM, FAAN
Professor

Running head: IMPACT OF BIRTH TRAUMA ON BREASTFEEDING

Impact of Birth Trauma on Breastfeeding: A Tale of Two Pathways

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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 breastfeeding.

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3 trauma. Up to 6% of these women develop post-traumatic stress disorder secondary to
4 traumatic childbirth.

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18 milk supply, Intruding flashbacks: stealing anticipated joy, and Disturbing detachment:
19 an empty affair.

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21 women down two strikingly different paths. One path can propel women into persevering
22 in breastfeeding while the other path can lead to distressing impediments that painfully

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- 2 PTSD, phenomenology

1 The World Health Organization (WHO) recommends exclusive breastfeeding for 6
2 months (2002). Healthy People 2010 calls for an increase in the proportion of mothers
3 who breastfeed their babies (U.S. Department of Health & Human Services, 2000). The
4 proposed 2010 target is to have 75% of mothers breastfeeding in the early postpartum
5 period, 50% at 6 months, and 25% at 1 year. Listening to Mothers II survey (Declercq,
6 Sakala, Corry, & Applebaum, 2006) revealed that at 1 week after delivery 51% of women
7 were breastfeeding exclusively, at 6 months postpartum 12% of women were exclusively
8 breastfeeding while at 1 year postpartum only 3% were exclusively breastfeeding. The
9 Ministry of Health (2002) recommended the following breastfeeding targets in New
10 Zealand: to increase exclusive breastfeeding rate at 6 weeks to 90%, at 3 months to 70%,
11 and at 6 months to 27% by the year 2010. Plunket (2007) reported that 52% of mothers
12 were exclusively breastfeeding from 2-6 weeks, 38% at 10-16 weeks, and 14% at 4-7
13 months postpartum in New Zealand. Plunket is New Zealand's largest provider of
14 services to support the health and development of children under 5 years of age.

15 Much more work needs to be done to achieve the recommendations of the WHO,
16 Healthy People 2010, and the Ministry of Health. In order to increase the number of
17 infants who are exclusively breastfed for 6 months, the WHO (2002) calls for addressing
18 the following potential problems: (1) nutritional status of mothers who are breastfeeding,
19 (2) nutrition of infants living in areas with deficiencies like iron, zinc, and vitamin A, and
20 (3) routine primary health care of infants. In New Zealand the Ministry of Health (2002)
21 noted these barriers to successful breastfeeding: (1) poor initiation of breastfeeding, (2)
22 perceived inadequate breast milk supply, (3) poor suckling/attachment, (4) pacifiers, (5)
23 infant formula, (6) early weaning and introduction of solids, and (7) maternal smoking.

1 None of these potential problems or barriers identified by these organizations addresses
2 birth trauma as a possible, pivotal factor impacting breastfeeding. The range of women
3 reporting birth trauma is from 32% (Maggioni, Margola, & Filippi, 2006) to 55%
4 (Ryding, Wijma, & Wijma, 1998). The purpose of this qualitative study was to explore
5 the impact of a traumatic birth on mothers' breastfeeding experiences.

6 Literature Review

7 *Birth Trauma*

8 Birth trauma is an event that occurs during labor and/or delivery that involves
9 actual or threatened serious injury or death to the mother or her infant. Experiencing this
10 extremely traumatic stressor, a woman's response can be intense fear, helplessness, loss
11 of control and horror. Even though the Diagnostic and Statistical Manual of Mental
12 Disorders (DSM-IV; APA, 2000) does not specifically list childbirth as one of its
13 examples of extreme traumatic stressors, childbirth certainly can qualify as an extreme
14 traumatic event (Beck, 2004a). Mothers' perceptions of the essential components of birth
15 trauma include lack of caring and communication by labor and delivery staff, provision
16 of unsafe care, and the glossing over of their traumatic experiences as the delivery
17 outcome took center stage (Beck, 2004b).

18 Reported risk factors for perceiving labor and delivery as traumatic include a high level
19 of obstetric intervention, dissatisfaction with labor and delivery care, feeling powerless,
20 and a history of psychiatric counseling (Creedy, Shochet, & Horsfall, 2000; Czarnocka &
21 Slade, 2000; Soet, Brack, & Dilorio, 2003).

22 Up to 6% of women go on to develop post-traumatic stress disorder (PTSD)
23 secondary to traumatic childbirth (Creedy, et al., 2000). One of the cardinal symptoms of

1 PTSD is the avoidance of stimuli or triggers related to the original trauma (APA, 2000).
2 PTSD can distance mothers from their infants since they are constant reminders of the
3 original trauma the women endured. This troubled mother-infant relationship is not
4 temporary for some women. As one mothers suffering from PTSD painfully shared, “My
5 child turned 3 years old a few weeks ago... I hope that as time passes I can forge some
6 kind of real closeness with this child. I am still unable to tell him I love him, but I can
7 now hold him and have times when I am proud of him” (Beck, 2004b, p.222).

8 Olde, van der Hart, Kleber, and van Son (2006) concluded their review of the
9 literature by calling for examining the chronic nature of traumatic births, particularly
10 looking at childbirth related posttraumatic stress lasting more than 6 months after
11 delivery. Mother-infant attachment problems, sexual avoidance and fear of childbirth are
12 some of the long-term effects of traumatic childbirth (Bailham & Joseph, 2003; Beck,
13 2004b). Women also suffer from emotional and physical distress surrounding the yearly
14 anniversary of their birth trauma (Beck, 2006).

15 *Factors Impacting Breastfeeding*

16 *Labor stress and lactogenesis.* Chen et al (1998) investigated the relationship
17 among labor and delivery, stress hormones, and lactation outcomes in 40 women. At
18 delivery women who had experienced longer labors had elevated stress hormone levels in
19 their blood, and lower breastfeeding frequency on the first day postpartum. On day 5
20 after delivery, primiparas who had a long duration of labor had lower milk volume.
21 Dewey (2001) reported that a delay in lactogenesis was related to prolonged duration of
22 labor and emergency cesarean delivery. Grajeda and Perez-Escamilla (2002) reported that

1 stress during labor and delivery, as reflected by cortisol levels, was a significant risk
2 factor for delayed onset of lactation.

3 *Postpartum depression.* The only research located on the impact of any
4 postpartum mood and anxiety disorder on breastfeeding has focused on postpartum
5 depression. No consistent pattern, however, has been confirmed between breastfeeding
6 and postpartum depressive symptomatology. Some studies have found that mothers with
7 elevated levels of depressive symptomatology were more likely to wean early and bottle
8 feed than mothers who were not depressed (Dennis & McQueen, 2007; Dunn, Davies,
9 McCleary, Edwards, & Gaboury, 2006; Forester, McLachlan, & Lumley, 2006;
10 McLearn, Munkovitz, Strobino, Marks, & Hou, 2006). Opposite findings have been
11 reported in which women who breastfeed had significantly lower postpartum depressive
12 symptoms than nonlactating mothers (Breese, et al, 2006; Groer, 2005; Mezzacoppa &
13 Katkin, 2002). In other studies, no relationship between levels of postpartum depressive
14 symptoms and breastfeeding were found (Boyd, Zayas & McKee, 2006; McCarter-
15 Spaulding & Horowitz, 2007). No studies were found that examined the impact of
16 traumatic births on breastfeeding.

17 Methods

18 *Research Question*

19 What is the essential structure of women's experiences of the impact of birth
20 trauma on their breastfeeding experiences?

21 *Sample*

22 Inclusion criteria were as follows: (a) the mother perceived her childbirth to be
23 traumatic, (b) her birth trauma in some way had impacted her decision to breastfeeding

1 and/or her breastfeeding experience, (c) her age was at least 18 years, and (d) she could
2 articulate her breastfeeding experience.

3 This Internet sample consisted of 52 mothers who perceived their traumatic births
4 had an impact on their breastfeeding experiences. The obstetrical and demographic
5 characteristics of the sample are listed in Table 1. In this sample, the birth trauma was
6 either emotional trauma and/or physical trauma. In Table 2 are listed the most frequently
7 reported types of birth trauma. An example of birth trauma that was only reported once in
8 this study was necrotizing fasciitis following cesarean delivery. Nineteen (37%) of the
9 women reported having been diagnosed with PTSD due to childbirth. At the time of their
10 participation in the study 16 mothers (31%) were currently under the care of a
11 therapist/counselor.

12 *Research Design*

13 The method of inquiry for the study was Colaizzi's (1973;1978) existential
14 phenomenological research method. The outcome of this method is a fundamental
15 structure of the phenomenon being studied, in this case, the impact of birth trauma on
16 breastfeeding. Using this method, the researcher phenomenologically reflects on the data
17 in order to explicate the phenomenon's essences.

18 Written descriptions were the source of data in this study of the impact of birth
19 trauma on breastfeeding. When the source of the data comes from written descriptions,
20 Colaizzi calls for protocol analysis to be used to analyze the data. According to Colaizzi's
21 (1973; 1978) method prior to conducting a phenomenological study, the researcher
22 should perform a personal phenomenological reflection to uncover the meaning to herself
23 of the phenomenon under study and to identify the phenomenon. The researcher uses

1 imaginative presence to perform the individual phenomenological reflection (IPR). After
2 the researcher completes an IPR, the next phase in Colaizzi's method is undertaken, that
3 being, the empirical phenomenological reflection (EPR). Seven procedural steps are
4 involved in phenomenologically analyzing written protocols in EPR. These seven steps
5 include:

- 6 1. Read and re-read the written protocols in order to get a feel for them.
- 7 2. Extract significant statements from each written protocol that relate to the
8 phenomenon under study. Any repetitious statements are eliminated.
- 9 3. Formulate the meanings for each significant statement.
- 10 4. Organize the formulated meanings into cluster of themes. The researcher validates
11 these themes by returning to the original protocols.
- 12 5. Write an exhaustive description of the phenomenon being studied.
- 13 6. Tighten up the exhaustive description into "as unequivocal a statement of
14 identification of its fundamental structure as possible" (Colaizzi, 1978, p.61).
- 15 7. Return to some participants to validate the fundamental structure. If any new,
16 relevant data are shared by any participants, these data are integrated into the
17 fundamental structure of the phenomenon under study. Three mothers who
18 experienced PTSD due to childbirth reviewed the fundamental structure and all
19 felt it "hit the nail on the head".

20 *Procedure*

21 Approval from the university's Institutional Review Board was obtained. A
22 recruitment notice was placed on the website of Trauma and Birth Stress (TABS), a
23 charitable trust located in New Zealand. The second author was one of the five women

1 who founded TABS. Its mission is to provide support to mothers who have suffered
2 through traumatic childbirths and to educate healthcare professionals and the lay public
3 on PTSD due to birth trauma. Their website is www.tabs.org.nz and their email address is
4 ptsdtabs@ihug.co.nz. For the 11 month data collection period, the average number of hits
5 to the website was 13,264 per month.

6 Hamilton and Bowers (2006) suggest that the response rate be computed for
7 Internet research. The response rate for this study was based on the number of women
8 who initially made contact with the researcher for additional information about the study
9 and then went on to participate in the research. In the current study 129 women initially
10 responded to the Internet recruitment notice and requested more detailed information
11 about the research. Out of these 129 women, 75 participated in the study for a 58%
12 response rate. Twenty-three of the 75 women who did send their breastfeeding
13 experiences on attachment to the researcher did not meet all of the sample criteria and
14 consequently were not included in the sample. The reason for not including these 23
15 mothers was that they had not experienced a traumatic birth. These women wanted to
16 share their difficulties with breastfeeding. The following is an illustration of this: “ I think
17 I made a mistake as the birth of my daughter was not traumatic but we had problems with
18 breastfeeding. You may not want to use my story. I don’t want to jeopardize your study at
19 all since the birth was fine.”

20 An information sheet and directions for the study were sent as an attachment to
21 interested participants via email by the first author. After reading these two documents,
22 prospective participants had the opportunity to email the researcher to ask any questions
23 that they may have had about the study. Participation in the research required the mother

1 to write her story of the impact her traumatic childbirth had on her breastfeeding
2 experiences in as much detail as she wished to share. Participants sent their stories to the
3 researcher over the Internet as an email attachment. Sending their stories implied
4 informed consent. Follow up emails to participants were made at times to ask women to
5 clarify a point they had made or to provide a specific example. The length of time it took
6 for mothers to send their stories after they had received the information sheet and
7 directions ranged from 1 to 10 weeks. A telephone interview was conducted with one
8 mother from Canada. She initiated the study via the Internet but preferred to discuss her
9 breastfeeding experiences over the telephone.

10 *Results*

11 Analysis of the 52 stories of the impact of birth trauma on breastfeeding yielded
12 249 significant statements which were collapsed into eight themes. The second author
13 followed the decision trail of the first author and confirmed the themes that emerged from
14 Colaizzi's method.

15 Three of the women in the study chose not to initiate breastfeeding. These mothers had
16 experienced postpartum depression and/or PTSD with previous births. These women
17 knew their limits and wanted to protect their mental health so they could be the mothers
18 they wanted to be for their newborn infants. As one mom shared, "In the end (having
19 already suffered a breakdown 4 years ago and knowing the signs) I chose my own mental
20 health and sanity." Another mother revealed that "I clung dearly to my emotional
21 equilibrium, rather than allowing what I had heard too clearly of the emotional
22 difficulties of breastfeeding to be my downfall."

1 Forty-eight mothers who had experienced traumatic births chose to breastfeed.
2 The duration of breastfeeding for this sample ranged from 48 hours to 27 months. Each
3 of the eight themes describes factors related to birth trauma that promoted or impeded
4 breastfeeding. These themes are portrayed as weights on a scale that, depending on the
5 number of these factors a woman experienced and their weight, tipped the breastfeeding
6 scale in one direction or another (Figure 1). The first three themes helped to facilitate
7 breastfeeding while last five themes hampered or disrupted mothers' experiences related
8 to breastfeeding. Each woman experienced a different constellation and weighting of
9 these themes or factors which inevitably led them down a path that facilitated
10 breastfeeding or another path that hindered their breastfeeding attempts.

11 **Theme 1. Proving oneself as a mother: Sheer determination to succeed**

12 Repeatedly mothers shared that after “failing” at giving birth, they wanted to do
13 something “right.” Words such as determined, resoluteness, unfaltering, steadfastness,
14 and strength of purpose all described these women. Part of the tenacity to succeed at
15 breastfeeding after experiencing birth trauma was the need for women to “prove”
16 themselves as mothers. One woman who had an emergency cesarean birth revealed that
17 “breastfeeding became my focus for overcoming the birth and proving to everyone else
18 and mostly to myself that there was something that I could do right. It was part of my
19 crusade, so to speak, to prove myself as a mother”.

20 A primipara who had a prolonged labor which ended with a vacuum extraction of
21 her infant vividly recalled “a sense of failure at not having the birth I expected, and guilt
22 at feeling that it was just a horrible, painful, bloody experience. In my mind, I think being

1 able to breastfeed successfully was the only and last chance I had to ‘normalize’ my
2 horrible experience with giving birth so I was bloody determined to do it.”

3 After delivering her premature infant at 32 weeks gestation via emergency
4 cesarean delivery due to severe pre eclampsia, this mother vehemently felt that, “I had
5 failed in my first task as a mother, to carry her to term. I had lost so much because of her
6 premature birth that I was going to be damned to hell before I was going to give up on
7 nursing her, especially before it even started. Breastfeeding after a traumatic birth,
8 especially one that results in a NICU stay, is almost as act of defiance. Defiance against
9 the detachment and almost loathing you feel towards the child”.

10 **Theme 2. Making up for an Awful Arrival: Atonement to the Baby**

11 Women repeatedly explained their decision to breastfeed was driven by their need
12 to make amends to the infants for the traumatic way they had arrived into the world, be it
13 by emergency cesarean delivery, failed vacuum extraction followed by forceps, etc.
14 Mothers were unyielding in their resolve to make atonement to their infants for their
15 “sin” of the traumatic birth. As one primipara admitted, “breastfeeding became a form of
16 forgiveness for me. Giving my daughter the best possible start, I breastfed her for 27
17 months. A multipara who had an emergency cesarean birth revealed that,
18 “breastfeeding became almost an act of vindication. I HAD to make up for failing to
19 provide my daughter with a normal birth, so I sure wasn’t going to fail again.”

20 After experiencing the trauma of an emergency cesarean under general anesthesia,
21 this multipara described “I have very sensitive breasts and never had any intent of
22 breastfeeding throughout my whole pregnancy. I changed my mind after I had the
23 traumatic birth because I wanted to make my baby feel more secure after I wasn’t there

1 for him straight away. I didn't care anymore about the privacy of my breasts. They had a
2 greater purpose."

3 **Theme 3. Helping to heal mentally: Time out from the Pain in One's Head**

4 After experiencing traumatic childbirth, some mothers disclosed that
5 breastfeeding was soothing. As one multipara who had suffered through postpartum
6 hemorrhage explained, "breastfeeding was a time out from the pain in my head. It was a
7 'current reality' - a way to cling onto some 'real life'. Whereas all the trauma that
8 continued to live on in my head belonged to the past even though I couldn't seem to keep
9 it there."

10 Breastfeeding helped to heal women and restore their self-esteem and faith in
11 their bodies. One woman who had delivered prematurely by emergency cesarean birth
12 revealed that "my body's ability to produce milk, and so the sustenance to keep my baby
13 alive also helped to restore my faith in my body, which at some core level, I felt had
14 really let me down, due to a terrible pregnancy, labor and birth. It helped to build my
15 confidence in my body and as a mother. It helped me heal and feel connected to my
16 baby".

17 A mother who had been diagnosed with PTSD due to childbirth successfully
18 breastfed her preterm daughter for over 2 years. As she shared, when she breastfed, "I
19 would cover her up to feed her and hide her little head in the clothing. Not because of
20 dignity, but because I did not want anyone else to see the magic and healing that was
21 happening between us. Being able to breastfeed my daughter, despite all the odds, is my
22 proudest achievement in life. I wear it in my soul as a badge of honor."

23 **Theme 4. Just one more thing to be violated: Mothers' Breasts**

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

7 One woman who had given birth to a 33 week premature infant by an emergency
8 cesarean delivery found it hard, while her baby was in the NICU, to have other people
9 handling her breasts as they tried to get her baby to latch on. “I was sick of everyone
10 grabbing my breasts like they didn’t even belong to me. My breasts were just another
11 thing to be taken away and violated.”

12 A primipara, who had an induction followed by a failed vacuum extraction and a
13 cesarean delivery, divulged that “When I breastfed my baby, I felt like it was one more
14 invasion up on my body and I couldn’t handle that after the labor I had suffered.
15 Whenever I put her to breast, I wanted to scream and vomit at the same time. After a
16 horrible 8 weeks, I made the decision to stop breastfeeding. It was crucial in me
17 reclaiming some power for myself, in taking back control of my life, my body and my
18 right to choose what kind of care was best for my child.”

19 A mother, who had endured the loss of her longed for baby with her first
20 pregnancy, developed PTSD due to her traumatic experiences during that childbirth.
21 After her second pregnancy, her response to breastfeeding her newborn reflected the long
22 term effects of her previous birth trauma. “The body anger. How was I to know if I could
23 succeed at breastfeeding. So why do it when to learn and to do it, invites assistance from

1 health professionals, and if you even touch my body again, or touch me like that, I am
2 going to kick you. I already knew too well the invasion of the privates of one's body.”

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

4 Be it the pain of a cesarean birth, a 4th degree tear, exhaustion from a postpartum
5 hemorrhage, etc. the mothers' pain took a toll on breastfeeding. Just as the psychological
6 trauma weighed in on breastfeeding experiences so did the physical trauma. After
7 suffering severe physical trauma during a vaginal delivery and postpartum hemorrhage, a
8 primipara vividly recounted her painful attempts at initiating breastfeeding. “Nursing
9 required sitting up, putting pressure on my pointless episiotomy. When the nurses would
10 check my bottom, they would visibly wince before pulling the blanket back up. I snuck a
11 peek myself at one point and was appalled to see that my labia were so swollen that they
12 looked like testicles. I hated breastfeeding because it hurt to try and sit to do it. I couldn't
13 seem to manage lying down. I was cheated out of breastfeeding. I feel I have been
14 cheated out of something exceptional.”

15 For some women whose physical trauma tipped the scale into deciding to stop
16 breastfeed early on, their decision still haunts them. This is vividly illustrated by the
17 following passage: “For me I've gotten over the fact that I nearly died having my baby,
18 that I was pretty well ripped and stretched and re-stitched and couldn't breastfeed her. But
19 I hurt for her pain. Somehow I have to forgive myself for stopping breastfeeding after
20 only a short time and not giving her something I couldn't possibly have given her in the
21 state that I was in. Physically I've gotten over her birth, the scars have healed and my
22 iron count has returned to normal, but emotionally I'm still torn. I can't turn back the

1 clock, somehow I'm just going to have to count my blessings and dismiss my failure to
2 breastfeed.”

3 **Theme 6. Dangerous Mix: Birth Trauma and Insufficient Milk Supply**

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

15 For some women their birth trauma delayed their milk coming in. A woman who
16 had a forceps delivery without any pain medication and whose her baby was not
17 breathing at first recalled that having this traumatic birth “had a large impact on my
18 breastfeeding experience. I was in a lot of shock and my milk did not come in for quite a
19 while. My baby was starting to become dehydrated.”

20 **Theme 7. Intruding Flashbacks: Stealing Anticipated Joy**

21 Uncontrollable flashbacks from traumatic births had a detrimental, domino effect
22 on women's breastfeeding experiences. While trying to breastfeed these intrusive,

1 unwelcome flashbacks caused women great distress leading to not only the mothers
2 crying but also at times their infants becoming upset.

3 With her first delivery one woman endured a long, painful labor in which her
4 epidural had not been working. She ended up with a forceps delivery and stated “I had
5 flashbacks to the birth every time I would feed him. When he was put on me in the
6 hospital, he wasn’t breathing and he was blue. I kept picturing this; and could still feel
7 what it was like. Breastfeeding him was a similar position as to the way he was put on
8 me. I would get really upset and cry when I fed him which would cause my baby to cry.”

9 Another primipara shared that “Probably the worst time was breastfeeding at
10 night. I would be half awake, half dreaming, and I would have flashbacks and dream (or
11 hallucinate?) that my breast would turn into the face of a witch and cackle and laugh
12 menacingly at me. Other times, my daughter’s head would turn into the witch and try to
13 eat my breast off.”

14 For some women the anguish of these troubling flashbacks caused them to make a
15 decision to stop breastfeeding early in an attempt to find some comfort and solace. As
16 one mother divulged, “The flashbacks to the birth were terrible. I wanted to forget about
17 it and the pain so stopping breastfeeding would get me a bit closer to my ‘normal’ self
18 again.” One mother who had been sexually abused as a child, disclosed that “When I
19 placed my baby to the breast I experienced panic attacks, spaced out and dissociated. It
20 triggered flashbacks of my abuse as a child.” After 3 months this mother made the painful
21 decision to stop breastfeeding. In her own words she explained that “Eventually I realized
22 if I continued breastfeeding with all its flashbacks, panic attacks, and anxiety, I would
23 totally lose my mind.”

1 **Theme 8. Disturbing Detachment: An Empty Affair**

2 Feeling distanced and detached from their infants was yet another way in which
3 birth trauma tipped the scale towards impeding breastfeeding. “Breastfeeding my son in
4 the first few months, certainly the first 6 but possibly as much as 9 months was an empty
5 affair. I felt nothing at all. Breastfeeding was just one of the many things I did while
6 remaining totally detached from my baby”. Another mother admitted that “I hated having
7 to offer my body to my child who felt like a stranger”.

8 After surviving a postpartum hemorrhage, this multipara shared that “the first 5
9 months of my baby’s life (before I got help) are a virtual blank. I dutifully nursed him
10 every 2 to 3 hours on demand, but I rarely made any eye contact with him and dumped
11 him in his crib as soon as he was done. I thought that if it were not for the breastfeeding, I
12 could go the whole day without interacting with him at all. The nursing chair became a
13 place where I would nurse the baby and zone out (my therapist tells me the term is
14 dissociation)”.

15 One woman had an emergency cesarean birth under general anesthesia. On
16 contemplating how her birth trauma affected her breastfeeding, she disclosed that “I
17 didn’t feel like a real mother as I was unable to give my daughter a normal birth. I felt
18 very disconnected from this baby as I breastfed her. I felt she could be anyone’s baby as I
19 hadn’t seen her being ‘removed’ from me and because I didn’t see anything that was
20 going on.”

21 *Discussion*

22 Just as in Charles Dickens’s (1859) *A Tale of Two Cities* which is the story of two
23 men, Charles Darnay of Paris and Sydney Carton of London, who looked similar but

1 were very different in personality, the results of this phenomenological study seemed
2 analogous to this story. All the women in the sample were similar in the fact that they
3 perceived that they had suffered through a traumatic childbirth but the impact this trauma
4 had on their breastfeeding was a tale of two strikingly different breastfeeding
5 experiences. For some women the traumatic birth led them down a path that propelled
6 them into persevering with breastfeeding while for other mothers their path led them to
7 distressing impediments that curtailed their breastfeeding attempts. *A Tale of Two Cities*
8 is a story of great sacrifices being made for the sake of principle. Tremendous sacrifices
9 were also made by the mothers in this study. An example of one of these great sacrifices
10 involved the three women who decided not to initiate breastfeeding in order to preserve
11 their mental health so they could be the best mothers they could for their infants.

12 Providing mothers with support, information, and encouragement to continue
13 breastfeeding is just one half of clinicians' responsibility. Letting women know that they
14 have the right to choose not to breastfeed without guilt or judgment is the other equally
15 important half. Pressure to continue to breastfeed no matter what obstacles mothers may
16 face compounds their feelings of shame and inadequacy. Clinicians need to support these
17 vulnerable mothers and advocate for their decision not to breastfeed. Failure to do so
18 could lead these fragile women into a downward spiral as illustrated by the following
19 mother: "my breastfeeding trauma increased and I felt guilty-like a dismal, horrific,
20 disgusting failure. Breastfeeding was being pushed very hard and I felt like I was going to
21 be judged and condemned if I gave up breastfeeding. At the moment though that I finally
22 gave myself permission to give up on breastfeeding, things started looking up. I slowly
23 started to feel a sense of connection with my baby and with my life."

1 Kendall-Tackett (2007) proposes that in new mothers past or current
2 psychological trauma in addition to postpartum pain and sleep deprivation can act as
3 stressors that lead to elevated levels of pro-inflammatory cytokine levels. Kendall-
4 Tackett proposes that breastfeeding provides a protective effect on the mental health of
5 mothers since it decreases both stress and the inflammatory response. She warns,
6 however, that these positive results only apply when breastfeeding is going well and
7 especially if mothers are not in pain.

8 In this current study the three themes that promoted breastfeeding and the five
9 themes that hindered it addressed a range of possible factors that impacted mothers'
10 experiences after birth trauma. Not every mother experienced all of these weighted
11 factors. In addition some women experienced similar effects of their birth trauma, such as
12 feeling violated, but the weight of these specific factors was different for each woman.
13 Mothers presented with a different constellation of factors or weights which resulted in
14 the breastfeeding scale tipping in one direction or another. For establishing successful
15 breastfeeding, a balanced scale is not what is desired. Further research is needed to
16 determine if there are predictors to assist clinicians in knowing which path a mother may
17 follow regarding breastfeeding after a traumatic birth.

18 Insufficient milk supply was frequently cited in mothers' descriptions of the
19 adverse impact of their birth trauma on breastfeeding. This confirms previous research
20 that found a delay in lactogenesis in women who had elevated stress in labor and
21 delivery, emergency cesarean deliveries, and prolonged labor and delivery (Grajeda &
22 Perez-Escamilla, 2002).

1 Prior to discharge from the hospital after childbirth, clinicians need to explore
2 with mothers whether or not they perceive their labor and delivery as traumatic. Women
3 who answer affirmatively need to be followed more closely once they are home and
4 arrangements made for support regarding their mental health and their breastfeeding
5 efforts. These women also should be screened for PTSD symptoms secondary to their
6 birth trauma. Necessary referrals to mental health providers can then be made. Clinicians
7 need to remember that birth trauma not only affects the mother but also her developing
8 relationship with her infant. The best way we can assure the safety of children is to
9 ensure the mental health of their mothers.

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Figure Caption

Figure 1. Breastfeeding Scale

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

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Table 2.

Most Frequently Reported Types of Birth Trauma

-
- Emergency cesarean delivery
 - Postpartum hemorrhage
 - Premature birth/ NICU
 - Forceps/vacuum extraction
 - Severe preeclampsia
 - Third or fourth degree lacerations
-
-

Figure

