Abstract

Problem

While perinatal mental health issues are considered to have an impact on a mother's parenting capacity, there is limited research exploring mothers' perceptions of their relationship with their child following traumatic birth experiences and how these might affect their parenting capacity.

Background

Birth trauma is a well-recognised phenomenon which may result in ongoing physical and perinatal mental health difficulties for women. This may impact on their attachment to their children, their parenting capabilities, and their self-identity as mothers.

Aims

To explore maternal self-perceptions of bonding with their infants and parenting experiences following birth trauma.

Methods

In-depth interviews with ten mothers were undertaken using an Interpretative Phenomenological Analysis methodology.

Findings

Women who experienced birth trauma often described disconnection to their infants and lacking confidence in their parental decision making. Many perceived themselves as being 'not good enough' mothers. For some women the trauma resulted in memory gaps of the immediate post-partum period which they found distressing, or physical recovery was so overwhelming that it impacted their capabilities to parent the way they had imagined they would. Some women developed health anxiety which resulted in an isolating experience of early parenthood.

Conclusions

Women who have suffered birth trauma may be at risk of increased fear and anxiety around their child's health and their parenting abilities. Some women may experience this as feeling a lower emotional attachment to their infant. Women who experience birth trauma should be offered support during early parenting. Mother-Infant relationships often improve after the first year.

Keywords

Birth trauma; attachment; parenting; mothering; self-efficacy; post-traumatic stress disorder; mothers

Statement of significance

Issue:

Traumatic birth experiences may significantly impact on a mother's mental health. This impact may have ongoing consequences for her capabilities as a parent, the way in which she perceives her ability to parent, and her assessment of herself as a 'good enough' mother.

What is known about this subject:

Literature currently indicates that mothers who experience perinatal mental health (PNMH) illnesses may find it harder to respond appropriately to their infants and may be less able to regulate their own emotions and model emotional regulation for their children. Emotional dysregulation in children has been linked to difficulties in childhood interactions with peers, and ongoing relationship issues into adulthood. To date few published studies have investigated bonding from the mothers' perspective between mother and child following birth trauma.

What this paper adds:

Other than anecdotally, little is understood or known about a mother's experience of parenting through PNMH illness. Exploring mothers' perceptions of their parenting experiences and capabilities may inform the development of services which are there to support parents with PMNH illnesses, and early parenting. This also goes some way to explore the link for women between their birth experience and how they feel able to parent. Those women who struggled to develop a relationship found that this improved over time. This may also give hope to mothers who are struggling with their parenting relationships.

Introduction

Birth Trauma

Birth trauma is a well recognised phenomenon in childbirth which may impact on up to 30% of women globally each year (Soet, 2003). For some women the trauma may go on to affect their mental health, resulting in or compounding previous perinatal mental health (PNHM) illnesses including, but not limited to, anxiety, maternal obsessive compulsive disorder (OCD), and post-traumatic stress disorders (Ionio, 2013). Not all women who experience birth trauma go on to develop clinically-diagnosable symptoms of post-traumatic stress disorder (PTSD). Some women may experience these symptoms, which while being sub-threshold for diagnosis, still impact on day-to-day living, but for which they feel unable to seek support. It is generally understood that up to half of all women living with PNMH illnesses do not seek support for these (NCT, 2017).

Impact of Birth Trauma on Parenting

Living with mental illness is understood to potentially impact on day-to-day living, and can have a negative effect on self-efficacy, long- and short-term health, and social interactions (Mind, 2016). This is exacerbated when the illness is mis- or un-managed. Perinatal mental illness is no different, but the impact is not only on the mother, but also on her most intimate relationships, particularly that with her child. Current research suggests that for some children, living with parents who suffer PNMH illnesses can have long-term effects on their development and physical and mental health (Paschetta, 2014).

There is limited current research which explores the impact of birth trauma on parenting from the mothers' perspectives. To date, research has explored early mother-child interactions (Ionio, 2013), women's perceptions of their infants (Davies, 2008), and changes in a mother's perception of her infant over time in relation to PTSD symptoms (McDonald, 2011). The qualitative data which do exist point to disruption in relationships, and the complex interactions of the breastfeeding relationship following a traumatic birth (Elmir, 2010).

Methods

Study Design

Mothers were invited to participate in a two-phase mixed-methods study. Phase one was participation in an online survey which was designed to explore experiences of support seeking for PTSD following traumatic births, experiencing symptoms consistent with PTSD, and perceptions of the impact of their birth on parenting their child. Phase two was an in-depth interview phase, which involved self-selection for participation in face-to-face semi-structured interviews. Some of the findings from this second phase are discussed in this paper.

Phase one was used to gain an understanding of the scope of the problem, and to gather a wide range of experiences, as well as to offer recruitment into Phase Two for participation in an in-depth interview about their experiences.

Interpretative Phenomenological Analysis (IPA)

The study used qualitative interpretative methods to explore women's perceptions of seeking support following birth trauma and their perception of how the birth impacted on their parenting. Birth trauma is a subjective experience which is personal to the women who have given birth and the way in which they experienced their care and birth. IPA is an idiographic inductive method in which the researcher's positionality and their interpretation of the meaning which participants ascribe to their experiences is part of the analytical process (Smith, 2004). IPA was used as the methodology of choice as this allows the individual analysis of each participants story, while then creating an analysis which recognises commonalities between experiences. In healthcare research this is particularly pertinent where focusing on patients lived experiences and the meaning which they ascribe to their interactions within their environment (Biggerstaff & Thompson, 2008). For this subject area, the perceptions of women on their own parenting, this aligns with the philosophy of IPA, in which the interpretative analysis of the research data aims to gain an understanding of the participant's inner world (Biggerstaff & Thompson, 2008).

The study was undertaken in part fulfillment of a Masters Dissertation. This paper describes the findings from questions two and three from the semi-structured interviews (see Table 2). The interview schedule consisted of 5 open-ended questions that were used as a guide to explore parents' experiences of early parenting following the birth of their baby. The interviewer had the freedom to probe the interviewee to elaborate on the original response or to follow a line of inquiry introduced by the interviewee. Cues and prompts were also used by the researcher to allow the interviewee to discuss the topic further. This was a discussion point around women's perceptions of how their birth impacted their parenting.

Recruitment strategy

Recruitment for the survey was performed using a combination of purposive and snowball sampling. The survey was disseminated online through multiple social media networks, including parenting and maternal health forums on Facebook; perinatal mental health networks on Twitter (#MatExp); and personal networks. The survey asked about mothers' birth experiences – thoughts and feelings around the birth; ongoing symptoms consistent with those of PTSD; experiences of seeking support; and the impact that they felt their birth had on their early parenting experiences. For the purposes of the study, birth trauma was defined as any birth experience which the participants felt were traumatic. The survey relied on

participants' self-reporting of symptoms consistent with PTSD *(American Psychiatric Association, 2013)* (see Table 1) rather than using a validated survey.

As a final part of the survey, participants could choose to volunteer for phase two of the study – in-depth semi-structured interviews. Women who had indicated willingness to be contacted by the researcher and who met the eligibility criteria were contacted following survey submission.

Survey Data collection began in March 2016 and continued through to June 2016 when responses stopped. Interviews were held in participant's homes between April 2016 and June 2016. This study was conducted as a Masters Dissertation, hence the short time-frame for data collection was due to time constraint for the study and write-up overall.

Eligibility

Women were eligible for inclusion in the study if they had had a birth which they considered to be traumatic; had indicated in the survey that they were willing to be interviewed about their experience and recorded; and had read the Participant Information Leaflet and signed the consent form prior to interview.

The second phase of the study was designed using the principles of Interpretative Phenomenological Analysis (IPA). Interviews were undertaken as in-depth semi-structured interviews. Following discussion about their birth experience and support seeking, the discussions explored the first time they held their baby after birth, the beginning of the parenting relationship when they were at home, and how they felt their relationship with their child was at the time of interview. The discussions were framed around a guide, but open enough to allow the women to talk about the experiences which were most important to them, on order to achieve both consistency and diversity in data collected.

Ethics

The key ethical issues for this study were confidentiality and the potential for emotional distress for participants, alongside lone-working practices for the primary researcher. The information sheet detailed women's right to confidentiality in data handling and reporting; within the bounds of safeguarding where necessary. All names used in this and other reporting from the study are pseudonyms and any identifying details were removed. Steps to be taken if a woman showed signs of distress were also explained, both in the participation information sheet, and verbally prior to interview, whereby women could pause, stop, reschedule or finish participation in the interview at any time. (First author) followed the lone-worker policy per University of Warwick guidelines, also within her usual practice, following local Council policy as a lone worker within her other role (community based Infant feeding support). Ethical

approval for this study was granted through University of Warwick Biological and Scientific Research Ethics Committee (REGO-2016-1752).

Data analysis

The recordings were all transcribed by the primary researcher. Using the principles of IPA, each transcript was read multiple times to ensure familiarity with the data. The transcripts were then coded manually and visually by identification of themes and sub-themes, with illustrating excerpts from the transcripts. All transcripts were read through, and codes and themes checked and discussed. IPA is a reflexive idiographic process (Smith, 2004). The primary researcher has experience and specific interest in working in the field of perinatal mental health support (voluntary) and breastfeeding support. This was reflected on using reflexive diaries, and discussion with her (Masters Dissertation) supervisor. Only themes which were agreed on between both researchers were incorporated into the final analysis.

Data saturation

Using the principles of IPA, data saturation for this study was acknowledged to be when no other themes were being developed from each dataset. Saturation in qualitative analysis may never happen, as particularly within IPA, researcher reflexivity is an integral part of the analysis, and going back to transcripts over time may allow for variations in interpretation, and further development of themes. Participant numbers were restricted by those who had volunteered to participate. The impact of this on the findings of this paper is discussed later (see Strengths and Limitations).

Findings

Twelve women indicated through the completed surveys (n=72) that they were willing to be interviewed. All were initially invited to participate and ten consented to be interviewed. The characteristics of the participants, as indicated in the initial survey, are given in Table 1. All interviews took place in the women's homes. One woman (Erin) was interviewed in relation to two traumatic births; these are listed separately in the table. Interviews lasted between 35 and 90 minutes and were recorded on a dictaphone and transcribed. All women were at least 18months post-partum from their traumatic birth; two were pregnant and seeing their local perinatal psychology team.

All of the women interviewed had experienced their child's birth to be traumatic and distressing. Five women had a birth which they also described as physically traumatic, involving either forceps, surgery immediately following birth, or an emergency caesarean birth. Five of the study group were also separated from their infant immediately following birth and did not have skin to skin contact. Of those who did have skin-to-skin contact after birth, one woman (Heather) had no memory of having skin-to-skin contact after birth. All of the women

who participated in the interviews had self-reported through the online survey that they had experienced symptoms consistent with PTSD following their birth experience. At the time of interview, only two of the ten women interviewed also self-reported a clinical diagnosis of PTSD, as diagnosed by their mental health professional. Feeding method and the impact on birth on initiation of breastfeeding was a key theme for all women in this study.

Analysis of the interview data yielded five main themes (Table 3): The first meeting and then (missing moments); Looking through from the other side; There's no such thing as can't (breastfeeding); The job of parenting (beginning relationships); and Moving on together (relationships now). These themes, along with lower level subthemes, descriptions of our interpretation of the meaning of the theme, and illustrative quotes are displayed in Table 2.

The themes which emerged followed an approximate timeline from the birth to postnatal period. Part of this was due to the structure of the discussion guide, in which the birth was discussed, before moving to thoughts and feeling about being at home, and how relationships between parent and infant were, and then changed over time. This also fitted with the way in which each woman narrated her own story, that there was an order in which events unfolded, and that each event had an effect on the trajectory which the subsequent experiences followed.

At first, and then… [Missing moments]

This theme was focussed on the moment of birth and the initial meeting between mother and child, along with the mother's expectations of that meeting. It was characterised by sub-themes around 'Relief', 'Dissociation', and 'Not Remembering'. Some women immediately lost contact with their newborn and were unsure if they had even survived the birth, or where they were. The inability to remember details from immediately post-birth, or memories that were captured in photographs, or remembered by others was a recurrent theme for some women which contributed to feelings of inadequacy, or a reaffirmation of the trauma of the birth.

For many women in this study, the moment of birth was characterised by relief that the labour and birth were over. In some cases, this was also the beginning of the cognitive dissociation between what they had expected birth and parenting to be like, *versus* their current reality. Some women experienced actual dissociation, where their memories of this early postnatal period are remembered as an out-of-body experience, looking down on themselves with their babies, rather than remembering the event from within. Others described feeling nothing at all

> *…she came out - and they put her on me - and I felt - nothing. So, you hear people feeling relief, I don't think there was relief, there was just nothing. I was just looking at*

this creature, and was just weirded out by it, just completely weirded out. I suppose shock, is what I felt, erm – I wanted her off me. So I could at least, just to get your head together and to work out what's just happened, and to regroup, and to feel a bit more like myself again, and you can't do that when this thing is on you…and it's interesting that that, that concept of her being a thing that is on me, that I can't, can't regroup while she is, has lasted, that if I'm trying to do something, and she's "ma, ma, ma, ma" (lilting) in my head, I need her just to stop, just stop, just stop, and that's, that's really lasted. And that's very much how I felt then, that just 'OK very nice, just take it away now'. So I can work out what just happened. (Laura)

Due to the need for maternal surgery, or neonatal care, some women immediately lost contact with their newborn, and were unsure if their child had even survived the birth, where they were, or who they were with. This inability to remember the first details of meeting their baby, or memories that were captured in photographs, or remembered by others was a recurrent theme for some women which contributed to feelings of inadequacy about the birth and themselves as parents, and also serve as a reaffirmation or reminder of the trauma of the birth.

She didn't feel like – she was mine. I suppose because I didn't know anything about the birth happening, it was like I hadn't had a baby. It could have been anybody […] I felt sorry for her cos she's got tubes stuck up her nose, but it wasn't like 'oh this is my child' (Elizabeth)

For some women a strongly associated category was the use of visual reminders, or the connection that visual memories had for women. Some realised very early on that they had gaps in their memories. Heather compensated for this by booking an 'emergency' newborn photography session to capture the memories that she was aware of having missed out on.

I was aware of missing out on her being 4 days, 5 days, 6 days old. Partly from being in hospital [re-admittance on days 4 and 5, after discharge on day 3 due to blood pressure] and being stuck in hospital, but also being at home. I was spending most of my time in bed crying, listening to [partner] walking around downstairs with her. Listening to her crying and then me crying even more. So I was thinking, part of it was a guilt thing, you know, she's never going to be 7 days old again, and I've missed it. (Heather)

Simultaneously, Heather also used photography, during her most desperate moments, to remind herself why she would never go through this again, in case her memory diminished the awful reality she was currently experiencing.

*I did use to take photos of myself though, selfies, I'd be in bed, with like, snot, and I'd take a selfie so that if I *ever thought*, about having another kid – I could look at that… I thought what I don't want to do, which is what everybody else in the whole world, obviously has done, it to have one child, and then forget how terrible it was, and have another! So I was protecting myself from ever, getting into that situation, by taking selfies, covered in snot (Heather)*

Looking through from the other side

This theme was a key moment in which extra support following the trauma of the birth felt withheld or conversely unnecessary. The sub-themes focussed on 'Expectations [myself and others]'; 'This isn't real/This isn't me'; 'There's no safety net'. For many women, this homecoming was the critical point when post-natal life was expected to continue as normal, while their day-to-day experiences jarred with previously-held expectations of life as a parent, and perceptions of societal expectations of life as a new parent. For others, ongoing health issues marred their early parenting experiences. 'The other side' refers to both the post-birth expectations of life as a new parent, and also captures the feelings of otherness and separation which some women experienced following the trauma of birth.

The visual experience was captured as part of the 'Looking through from the other side' theme, in which both visually and psychologically women in this study described feeling separate and other; both from what they expected life to be like, and who they recognised themselves to be.

I can remember being home, and people being here visiting and just looking at their faces and it feeling as though I was completely 'other', separate from everything, as it [the birth] was such a weird experience, and there doesn't seem to be anything rational about that […] It was like being in Alice in Wonderland or something, I felt like, I was changed forever, and that I almost didn't belong in this world anymore (Laura)

Coming home was really strange like being in a parallel universe. I knew it was my home but it didn't feel like it was (Elizabeth)

I felt like I was in a bubble, looking out at everyone else living a normal life (Anna)

My experience, if I try to visualise it, is that moment I saw myself in the mirror, I look, what can only be described as ghost-like. And I didn't recognise myself. And I think that is more – yes, in a physical sense. But actually, in an emotional sense. Because I've never had a baby before, I didn't know how I was going to react. I remember looking at myself and thinking 'that's not me' […] even in myself, I didn't recognise myself. I'd become very clingy I didn't want [husband] to leave me alone with him, I

certainly didn't think I could look after him I had no idea what I was doing. I felt like a child again. Inadequate. I felt like I had no idea what I was doing (Louise)

Louise describes her awareness that she was unsure as to how she might respond to first becoming a mother. But also her feelings of inadequacy and lack of confidence in herself and her decision making.

Part of this theme, 'Expectations' refers to the expectations which women had of themselves prior to giving birth, which they then felt unable to achieve. This sub-theme also encompasses the expectations which women perceived as societal pressures. This linked to other comments and concepts around breastfeeding, and our expectations of what 'good' parenting is, and how much of that is informed by both our own experiences and what we see around us daily.

There's no such thing as can't? [Breastfeeding and Being a Mother]

Although there were no planned discussion points around feeding, the breastfeeding relationship was a focus for all women in this study, which was tied in with their perceptions of their bodies' capacity to birth, and how they had imagined themselves as parents. The sub-themes focused on either 'I will not fail again'; or 'I cannot be a good mother'. An unsuccessful breastfeeding relationship added to their sense of inability to soothe and nurse their baby, which was intertwined with their ability to successfully mother.

The breastfeeding relationship, or lack of, had a huge impact for many women in the way in which they had imagined themselves parenting, and their perceptions of what 'good' parenting looked like. For some of these women the inability to breastfeed their babies the way they had expected compounded the trauma of birth. Their perceived lack of ability to breastfeed became conflated with their position relative to their baby of being their source of comfort.

I felt a lot around that time about not being able to be what she needed me to be. So I couldn't feed her, which was a big thing. The fact I couldn't feed her meant I couldn't comfort her, couldn't bond with her, meant I wasn't good enough for her. The fact that she, I felt she didn't like being held, was just because, I couldn't give her any comfort anything – it was a really strong feeling about all of it was, to let – I need someone else to come round because they can give her what she needs, but I can't (Laura)

The absolute thing – I can't look after this baby, I can't even feed it (Elizabeth)

For others breastfeeding became the thing that they could do, or would stop at nothing to do, in order to either prove others wrong, or to prove something to themselves about their bodies' capabilities.

I think not having the birth I wanted, *I was like 'no, we're breastfeeding, screw it! Doesn't matter – whatever else happens this is going right, this bit I can do* (*Isla)*

Parenting is a job [Beginning Relationships]

The sub-themes in this overarching theme were around 'Practical tasks'; and 'Being overwhelmed'. Women saw the start of their parenting journey as contributing to this emotional disconnect from their infants where their self-knowledge and understanding of their own bodies was dismissed by professionals, which in turn led to them doubting further decision making and knowledge about parenting. They began to mistrust their own instincts. They also felt they couldn't talk about what they really felt for fear of being branded 'bad mothers' or having children removed.

This was the most predominant theme for this study group. Being at home, was for most of the women in this study, described as both a terrifying and isolating experience. This period did not only encompass the initial post-partum few weeks, but for some lasted much longer.

I would say, until 6 months, we were just surviving. And then obviously we had the tongue-tie. And that gave us a good leap with feeding, so I think that would have been around 6 ½ months, maybe 7 months. Gosh that's a long time. That sounds awful. But maybe do – do people really struggle – I feel awful for saying that. I hated it – I hated him – and that's awful to say – that sounds awful doesn't it (Emily)

Where babies had been in the neonatal unit, having the extra reassurance and staff on hand gave women a sense of security that they weren't on their own. Coming home, with no alarms, or extra support added to anxiety levels.

So we were fairly keen to be reassure we were doing it right, because there weren't any other, like there weren't any monitors, when we got home, so there wasn't anything saying, because they'd been checking his blood sugars every so often and there wasn't anything saying his oxygen levels were fine, and yeah he wasn't on an IV so it mattered if he fed (Isla)

For some women though this anxiety was compounded by visitors and input from healthcare professionals (HCP).

I just got very, very protective, I didn't, I didn't like, you know, we had visitors, different ones come and I literally, was like, you know, "no, no, no, don't touch" things like that I didn't want anyone else holding her […] I used to hate going to the weighing clinics, and things like that, because it was just that – you know – everything about it was – I

hated – it was alien, it was horrible. I hated it. I always found them intrusive – like they doubted you and second guessed you, and - I always felt checked up on […] I felt like I was being questioned all the time about everything (Anna)

This anxiety for some added to the fear and isolation they felt in their early parenting experiences. For Heather, who suffered from flashbacks of the birth and then intrusive thoughts about accidents befalling her baby if she wasn't present, her postnatal period was exhausting and terrifying

This whole thing would be playing in my head so it wasn't like I was asleep while they [partner and child] were gone. I was upstairs having a panic attack because I didn't know where they were or what was going on. I was just waiting for them to come home, even though it was supposed to be giving me a break. It wasn't giving me a break, so – it was just – it was just exhausting. Aside from being tired, and the standard new-born stuff, I was permanently, 24-hours a day, on high alert for – it always had to be me, and I felt that it was solely my burden (Heather)

Some women who were away from family, or had poor relationships with family that were geographically close, described feeling that they had no-one to turn to for support, or that there was a fear that parents-in-law would take over parenting; some of this was conflated with trauma over the loss of the breastfeeding relationship. For those women who did have close family support, this may play either a positive, or a negative role, particularly in terms of feeling they were able to access further support

my mother in law, I remember saying at the time, "well, whatever you do, don't go to the doctors and say that you've got depression because social services will take that baby away" and I, I work in that kind of environment, I know that's not true. God I know that there are situations where babies need to be taken away and they're not gonna do it. But at the time she was saying that, "You're fine, it's normal, it's normal to have baby blues" and I knew it wasn't normal, it really wasn't normal. (Laura)

There was a disconnectedness between not feeling that they cared emotionally and simultaneously not being want to be seen or labelled as an uncaring or unfit mother. This also gave them a sense of things they were capable of, and things they weren't capable of.

No wanting her to wake up. Because I couldn't, I didn't feel like I could give to her at all […] and if there were specific things that needed doing, she needed her nappy changing – fine! Because I know how to ***do*** *that, you pick her up and take her upstairs. Or if she needed a bottle, great – I know how to do that – but it was those bits that*

weren't routine, like the bits where you're supposed to interact, and I just had no idea how to do it, or what to do (Laura)

This in some cases took the form of needing an acceptable social story about not wanting to spend time with their baby. Sometimes going back to work earlier than planned, using the societally acceptable story in which their career was important to them, was less about needing to feel more than a mother and regaining some of their identity, and was more about being able to get away from the house, and hand care of their infant to someone that they perceived as more competent at caring for their baby than they felt they were.

I'm not sure how honest I was with her [counsellor] about how I felt. Cos it's not acceptable to say – 'I can't stand my baby' is it? It's not acceptable to say that […] I needed a narrative again, about why this wasn't working. And this wasn't working because, I'm a high-flying career woman. Not like you Mummy types with your boobs, out. No, no, look at me! Because that made me feel better about myself (Laura)

As seen above, women often described their parenting capacity as task oriented, in terms of both their physical ability to interact with their infant and their emotional ability to be present with their infant. For mothers who were struggling to feel emotional attachment, physical caring tasks were things they could do, which were logical and didn't need emotional input. Whereas for others, the resulting injuries or infections from birth meant that the physical tasks they felt they should have been able to do were harder, which contrasted with the motherhood they had imagined themselves beginning.

I was very, upset with all the, the things that were being put in my way – the fact that I wasn't mobile, like I couldn't move, that I couldn't hold him when I needed to hold him. Being at home I felt - I was in a lot of pain, but I felt happy and confident with what I was doing in terms of him. And then, I was readmitted to hospital, so I wasn't home for very long, and that was horrific and horrible (laugh) I really struggled with that. I had IVs and stuff in my wrist, I couldn't hold him properly, and I felt like I was having to ask for support in breastfeeding him...I was watching the other girls from my NCT [National Childbirth Trust] group, kind of bounce back (laughter) and be able to drive and go out and enjoy having their little one. And I felt trapped and scared. And really kind of, it took, I could barely walk to the end of the road even after 10 weeks. It took me a long time, to, to get my fitness back. (Nancy)

For many women in this study this lack of trust in their abilities, and in their own self-belief began during their labour and birth experience.

I think that maybe the birth was where I was second guessing myself. You know, maybe they're right and I'm not. I sort of knew, that I was right. But then they are in this position, you know of knowing about birth, and they are professionals" (Amy)

I felt like I was quite assured, in a lot, from a mental perspective, in what I do and the way I deal with people. And certainly when I wasn't being listened to, I like, like, maybe actually I don't know what I'm talking about. Maybe the reason they are professional, and I am not, in that particular area, if because they know what they are talking about. So I did lose a lot of my judgement and my confidence in what I was doing for [my child] (Emily)

I didn't have PND, but I was miserable and anxious because things had not gone the way we planned them to go and I wasn't sure why, and I felt like I couldn't do being a mum and having a baby properly (Isla)

Current NICE Guidelines (NICE, 2015) indicate that debriefing services should not be offered as standard to all women; but the women in this study had all had births which they felt were traumatic, and in many cases weren't sure what had happened or why. This fed into their uncertain start as parents. For women who historically had a more complicated relationship with their bodies to this point, with ongoing health or reproductive issues, these traumatic birth experiences seem to contribute to continued disbelief in their physical capabilities. These beliefs were then confirmed by their perceived failure to give birth in the way they had planned or hoped for; which meant they were unable to parent effectively as they were unable to move past the birth.

Moving on together [Relationships now]

This final over-arching theme was characterised by sub-themes which centred on 'Recovery as a journey'; 'They are amazing'; and 'What happens next time?' This encompassed developing a feeling of joy in parenting, in the developing relationship and the person that their baby was turning into. It also referred to the hope that they had not emotionally scarred or damaged their infant long term due to the unanticipated start to the relationship. There was also an understanding, or appreciation of how hard a task parenting was, and whether this was a personal weakness, or part of a societal perception *versus* expectations.

Women in this study described how their relationships with their children changed over time. For some this was towards the end of the first year of parenting, and was a gradual change in the relationship and their feelings towards their infants.

I think I didn't decide that I liked her, until she was definitely over 10 weeks old. And I couldn't say that I loved her, until she was nearly 1 year old. And prior to that, she was an obligation. There was no emotional connection (Heather)

Often the relationship began to change as their baby grew through infancy, and as their personality became more evident, but also as they were able to see more responsiveness from their child.

Definitely my connection with him took a long time. Certainly when he was younger, when they're a warm squidgy ball, rather than a little person. He's definitely, a little person now. You see his wonderful personality shining through, as much as he's a monkey too. But certainly I'm getting a lot from him, because he's able to communicate in his own little way. But when they're a ball of chubbiness, and it's hard because you don't necessarily know what's going on (Emily)

You've got measurable outcomes where you can go 'Yes, he wants to go to me' […] and there was part of me that was elated when he curled into me, okay, he's in the clingy phase, but he, he hugged into you. And I thought YES he wants me! (Louise)

Here it is also evident that the inadequacy which Louise described earlier (Looking through from the other side) seems to then run through her parenting experiences, from being unable to establish breastfeeding, and hence feeling unsure that her baby would know her as his mother, and it was not until she was able to see recognisable positive feedback from her child that she could self-assess as doing a good job.

Discussion

There is little published literature which discusses the impact of birth trauma on parenting from a mother's perspective. Much of the known and researched sequelae focusses on ongoing mental health issues; the potential impact on a developing child of perinatal mental illnesses; the impact on the couple relationship, and subsequent family planning practices. There is more recent work which focuses on Adverse Childhood Events (ACEs) and their effect in childhood and into adulthood (NHS Health Scotland, 2017; Spratt, 2012).

Recent research findings support the idea that not only can breastfeeding be impacted by the physical and emotional sequelae of birth but also that the lack of a wanted breastfeeding relationship can bring its own trauma (Brown A. , 2018; Brown A. J., 2012). For many women, these are combined issues; it is becoming better recognised that women who have had traumatic births may have a more challenging time establishing breastfeeding. Of the women in this study, three were unable to establish a breastfeeding relationship; all three were among the five women in this study who did not get immediate skin-to-skin contact after birth, and

were also less likely to have been supported to express colostrum/milk in the hospital. At least one of these women also developed mastitis in the immediate postnatal period, despite being unable to breastfeed her child.

Emotionally connecting

The lack of an emotional connection was felt by some of the women in this study. Those who did not feel that 'rush of love' immediately after birth, or even actively felt dislike for their infants, hid how they felt, because of the fear of being seen as a bad mother, or having their child taken away. Current research indicates that bonding starts from conception for many women and that for some, low attachment in the pre-natal period may predict attachment and bonding difficulties postnatally (Petri, 2018). Women who feel a disconnection to their infant before birth may subsequently struggle to adequately respond to their infant cues, or feel that they are unable to 'read' their baby as well as other people in the family. The use of positive feedback reinforcement, which Emily and Louise talk about, when feedback from babies is more explicit seemed here to have worked in a similar way to the use of recorded video interactions to improve parenting and maternal sensitivity. Video Interactive Guidance (VIG) has been used to some effectiveness by trained professionals to support relationship building between mothers and their infants by the use of recorded interactions. There is currently limited evidence for the use of VIG, although there is more research supporting the use of a similar but alternative method, Video Feedback to Promote Positive Parenting VIPP) (Ryan, 2017) .

In this study, at least one mother (Heather) described that the disconnection between herself and her baby started during the antenatal period. She was not expecting to get pregnant as quickly as she had, so didn't really 'believe' the [multiple] pregnancy tests. She was expecting to feel a connection at various other key moments, i.e., the dating scan, anomaly scan, first movements, birth. Foetal attachment, and 'keeping the baby in mind' was not something that she remembers being mentioned or discussed with her community midwifery team. The lack of attachment to a foetus which can indicate or predict ongoing attachment issues in perinatal period, is also often seen in women who may have had multiple or recurrent miscarriages; as a form of self-preservation, where they either did not expect to get pregnant again, or are not certain that the pregnancy will result in a live birth (Ockhuijsen, 2013).

Socially constructed narratives

Mothers who have experienced a traumatic birth and subsequently developed symptoms of PTSD may have missing memories of the immediate post-partum period. Furthermore they may have struggled to feel connected to their child in the way that they expected to. These

missing moments may trigger feelings of guilt and shame in women, as the socially constructed stories of the 'first time' are often a key point in birth and parenting narratives.

Some women talked about their babies using dissociative, impersonal language, feeling that in the few months after birth the baby was an 'it' or a 'thing'. The concept of not loving a child is in many ways anathema to the way in which society venerates mothering and motherhood. Though there is a dichotomy in the way that mothers are viewed, where the work which women do in the home and in caring for children is seen as financially and therefore societally unproductive. In the media, high profile child abuse cases often focus on the mother as uncaring, where they should be protecting their infant (Brantley, 2019; Kuntz, 1997; BBC News, 2013). For example, searching for information about the death of the mother and step-father of Daniel Pelka brings up headlines using the words cruel, twisted, and brutal, while the stepfather is described once as a monster, and predominantly as a killer. Thus for a mother who is struggling with mental health issues, and PTSD, and is struggling to bond with her baby, there is an underlying fear which was voiced here by women that to admit to feelings which may be considered the antithesis of motherly, puts her at risk of having her child removed, and being classified as something monstrous herself.

The concept of parenting being solely the realm of women is a still prevalent in today's global society, although the balance is shifting somewhat, with recent research pointing to the concept of unpaid labour; there is still a high inequality level in household chores, which globally women bear the brunt of (Cerrato, 2018; Fernández, 2016). Anecdotal accounts also indicate that women are more likely than men to work outside the home, while continuing to work the way they always have inside the home. Many women take on the responsibility for the running of the household and other caring responsibilities (Jurativac, 2014). This may have been instilled from early childhood due to the gendering of toys and acceptable games, and concept of 'having it all' lifestyle, and expectations of partners based on their own experiences of being parented, while at the same time ignoring or dismissing the mental load which it takes to run a household and its subsequent impact on mental health (Landstedt, 2016).

Grief responses

Women may experience disenfranchised grief over the loss of the birth and the parenting experience they were expecting to have. Disenfranchised grief is that which cannot be openly acknowledged or publicly supported (Doka, 1989). For women in this study their medical and social support networks were perceived as being more concerned with the health and safe arrival of their baby than with their [mothers'] feelings about the birth. Dealing with this grief, combined with stress responses triggered by the birth experience and the care they received,

left many women feeling detached from their baby and unable to fulfil what they perceived to be their expected role of mothering their child. The grief model postulated by Straube and Schut (1999) describes a dual-process model in which people move between different processes and different activities within each process. The first are loss-oriented activities and stressors are those directly related to the loss or bereavement. These including crying; sadness, denial or anger; dwelling on the circumstances of the loss; and avoiding restoration activities. The second process is around restoration-oriented activities and stressors which associated with secondary losses. Secondary losses can be defined as those which are related to lifestyle or relationships. These activities may include adaptation (to a new or different role); managing changes in routine; developing new ways of connecting with family and friends; and cultivating a new way of life. Women in this study described both avoiding discussions of pregnancy and birth, and may avoid talking about their own birth story. These secondary losses and the process for restoration can be reflected in many of the changes which women undergo in beginning parenting (Laney, 2015). Research shows that these psychological changes, and the start of maternal-infant bonding often begin at the point at which women start to think about becoming pregnant, or at the point of confirmation of the pregnancy (Dow, 2017; Spinner, 1978). This is the point where women start to reflect on their own upbringing and the way in which they were parented. For women who have suffered birth trauma the loss may be further exacerbated by the disconnection between the ways they perceived their parenting journey would begin, and how this actually happened.

Chaos and Mundanity

For all the women in this study, the immediate post-natal period, and often their first year as a parent was characterised by conflicting senses of both chaos and mundanity. This initial period of motherhood is often a time when women feel overwhelmed, and previous routines and norms disappear (Horne, 2005). Within the 'Looking through from the other side' in the sub-theme of 'this isn't me/this isn't real' women describe what appears to fit with the theory of a psychic reorganisation, which refers to the recognised phenomenon which is a reorganisation of self and concept of self in preparation for and in becoming a mother (von Mohr, 2017). For some women the trauma of the birth became a point at which these women seemed to have become unanchored from their established norms of behaviour, and expectations of behaviour, leaving them adrift and trying to find security in controlling that which they could control where possible; or readjusting by going back to previous norms (i.e., returning to work earlier than planned) because these are known quantities.

Support seeking

There was felt to be a stigma about asking for support, or feeling that motherhood was not progressing as women had expected, or in line with perceived societal expectations or conventions. None of the women in this study were able to access the specialist support services locally in their early postnatal period; this was in many cases due to fear of the outcome – would they be seen as unfit and have their baby taken away; for some women it was a lack of awareness about the specifics of their illness, and an inability to adequately describe their feelings '*no, no, not suicidal, I wasn't depressed, I just didn't want to feel like this anymore' (Laura)*. For others they fell outside of the referral criteria for the service, due to either length of time since birth, or not being ill enough to meet the threshold criteria for referral.

Strengths and limitations

As an IPA study, the themes which have emerged were individual to each woman's experience. However the chronological order, and the overarching themes could be drawn across all narratives. Women in this study were a self-selected group and may therefore not be describing experiences which are representative of all women who have experienced a traumatic birth. However, of the total study population (n=72) only 2 stated that they did not think their birth experience impacted on their parenting.

The women in this interview study group all described a history, or understanding, of support seeking for other mental or physical health problems, this may have made them more likely to volunteer to take part as may feel they have a better grasp on being able to describe their mental health. Many also struggled to access support despite this previous knowledge and experience, so may have also felt a need to highlight these shortcomings in their care.

All respondents were also at least 18-months post-partum, and as described in their responses, now felt that their parenting and relationship with their child had improved. This group may have felt less fear about admitting to their earlier feelings, or lack of, because of these subsequent improvements. Mothers who are earlier in their journey, or later, but not feeling any positive changes to their parenting or parent-infant relationship may not have volunteered to take part due to stigma and fear. The population in this study were a relatively homogeneous group, being predominantly white, British and in heterosexual relationships. The experiences of these women may not be generalisable across other cultural or minority demographic groups.

Conclusions

Women's experiences of a traumatic birth may cause them become emotionally distant from their infant for much of the first year of their parenting journey. Some women find that when

their self-knowledge and self-perception of their own bodies is dismissed or questioned in labour, this impacts their self-belief in their capacity to parent. A traumatic birth may render breastfeeding as either an impossible task, due to physical and psychological difficulties, or it may become a focus and a source of determination to succeed.

As time passes women are able to create stronger and more loving and caring relationships with their infants. For some this is with the help of psychological support; others found that this happens as they are able to register positive feedback from their infant in their interactions.

Women's responses to a traumatic birth appear to align with a dual-process grief model, which may be compounded by feelings of disenfranchisement when their baby is still with them, but nevertheless they feel a sense of loss in relation to the birth experience they were hoping for. This could present a useful avenue for further exploration.

As this study population was homogeneous, further worked is planned to explore the experiences of diverse populations who experience birth trauma. Further work is also required to identify the types of support which all mothers would find acceptable and accessible in order to overcome difficulties with processing and understanding traumatic birth experiences, and supporting their emotional attachment to their infants.

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Tables