PREVENTION

The impact of negative birth experiences on mother/infant relationships

—by Kathleen Kendall-Tackett

Having a baby is a pivotal event, and one that women tend to remember. In fact, women have been shown to accurately remember details of their first births even 20 years later (Simkin, 1992). If a woman has a negative or traumatic birth experience, its impact may be felt for years. But does a woman's birth experience influence how she interacts with her baby? As child abuse professionals, we have a stake in the answer to that question. In the present article, I describe what we know about the influence of birth experiences on mother/infant interactions.

What is a negative birth experience?

A surprising number of professionals minimize the impact of birth experiences or feel that negative birth experiences do not exist. Two years ago, an editor of a prestigious journal in obstetrics told me that negative birth experiences were a thing of the past. Other professionals are quick to point out that women's negative perceptions of birth are the result of their "high expectations." While many women have acceptable or pleasant births, not everyone does. Some women have had horrifying birth experiences: two women I have spoken with, for instance, had cesarean sections with no anesthesia. Other women have had birth experiences that appear to be "normal," and yet the women were negatively affected by them. Negative reactions included depression, anxiety, persistent thoughts about the experience, or fear of hospitals and doctors. This casual dismissal of women's feelings about a major life event is naive. It would be much more fruitful if we listen to what women have to say about birth, and consider how it could influence their relationships with their babies.

Does a woman's birth experience influence how she interacts with her baby? As child abuse professionals, we have a stake in the answer to that question.

When research studies have considered the question of negative birth experiences, the general paradigm is to compare emotional reactions to cesarean sections and vaginal births. While women's reactions to different types of births vary a great deal, some general statements can be made. First, cesarean sections are more likely to be perceived negatively than are vaginal deliveries (although this is not always the case). Among women who have had cesarean sections, the reactions are more likely to be negative if a women was under general anesthesia, if it was an emergency rather than a planned operation, and if no support person was present (see Kendall-Tackett, with Kantor, 1993, for a complete review of this research).

But wide variations in reactions suggest that we should make a habit of considering women's subjective reactions to childbirth. For example, did the woman feel powerless during her labor? Was she afraid that she or her baby might die? Did she feel betrayed by her doctor, the hospital, the baby's father, other members of her family, or her body? Did she feel physically damaged by the experience? A women's experience of birth can be related to her childhood as well. A woman who is a survivor of sexual abuse is more likely to have a negative birth experience. Recent research has revealed that women can have flashback of their sexual abuse experiences during labor (Courtois & Riley, 1992), and sexually abused women may have more medical interventions than their non-abused counterparts (Jacobs, 1992). These medical interventions include use of anesthesia and analgesia, forceps or vacuum extraction, and cesarean sections. Psychological variables, such as those described above, help explain some of the divergent reactions to births.

How does a birth experience influence the mother/infant relationship?

In their recent book, Klaus, Kennell, and Klaus (1993) compiled the results of six studies that examined the effects of doula support during labor (a "doula" is an experienced woman who provides emotional support during labor). Women were randomly assigned to "doula" or "no doula" conditions when they arrived at the hospital. This support was in addition to any they might have received from husbands or other labor companions.

The women who had doulas had significantly shorter labors and fewer medical interventions (i.e., pain medications, assisted births, or cesarean sections). Particularly intriguing were the mothers' perceptions of their infants at six weeks postpartum. The mothers who had doulas were significantly more likely to describe their babies as beautiful, clever, and easy to manage, and to report that they cried less, and were "better" when compared to a "standard baby." They also perceived themselves as closer to their babies and communicating better with them. They were pleased to have their babies and found that becoming a mother was easy. In contrast, the no-doula mothers were more likely to describe their baby as "just slightly less good" or "not as good" as a "standard baby." They were also more likely to think that anyone could care for their babies as well as they could. The women in this study were not considered at-risk for child maltreatment, and yet simply having or not having emotional support during labor influenced their perceptions of their infants six weeks later.

Trowell's (1993) findings showed even longer-lasting effects. In her three-year longitudal study, women who had had cesarean births (N=16) were compared with women who had had vaginal births (N=18) on their perceptions of their infants at one month, one year and three years postpartum. At one month, the cesarean mothers were significantly more likely to be depressed and to express doubts about their ability to care for their infants. At one year, the cesarean mothers were more likely to

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describe motherhood as negative, and to describe themselves as resentful, overwhelmed or angry. They were significantly less likely to have positive interactions with their children on the Strange Situation Test. At three years, the cesarean section mothers were likely to report serious problems in their relationship with their children, and to describe them as "unmanageable," "out of control," or "nasty." The mothers were also more likely to report the use of physical punishment. In addition, the children born via cesarean section were less likely to have completed their full course of vaccinations.

Wide variations in reactions suggest that we should make a habit of considering women's subjective reactions to childbirth.

While the results of the Trowell (1993) study are certainly startling, the results should be interpreted with caution. First, the sample size is small. Second, the women in the cesarean group had cesareans that were emergencies (vs. planned) and were conducted under general anesthesia. Both of these conditions have been demonstrated to increase the likelihood of a negative psychological response. Third, these results do not mean that all women who have had cesarean sections are more likely to abuse or neglect their children. Even with these cautions, the findings of Klaus, Kennell, and Klaus (1993) and Trowell (1993) at least suggest that we consider the impact of birth experiences when working with new mothers, especially those having difficulties with their infants.

How does a negative birth experience undermine a mother-infant relationship?

The mechanisms by which a negative birth experience undermines the mother-infant relationship are a matter of some speculation. One likely explanation is found in Klaus et al. (1993). Women who had doula support during labor felt more positively about themselves after their births. Specifically, they showed "significantly less anxiety, fewer signs of depression, and a higher level of self-esteem" than women who did not have doulas (Klaus et al., 1993, p. 45). On the other hand, women who had negative experiences may have felt that they needed to meet their own emotional needs before they could meet those of their babies, a reaction noted by Affonso (1977). The "no-doula" mothers were more likely to be depressed, and they may have felt socially isolated, especially if they couldn't talk to anyone about their birth experiences (a phenomenon Silver [1985] describes as "sanctuary trauma"). If mothers feel depressed and alone, they are not as likely to feel good about themselves as parents. This belief is underscored by the Klaus et al. (1993) finding that non-supported mothers felt that anyone could take care of their babies as well as they could. Baumrind (1993) has convincingly argued that parents need to believe in their own effectiveness, and this belief enhances their caregiving ability.

A woman who is a survivor of sexual abuse is more likely to have a negative birth experience.

One woman's experience

Elizabeth is a white middle-class woman who gave birth in a prestigious hospital in a large city. She had an assisted vaginal delivery. I selected her story because it would not fit the normal definitions of a "negative" experience used in research studies, and yet many of the themes I've described are present. (Note: In research studies, "negative" is often defined by objective factors such as whether she had a cesarean section. This type of data is usually collected from patient records. It is rare for a study to ask a woman how she felt about her experience.) Elizabeth was clearly troubled by her birth experience, and felt its influence for months as she tried to get to know her infant son.

> I had 25 hours of labor. It was long and hard. I was in a city hospital. It was a dirty, unfriendly, and hostile environment. There was urine on the floor of the bathroom in the labor room. There were 100 babies born that day. I had to wait 8 hours to get into a hospital room post-delivery. . . . There were 10-15 women in the post-delivery room waiting for a hospital room, all moaning, with our beds being bumped into each other by the nursing staff. I was taking Demerol for the pain. I had a major episiotomy. I was overwhelmed by it all and in a lot of pain. I couldn't urinate. They kept catheterizing me. My fifth catheterization was really painful. I had lots of swelling and anxiety because I could not urinate. My wedding ring had stuck on my finger from my swelling. The night nurse said she'd had patients that had body swelling due to not urinating and their organs had "exploded." Therefore, she catheterized me again. They left the catheter in for an hour and a half. There was lots of pain. My bladder was empty but they wouldn't believe me. I went to sleep and woke up in a panic attack. I couldn't breathe and I couldn't understand what had happened.

Later, she described her relationship with her son.

> I felt completely out of control when he cried from 5 p.m. to 10 p.m. nightly with colic. A couple of times I shook him, and one time I hit him on the back. That was the most I did. I was completely desperate. After three weeks I was afraid to be alone with my son. I was feeling completely inadequate as a mom. My mother-in-law was there looking over my shoulder and telling me what to do, telling me I wasn't giving him enough milk. She was bonding with him—I wasn't. I did not have the emotional strength to fight for him back. She took over, thinking that was the right

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thing to do. Six weeks after he was born, I went back to work. This was really helpful. When I went back to work, the major anxiety and depression lifted. Work was something I could do. When the colic stopped, that helped too.

Although no study to date has directly examined the relationship between birth experiences and maltreatment, several studies indicate that a negative birth experience can undermine the mother-infant relationship, and may be particularly dangerous for women already at risk for abuse.

Elizabeth's story is interesting because prior to her birth, we would not have considered her at risk. She had adequate prenatal care, was in a stable relationship, she was well educated, and had financial resources. She feels that her birth experience started a downward spiral for her initial relationship with her son. Her mother-in-law, although trying to be helpful inadvertently undermined Elizabeth's already shaky confidence. She was eventually able to resolve her difficulties because she was persistent in seeking out answers and assistance. When she had her second child, her birth experience was much more positive and she did not experience depression or other feelings of inadequacy.

Other mothers I have interviewed have described an intense feeling of disconnection or lack of "bonding" with their babies following difficult births. Underlying these feelings are often intense feelings of failure and feelings of inadequacy as mothers.

The women I have interviewed, and those in research studies, are generally white, middle-class, and married. I believe that mothers who are poor, single, or young are even more likely to feel powerless in a hospital setting, and threfore to be at increased risk for negative birth experiences. Although no study to date has directly examined the relationship between birth experiences and maltreatment, the above-cited studies indicate that a negative birth experience can undermine the mother-infant relationship, and may be particularly dangerous for women already at risk for abuse.

What can you do?

Professionals in the field of child maltreatment should, first, be sensitive to the potential impact of women's birth experiences. Professionals I have trained in this area frequently report that they are amazed at the number of times these issues arise once they are aware of them. Sometimes, these professionals are the only people who have taken the mother's concerns seriously. Many women who are afraid to complain about their births because they do not want to appear ungrateful for a healthy baby will confide in a professional who seems ready to hear and to help.

The second step is to validate the mother's experiences by empathizing with her feelings of anger, grief, or failure. She may achieve some

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clarity and sense of control by securing a copy of her medical records and discussing them with someone who can answer her questions about why certain things occurred. Her feelings of failure may be diminished if you help her re-frame her experience so that she sees that she did the best she could under difficult circumstances.

It is better not to become too "political" about the mother's experience until (if ever) she is ready to hear it. Some of the mothers with whom I have spoken have told me about well-meaning professionals who rail against unnecessary medical interventions or uncaring physicians. These women felt worse, not better, after hearing such criticisms.

Finally, refer the mother to organizations that can help (see box.) Also encourage her involvement in activities with other new and/or more experienced mothers. As she becomes more confident, she may be better able to face the challenges of parenting an infant—no matter how difficult her start.

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HELPFUL ORGANIZATIONS FOR NEW MOTHERS

C/SEC (Cesarean/Support, Education, Concern)

Provides information and support for those who have had Cesarean sections, and referrals to local support groups. They also have information on c-section recovery, Cesarean prevention, and vaginal birth after Cesarean.

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I CAN (International Cesarean Awareness Network)

A nationwide, volunteer-run, peer support organization. I CAN's priority is woman-to-woman support, particularly around the emotional issues associated with Cesarean birth.

P.O. Box 152, Syracuse, NY 13210 • 315-424-1942

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[8] Id.

[9] Id.

[10] 727 P. 2d 226 (Wash. 1986).

[11] Walstrom v. State, 752 P.2d 225 (Nev. 1988).

[12] See National Center for the Prosecution of Child Abuse, Summary of Legislation Extending or Removing the Statutes of Limitation for Offenses Against Children (1992).

[13] Id.

[14] Id.

[15] *See, e.g.*, Keith Russell Ablow, "Recovered Memories: Fact or Fantasy," Wash. Post, June 22, 1993, (Health) at 7; Carol Tavris, 'Beware the Incest-Survivor Machine," N.Y. Times Book Review, Jan. 3, 1993, at 1; Lawrence Wright, "Remembering Satan-Part I," The New Yorker, May 17, 1993, at 60; Lawrence Wright, "Remembering Satan- Part II" The New Yorker, May 24, 1993, at 54.

[16] John Briere, *Studying Delayed Memories of Childhood Sexual Abuse*, The APSAC Advisor (American Professional Society on the Abuse of Children, Chicago, IL), Summer, 1992, at 17; Roland C. Summit, *Misplaced Attention to Delayed Memory*, The APSAC Advisor (American Professional Society on the Abuse of Children, Chicago, IL), Summer, 1992, at 21; Elizabeth Loftus, *The Reality of Repressed Memories*, 48 Am. Psychol. 518 (1993).

See also Sandra G. Boodman, "At 28, Kathy O'Connor of Arlington Says She Remembered That Her Father Raped Her. She Sued Him and Lost. Are Delayed Memories Like Hers True or False?", Wash. Post, April 12, 1994 (Health) at 12; John Taylor, *The Lost Daughter*, Esquire, May 1994, at 76.

[17] See, e.g., Jane Gross, 'Suit Asks, Does 'Memory Therapy' Heal or Harm?", N.Y. Times, Apr. 8, 1994, at A1.

[18] John Briere & Jon Conte, *Self-reported Amnesia for Abuse in Adults Molested as Children*, 6 J. Traumatic Stress 21 (1993); Judith L. Herman & E. Schatzow, *Recovery and Verification of Memories of Childhood Sexual Trauma*, 4 Psychoanalytic Psychol. 1 (1987); Elizabeth Loftus, et al., *Memories of Childhood Sexual Abuse. Remembering and Repressing*, Psychol. Women Quar. (in press); Linda Meyer Williams, *Recall of Childhood Trauma: A Prospective Study of Women's Memories of Child Sexual Abuse*, J. Consul. & Clin. Psychol. (in press).

[19] *See, e.g.*, Herman & Schatzow, *supra* note 19.

[20] Loftus, *supra* note, at 534.

[21] Id.

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