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Healing After Birth Trauma: Physical and Psychological Impact, Emotional Recovery and Supportive Nursing Interventions Among Mothers – Article Review

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Abstract: Birth is a life-changing moment; to some, it is exciting and hopeful, like fulfilment; while for others, giving birth may be terrifying or daunting or even traumatic. Birth trauma is when a woman may feel psychologically or emotionally distressed due to her childbirth experience, which she considers threatening, scary, or overwhelming. It might happen after an unplanned emergency caesarean section, or protracted/complicated labour, acute pain, post-natal complications such as obstetric haemorrhage or assisted reproductive delivery of the newborn, supplemented by severe maternal complications during birth or medical interventions and even induced separation from their baby. Importantly, birth trauma is subjective, and a medically uncomplicated birth may be experienced as traumatic by the mother.

Some of the emotional impacts following a traumatic birth include: fear, anxiety, sadness, anger, guilt, helplessness and loss of control, as well as lower self-esteem and difficulty adjusting to motherhood. In some women, these symptoms become prolonged and can develop into post-traumatic stress, depression or an anxiety disorder. Birth trauma may affect outcomes related to breastfeeding, maternal–infant bonding, subsequent pregnancy plans, and a woman's relationship with healthcare services.

Pregnancy and having a baby are an incredible time of physiological, psychological and social change. Each year, there are more than 140 million births worldwide, many of which are associated with significant obstetric or neonatal complications, morbidity or mortality. Internationally, the infant mortality rate is 2.9%, maternal mortality 0.2%, and 'near miss' maternal mortality between zero four% to 1.6%. Research indicates that approximately 1 in 3 mothers recall their birth as being psychologically traumatic, particularly if complications occur, and/or the baby dies, and/or adequate support is unavailable, and/or compounding intersectional forms of disadvantage coincide (e.g., ageism, racism, transphobia/cisnormativity/misogyny/classism/fatism/chronic illness and disability). Consequently, meta-analyses indicate that 4% of women giving birth have childbirth-related PTSD (CB-PTSD), and 1% of partners present at the birth were found to have clinically significant CB-PTSD symptoms in 17%.[1]

Thus, this necessitates early recognition and compassion. Nurses are crucial for promoting emotional healing through their therapeutic communication skills, active listening practices, respectful maternity care, emotional validation and psychoeducation, supportive counselling and assessment through screening with timely referral. This provides moms with a nurturing setting which may positively crystallize an impactful birth experience that ultimately leads to the healing process, strength in mind & body, and flourishing maternal mental health.

Keywords: *Birth Trauma, Emotional Recovery, Nursing Intervention.*

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I. INTRODUCTION

➢ *What is Birth trauma?*

The term birth trauma is used by psychologists to describe the emotional, psychological or physical distress a mother might feel when giving birth if s/he embraces a positive and overwhelming narrative of childbirth that leaves her unable to cope with the terror. Unexpected or complex events are less likely to be encountered, such as prolonged labour, severe pain, emergency caesarean section, instrumental delivery, postpartum haemorrhage, major perineal injury and neonatal complications/and separation from the newborn. But trauma at birth does not simply depend on the medical severity of childbirth. Clinically uncomplicated birth can be traumatic for women who feel frightened, helpless, ignored or unsupported, deprived of control over decisions.

Birth trauma can be extremely emotional, bringing feelings of fear, anxiety, sadness, anger and guilt all at once; helplessness to address the situation in your life; lack of confidence as a new mother; sleep disturbance and difficulty adjusting. Some mothers suffer from continuing intrusive memories, avoidance of triggers related to the childbirth experience (smell, sound, people), anxiety or post-traumatic stress. The findings also have implications for breastfeeding, maternal–infant bonding, relationships, future pregnancy intentions and healthcare seeking.

In many cultures, childbirth is perceived positively, yet research indicates between 20 and 40% of all women will deem the experience psychologically traumatic. Compared to a traumatic birth experience, it is defined as: A woman's experience of interactions and/or events directly related to childbirth which were perceived as distressing, resulting in both short- and long-term adverse consequences for a woman's health and wellbeing". The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) states that a traumatic event is one in which individuals directly experience, witness or learn about an event involving actual or threatened death, serious injury or sexual violence. Posttraumatic stress disorder (PTSD) is a trauma- and stress-related disorder that may occur following exposure to an event where death has either occurred or been threatened. PTSD is characterized by re-experiencing symptoms that appear within 3 months of the trauma, including flashbacks; avoidance of factors related to the event; negative mood and cognition; and hyperarousal.[2]

II. PREVALENCE

Established systematic reviews of epidemiological data across many countries show that about 30% of women worldwide find childbirth to be psychologically traumatic. That same figure can be found in surveys conducted from 2022 to 2026. To translate that into English: in any maternity ward of a hospital with ten new mothers, about three of them are trying to come to terms with what happened as an act of trauma. A traumatic birth does not guarantee a chronic psychiatric disorder. The majority of people who found birth traumatic will resolve it given enough time and support. But most will not.

Meta-analyses characterize global rates of full CB-PTSD (childbirth-related PTSD) to be 4%–4.7% in the general postpartum population as of October 2023. An additional 12.3% will fail to meet full diagnostic criteria and experience subsyndromal CB-PTSD: significant, chronic symptoms while not reaching the full diagnostic threshold. That group is not fine. Subsyndromal PTSD resulted in a real functional impairment where she was unable to bond with the infant and could not fall asleep despite being tired.[3]

III. PHYSICAL IMPACT ON THE MOTHER

Birth trauma can produce serious physical consequences, especially when childbirth is prolonged, complicated obstetrically, or managed with surgical procedures or injury. Physical effects include common ones such as perineal tears, pain from an episiotomy, pelvic–floor injury, vaginal or cervical trauma (need help finding these strains), postpartum haemorrhage; it can also cause severe pelmneuryphuria painfulness to the skin near where your pubis starts. Emergency cesarean birth could have repercussions including postoperative pain, discomfort in the wound area, reduced physical movement ability and fatigue affecting the recovery process in women. Profuse bleeding may cause postpartum anaemia, feebleness, syncope and poor performance in daily activities.

Many mothers suffer from chronic pelvic, back or perineal pain, urinary or faecal incontinence, sexual pain or dysfunction related to childbirth injuries. These issues can disrupt sleep, breastfeeding, ability to walk, bathing/care for self and ability to care for the baby. Physical complications, too, can aggravate emotional distress and delay total recovery for the mother.[4]

Physiologic birth trauma is the result of physical damage that occurs or injuries to tissue during labour and delivery involving mechanical stress. The physical effects can be divided into acute immediate injuries and chronic sequelae:

➢ *Immediate Physical Injuries*

- Perineal and Vaginal Lacerations: Somatic injuries may involve minor mucosal tears or third- and fourth-degree obstetric anal sphincter injuries (OASI) involving tearing into the anal sphincter or rectal mucosa.
- Musculoskeletal Injury: The levator ani muscle may be torn and avulsed from the pubic bone in cases of forceps or instrumental delivery.
- Nerve Damage: Prolonged pushing can compress or stretch the pudendal nerve, which may result in numbness or an altered sensation feeling in the area.

➢ *Long-Term Physical Complications*

- Pelvic Floor Dysfunction: A structural weakness of the pelvic floor is often associated with urinary or faecal incontinence and prolapse of pelvic organs.

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- Chronic pain and dysfunction: Women used to endure dyspareunia, which is painful sexual intercourse, and so a lot of pelvic or sacroiliac joint pain alongside extreme rectus abdominis muscle separation (diastasis recti)[5]

IV. PHYSICAL IMPACT ON THE BABY

Birth trauma can manifest in the form of physical symptoms which affect the newborn (this is particularly evident when labour has been prolonged, complicated or associated with a difficult delivery). How it affects depends upon what kind of paediatric birth complication occurred when, and also the condition of the baby during birth. Common birth injuries include scalp swelling or bruising (ecchymosis), cephalohematoma, injury to the facial nerve, and fractures of the clavicle or other bones; less frequently, brachial plexus injury. Some of these injuries are associated with complicated or aided vaginal delivery. Complications that can lead to breathing difficulty, poor muscle tone, abnormal reflexes, feeding troubles, seizures or other neurological complications occur in many newborns who had birth asphyxia or oxygen deprivation. Increased need for neonatal monitoring and the requirement of specialised medical care may also be due to Prematurity, low birth weight, or emergency delivery. Physical effects can also be short-lived with proper monitoring and treatment, or lead to hospitalization for longer periods of time or have lifelong developmental or neurological complications. This calls for an accurate assessment directly after birth.[6]

V. PSYCHOLOGICAL IMPACT ON THE MOTHER AND BABY BONDING

The psychological effect of birth trauma on the mother could relate to bonding with her baby soon after birth. A traumatic experience giving birth can lead to the mother feeling fear, helplessness, guilt, sadness, anger, anxiety, loss of power, and loss of confidence. Other mothers may go on to develop intrusive memories, nightmares, chronic avoidance of triggers related to childbirth, hypervigilance or even diagnoses of childbirth-related post-traumatic stress disorder (CB-PTSD). Symptoms of depression and anxiety can typically coexist with trauma symptoms, compromising maternal adjustment even further.[7]

Mother may also relate differently to her baby because of birth trauma. A mother who suffers severe trauma symptoms may struggle to connect emotionally, may withdraw from the baby or be consumed with anxiety about keeping the baby safe, or she may find her baby a living reminder of what happened at birth. A systematic review found that out of 21 studies, 19 reported a negative impact of childbirth-related PTSD on the mother–infant relationship, and postpartum depression mediated part of this association.[7]

A systematic review was conducted regarding Perinatal PTSD and the mother-infant bond. This systematic review included 22 studies (n =9472) and reported a positive association between perinatal PTSD symptoms and impaired MIB. However, the association could be confounded by (e.g., depressive symptoms, general psychological distress. A meta-analysis indicates a small-to-moderate positive correlation between PS and PD (r = 32); postnatal PTSD symptoms with MIB impairment (n = 8) and a moderate positive correlation between the two measures was observed. MIB (n = 15) and PTSCB-PTSD symptoms. Exploratory meta-analyses also suggest that for the CB-PTSD construct, general rather than childbirth-related PTSD symptoms are more closely related to MIB (n = 5). Findings suggest divergent relationships of PTSD versus CB-PTSD with MIB. However, additional research is still needed to better understand the association between maternal perinatal PTSD and MIB and the role of individual symptom domains in planning targeted interventions for MIB.[8]

VI. EMOTIONAL RECOVERY AFTER TRAUMATIC CHILD BIRTH

After a traumatic birth, emotional recovery is when a mother restores her psychological safety, emotional regulation, confidence and sense of control post-traumatic childbirth experience. Mothers may feel fear, sadness, anger, guilt, helplessness and anxiety at first, and they often get intrusive memories or lose faith. Empathy, active listening, emotional validation, appropriate information on the birth experience, familial support and expression of emotion are all factors that can promote the process of recovery. It is important for healthcare professionals to recognise the individual experience of the mother and deliver respectful, person-centred care. The World Health Organization underscores the need for information consistency, reassurance, emotional support, respectful care and appropriate mental-health assessment during the postnatal period (WHO, 2022)[9]. Identifying chronic trauma-related symptoms early and referring for supportive psychological care can facilitate recovery and enhance maternal well-being.

Emotional recovery from traumatic childbirth is a long-term process of restoring feelings of security, emotional stability, self-confidence and control as a mother after the painful birth experience. This may include fear, anxiety, sadness, anger, guilt or shame around not being the mother she wants to be but feels incapable of becoming due to having been so devastated by a traumatic birth experience — perhaps intrusive memories and sleep disturbances; an avoidance of reminders of the past trauma. For some women, these reactions can take the form of childbirth-related post-traumatic stress symptoms which impair maternal well-being and adjustment to motherhood. The postnatal consequences of childbirth trauma and PTSD remain critical for prevention and intervention, as evidenced by recent work.[10]

Healing from trauma after a traumatic birth is about making sense of losing control, feeling abandoned by medicine and mourning all the hopes and dreams you had for your birthing experience. Realizing how real that trauma is and refuting self-blame are two of the most important steps to healing. Specifically, in-depth mental health support—working with a perinatal trauma therapist using science-based modalities such as Eye Movement Desensitization and Reprocessing (EMDR) or Cognitive Behavioural Therapy (CBT)—to reframe and process distressing memories from

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childbirth-type PTSD. Grounding techniques, finding friends for peer support groups, and maintaining rigid boundaries against sharing your birth story allow mothers to build trust again with their body and help them create a strong mind.

An exploratory qualitative study investigated what healing from trauma at birth meant, drawing on a purposeful sample (n = 11) of women who had experienced diverse forms of trauma at birth. Semi-structured interviews were undertaken, transcribed and analyzed using IPA methodology. Key themes included healing as a process, not a destination; healing as being at peace with the experience; and healing as holding multiple truths. Healing was described by participants as active and nonlinear, with the presence of milestones, a gradual integration of one's experience into everyday life without drowning in it and acceptance of different priority systems or even changed feelings. The results emphasize the need to view trauma recoveries as slow-moving and to require spaces for storytelling with testimony honours, where the risks are carefully evaluated, and the possibility to bear both difficult and pleasant emotions is recognised. The study encourages more recovery research on birth trauma with the individual as an expert in their experience, and recommends a diversity of birthing individual and researcher characteristics. Integrating the lived experience of healing is paramount to fostering initiatives and programming that are client-centred in support of survivors of birth trauma.[11]

VII. NURSING INTERVENTIONS OF BIRTH TRAUMA ON MOTHERS

Maternal birth trauma nursing joint practice merges both acute physical treatment and early complication screening with trauma-defined psychological helping care of mothers. In the early stages immediately following a traumatic delivery, you focus on physical assessment and pain management (i.e., checking fundal firmness and lochia to prevent postpartum haemorrhage, along with direct inspection of surgical incisions or severe perineal lacerations). Analgesics, ice packs to reduce localised tissue swelling and sitz baths are used for the relief of pain, as healing continues. Physical injuries, such as pelvic floor avulsions or third- and fourth-degree tears that restrict mobility of the mother or basic caregiving of the baby, are common after delivery; therefore, nurses can support proper positioning, personal hygiene, and breastfeeding.[12]

At the same time, trauma-informed emotional care intertwines with everyday nursing. The nurse offers validation while allowing the mother to debrief on her childbirth experience in a safe, non-judgmental atmosphere. Mothers should be provided with clear, honest information about medical events in order for them to understand and process what has happened without blaming themselves. Nurses screen for early signs of childbirth-related Post-Traumatic Stress Disorder (PTSD) or postpartum mood disorders, looking for hyperarousal, intrusive thoughts related to delivery, and difficulty bonding with the newborn. Finally, thorough discharge planning prepares the mother with education on how to care for a wound, red-flag symptoms for warning signs, and referrals in an appropriate time range to multidisciplinary care such as targeted pelvic floor physical therapy counselling or perinatal trauma counselling.

VIII. SUMMARY

There is growing recognition that maternal birth trauma is a significant maternal health problem that can compromise physical recovery, emotional well-being and psychological adjustment in the postpartum period, as well as the capacity for mother–infant bonding. After a traumatic birth, mothers can suffer from fear, anxiety, sadness, guilt, helplessness, loss of control, intrusive memories and lower confidence. Recovery from trauma is dependent on timely recognition, emotional support, respectful maternity care, communication and appropriate psychological interventions. The holistic role of nurses in recognizing maternal distress, therapeutic communication, normalizing experiences and physical discomfort, promoting mother–infant interaction (training), adding supportive caregivers, and referring when needed is considered. Provision of early, compassionate, individualized care can bolster coping and resilience while affording a potentially healthier adjustment to motherhood.

IX. CONCLUSION

Healing from birth trauma extends beyond the physical; it is about regaining emotional safety, confidence, dignity and trust in the childbirth experience (or healthcare) itself. Supportive nursing care places mothers in an environment where they experience being heard, respected, understood and empowered. Therefore, nurses should incorporate psychological assessment into normal postnatal care and be mindful of ongoing trauma symptoms. Recovery can be aided with therapeutic communication, emotional validation, providing respectful care to clients and their families, breastfeeding assistance, mother–infant bonding support and referral within an appropriate time. A compassionate and trauma-informed approach might also assist mothers from distress to emotional healing, resilience, effective maternal adaptation, and enhanced overall postnatal well-being.

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