

Improving perinatal mental health outcomes: The role of support in assisting breastfeeding experiences following birth trauma

Abigail Wheeler^{a,*}, Fay Sweeting^a, Andrew Mayers^a, Amy Brown^b, Shanti Farrington^a

^a Psychology Department, Faculty of Science and Technology, Bournemouth University, Poole, BH12 5BB, UK

^b Public Health, School of Health and Social Care, Swansea University, Swansea, SA2 8PP, UK

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ABSTRACT

Background: Experiencing any traumatic event can have long lasting impacts on mental health. In the context of childbirth, a traumatic experience could directly or indirectly impact a mother's ability to successfully breastfeed and affect her long-term mental health. Being able to breastfeed successfully is known to improve mental health outcomes for mothers.

Aim: To explore how self-reported birth-related trauma symptoms affect breastfeeding and the role of support in shaping these experiences, to inform trauma-informed breastfeeding support services.

Methods: A convenience sample of 93 mothers responded to this study and took part in an online survey. Qualitative questions were used to explore participants' breastfeeding experiences, whether they felt a traumatic birth had contributed to this experience, and what support they received to subsequently breastfeed. Participants also completed the Posttraumatic Stress Disorder Checklist, or PCL-5 as part of the online survey, which is a standardised screening tool used in the assessment of PTSD symptoms. Participants who self-reported a traumatic birth and scored 32 or above on the PCL-5 were analysed further ($N = 50$).

Findings: Results showed that mothers had both positive and negative experiences of healthcare staff support with breastfeeding. Positive support, such as encouragement and advice from healthcare staff, was shown to be beneficial after birth trauma, enabling mothers to heal and recover from their experiences and supported bonding with their infant. Negative experiences, such as pressure from healthcare staff or challenges when breastfeeding, were reported to have had a detrimental perceived impact on mental health outcomes, leading mothers to seek further breastfeeding and wellbeing support following a traumatic birth.

Conclusion: Trauma-informed breastfeeding support is required to enable more positive mental health outcomes of mothers, following a traumatic birth.

Introduction

Statement of Significance

Problem	What is Already Known	What this Paper Adds
Mothers who have experienced birth trauma, often do not receive adequate or consistent support to breastfeed, which could negatively impact their mental health.	There is a link between birth trauma and poor breastfeeding outcomes. Successful breastfeeding could act as a protective factor for mental health, and negative breastfeeding experiences could be a risk factor for	This paper highlights the role postnatal support systems have in improving breastfeeding experiences following birth trauma and explores how trauma-informed care could be used to improve perinatal

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Problem	What is Already Known	What this Paper Adds
	mental health following birth trauma.	support services and maternal mental health outcomes.

Post-traumatic stress disorder (PTSD) is defined as a mental health condition caused by distressing, stressful or traumatic events (American Psychiatric Association, 2013). The DSM-5 outlines four clusters of symptoms: re-experiencing, for example nightmares and flashbacks, where the traumatic event is relived; negative cognition, such as emotional numbness, anger and shame; avoidance, and hyperarousal (Thakur et al., 2021). The DSM-5 criteria are based on general trauma

* Corresponding author.

E-mail address: awheeler@bournemouth.ac.uk (A. Wheeler).

and therefore may not fully reflect childbirth specific symptoms. With this in mind, around 4 % of mothers experience PTSD following birth trauma (Ayers et al., 2023). However, given the general trauma nature of the DSM-5 definition, this could influence underdiagnosis across the maternal population.

Birth Trauma can be defined as: "... a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/or long-term negative impacts on a woman's health and wellbeing" (Leinweber et al., 2022, p.687). Birth trauma is therefore subjective and dependent on individual circumstances, which makes measuring it a challenge due to the lack of standardisation. This presents as a potential problem in research, as two mothers with similar births may differ in their perception of the experience as traumatic. A physical trauma (e.g., blood loss) or medical intervention (e.g., emergency caesarean-section) could contribute to birth trauma for one mother, but not another (Webb et al., 2021; Common causes of Birth Trauma and PTSD, n.d.).

Traumatic births have been shown to influence breastfeeding experiences through impacting physical breastfeeding initiation (Norman et al., 2022). Norman et al. (2025) later explored that a traumatic birth could cause the perception of "failure", and maternal wellbeing is negatively impacted as a result. This framing of "failure" demonstrates a link to the societal expectation of being a good mother, highlighting how social narratives can compound feelings of inadequacy. Birth trauma was found to have negative impacts on breastfeeding and wellbeing, with this relationship occurring bidirectionally. These findings can be understood in the context of Childbirth-related Posttraumatic Stress Symptoms, a construct describing PTSD symptoms that occur specifically in response to traumatic birth experiences (Ayers et al., 2016; Dekel et al., 2017). Some mothers may find that breastfeeding and the physical contact involved in this could trigger distressing flashbacks of the birth, leading to an avoidance of breastfeeding. On the other hand, successful breastfeeding may negate the feelings of failure. There are few studies which examine these trauma symptoms and how they may impact breastfeeding behaviour, as this study aims to do.

While Norman et al. (2025) study explored the emotional and societal links between trauma and breastfeeding, other research explored postnatal PTSD after birth trauma, and the impacts on breastfeeding experiences. Findings showed mothers experiencing postnatal PTSD were 6 times less likely to initiate breastfeeding, compared to those who did not experience postnatal PTSD (Garthus-Niegel et al., 2017). Together these papers demonstrate a pattern of interaction between psychological distress and physical complications that reduces breastfeeding rates, however cross-cultural differences limit comparability.

Evidence suggests a two-way interaction between PTSD and breastfeeding. Chen et al. (2022) recruited participants 3 days after birth and assessed them using the Post-Traumatic Stress Disorder Checklist (PCL-C) at 42 days after birth. The PCL-C (Weathers et al., 1993) is the civilian version of the PCL checklist, including 17 questions relating to stressful past events, initially developed for soldiers or veterans (Norris and Hamblen., 2004). The PCL-C is a statistically strong tool, with high internal consistency and test-retest reliability. However, a 42 day follow up may not capture longer term trauma symptoms. 12.1 % of the cohort developed PTSD within 42 days after giving birth and mothers who exclusively breastfed had a lower risk of postnatal PTSD. While there is the potential of reverse causation, supporting mothers to exclusively breastfeed may reduce the risk of postnatal PTSD. To further support this idea, recent research demonstrates that breastfeeding success supports wellbeing by evoking a sense of purpose and achievement, making recommendations for future trauma-informed breastfeeding support (Wheeler et al., 2025).

Prior research has focussed on birth experiences, trauma, and breastfeeding. However, there is a lack of research around the support mechanisms impacting these factors. The aim for the current study is therefore to explore how support systems shape mothers experiences of breastfeeding after self-reported birth trauma, with the goal of

influencing trauma-informed breastfeeding support services.

Participants, ethics and methods

Study design

A qualitative design was used to enable a thorough exploration of mothers' birth and breastfeeding experiences. Participants were able to access the study via a direct link on the study advertisement poster. Participants were asked to complete an open-ended questionnaire, followed by the PCL-5 checklist (Blevins et al., 2015), both were hosted by the JISC (Joint Information Systems Committee) survey platform. Data was collected between April 2024 and June 2024.

Sample

A convenience sample of 93 mothers was recruited using social media (Facebook, Instagram, and LinkedIn). A visual advertisement poster was used by the authors to distribute the study to their social media networks. Posts included a clear description of the study, how participants could take part, the inclusion criteria and purpose of the research. The study was also advertised by birth trauma support groups to their networks, using the same poster.

Inclusion criteria consisted of being over the age of 18 and having breastfed or attempted to breastfeed. No restrictions were placed on time since the birth to capture immediate and longer-term perceived impacts. The year of birth of the infants was not collected, this was not a variable that was intended to be analysed for this study. This study focuses on mothers' experiences, exploring the perceived impacts of birth trauma.

The PCL-5 was introduced to maintain conceptual coherence and to understand the experiences of mothers who showed symptoms consistent with a trauma response. 50 participants from 93 scored 32 or above on the PCL-5 and were therefore further analysed. The DSM-5 (American Psychiatric Association, 2013) describes a cut off score for the PCL-5 between 31–33, therefore 32 was chosen for this study. Participants were asked if they considered their birth to be traumatic, and only those who answered "Yes" and scored over the DSM-5 threshold on the PCL-5 were analysed for this study, which was a total of 50. Although meaningful distress can exist below cut offs such as this, to enable the sample to measure the trauma-related symptoms caused by a self-reported traumatic birth, only those who scored significantly were analysed. There were 20 original participants who reported they felt their birth was traumatic but did not score over the DSM-5 threshold on the PCL-5 and were not included in this analysis to ensure consistency and reduce potential bias. The PCL-5 was chosen as a validated screening tool to explore those who met the criteria for a traumatic birth and avoid over or underestimation of traumatic experiences, giving the study greater validity. The PCL-5 was not used to diagnose PTSD in participants, but to identify individual mothers who had significant trauma symptoms following a traumatic birth.

Ethical considerations

All data was anonymised at the source and kept in accordance with GDPR and university regulations. Anonymisation was achieved by collecting and recording no identifiable data though careful consideration when developing the research questions. This was explained to participants in the Participant Information Sheet.

Participants were given the right to withdraw up to the point of submission, regardless of reason, if they felt they could not continue. All participants gave written informed consent to participate in this study as part of the online survey.

To mitigate potential participant distress, the questions were developed with support from birth trauma organisations to ensure sensitivity. Participants were also signposted to contacts for support in case of any

distress after completing the survey.

Some of the data collected in this research was later not analysed. The researchers justify this decision on the basis that using a standardised screening tool to further reduce the sample size, enables greater validity and reduces recall bias from participant defined parameters. In future, this data could also be revisited and re-analysed.

The study was granted ethical approval by the university, Ethics ID: 52358.

Data collection

Data was collected between April 2024 and June 2024. Screening questions eliminated participants who were under the age of 18 and ensured all gave informed consent to take part. JISC was used to host a qualitative questionnaire and advice and guidance from birth trauma organisations was sought to develop the questions.

Questions were initially designed by the lead researcher and focused on the broad breastfeeding experiences, birth trauma, support received, and the perceived impacts on mental health. These questions were then discussed with the supervisors and supporting organisations for their comments to ensure content validity and sensitivity due to the nature of the research. The questions were then finalised by the lead researcher (see Appendix A). Demographic information included the age of the mother, type of birth, and location of birth.

The PCL-5 was then adapted to specifically refer to birth. For example, instead of “In the past month, how much were you bothered by: Feeling very upset when something reminded you of the stressful experience?”, the birth-PCL-5 used the wording “In the past month, how much were you bothered by: Feeling very upset when something reminded you of your birth experience?”. This scale was used to measure indicators of PTSD and not as a diagnostic tool. Once completed, participants were debriefed through use of an information sheet signposting them to organisations that provide support for maternal mental health, should they require this. They were also given the researchers contact details to contact them regarding any element of the study.

Data analysis

Reflexive Thematic Analysis (RTA) was used to analyse the open-question survey data (Braun and Clarke, 2006, 2019). This method was chosen to allow for interpretation of the data inductively, while the lead researcher reflected on her own knowledge and interactions with the data throughout. During RTA, the subjectivity of the researcher is valued as part of the analytical process and allows for an in-depth exploration of themes emerging from the participant’s lived experiences. The findings therefore are representative of the authors’ interpretations of the participants’ experiences rather than their definitive realities. The lead researcher reflected on her impacts on the data as a woman without children, while carrying out this process. Other qualitative research methods, such as Content Analysis (Leavy, 2014, pp. 359–379), could be used to analyse this type of data, however the researchers wanted to delve deeper than surface-level categorisation and explore the meanings within participant responses. Data analysis was carried out using NVivo 20 (Qualitative Data Analysis Software). The lead researcher organised the dataset, generated the initial codes and remained reflexive at each stage. First grouping codes to form initial themes, these were then reviewed by the co-authors who advised on refining these. Codes were further reviewed by the authors, named and defined, and finally agreed by all. The lead researcher reviewed and calculated the PCL-5 scores of each participant against the DSM-5 (American Psychiatric Association, 2013) criteria.

Results

The 50 mothers were aged between 19 and 40 at the time of giving birth, with a mean age of 31.36 years old (Std Dev. 4.93). 70 % ($N = 35$)

experienced some form of complication with their birth, including haemorrhage, episiotomy, tear, and infection. Participant characteristic information can be found in Table 1. Breastfeeding duration ranges from less than a day to 5 years, this includes exclusive breastfeeding and combination feeding. While the themes align closely with the studies aims, they were inductively produced when analysing participant experiences, using RTA.

Three main themes emerged from the data, with seven subthemes. The first theme was Birth Trauma, with the subthemes: Consequences and Future Implications, and Diagnosis of PTSD. The second theme was Breastfeeding Experiences, with the subthemes: Fighting Against Pressure and Physical Challenges, and Breastfeeding for Recovery and Bonding. The third theme was Support, which included the subthemes: Finding Strength in Those Around Us, When Support Helps – and When It Hinders, and Perceived Influence on Mental Health. A coding tree can be found in Fig. 1.

Birth trauma

This theme includes statements sorted into the subthemes: Diagnosis of PTSD and Perceived Impact on Future Choices. Quotes demonstrate where mothers have attributed trauma to their birth and/or breastfeeding experience and highlight the subsequent perceived impacts this has had on their wellbeing and how this has shaped their future decisions.

Diagnosis of PTSD

28 % of participants ($N = 14$) shared they had been diagnosed with PTSD following a traumatic birth. References to nightmares and flashbacks, associated with trauma, demonstrate the perceived impacts a traumatic birth can have on mental health.

One participant describes the triggers for her PTSD being references to birth and pregnancy, as this is something that is commonly spoken about in the media, this participant is likely to encounter these triggers regularly:

Table 1

A table showing participant characteristics.

Location of Birth	Hospital – Consultant Led	39 (78 %)
	Hospital – Midwifery Unit	11 (22 %)
Nature of Birth	Spontaneous Vaginal Birth	5 (10 %)
	Induced	20 (40 %)
	Assisted Vaginal Birth – Forceps	11 (22 %)
	Assisted Vaginal Birth – Ventouse	6 (12 %)
	Caesarean – Planned	3 (6 %)
Method of Infant Feeding	Caesarean – Unplanned/Emergency	24 (48 %)
	Exclusively Breastfeeding	19 (38 %)
	Mixed – Breast and Expressing	8 (16 %)
	Mixed – Breast and Formula	20 (40 %)
Breastfeeding Duration	Exclusively Formula Fed	3 (6 %)
	<1 day – 4 weeks	9 (18 %)
	5weeks – 26 weeks	13 (26 %)
	27 weeks – 1 year	9 (18 %)
	1 year+ – 3 years	16 (32 %)
Birth Complications	3 Years +	3 (6 %)
	Haemorrhage	21 (42 %)
	Episiotomy	8 (16 %)
	Tear	10 (20 %)
	Retained Placenta	4 (8 %)
Age Range	Other	10 (20 %)
	19–24	3 (6 %)
	25–30	18 (36 %)
	31–35	18 (36 %)
	36–40	11 (22 %)
PCL-5 Score	32–40	10 (20 %)
	41–50	17 (34 %)
	51–60	15 (30 %)
	61–70	7 (14 %)
	71–80	1 (2 %)

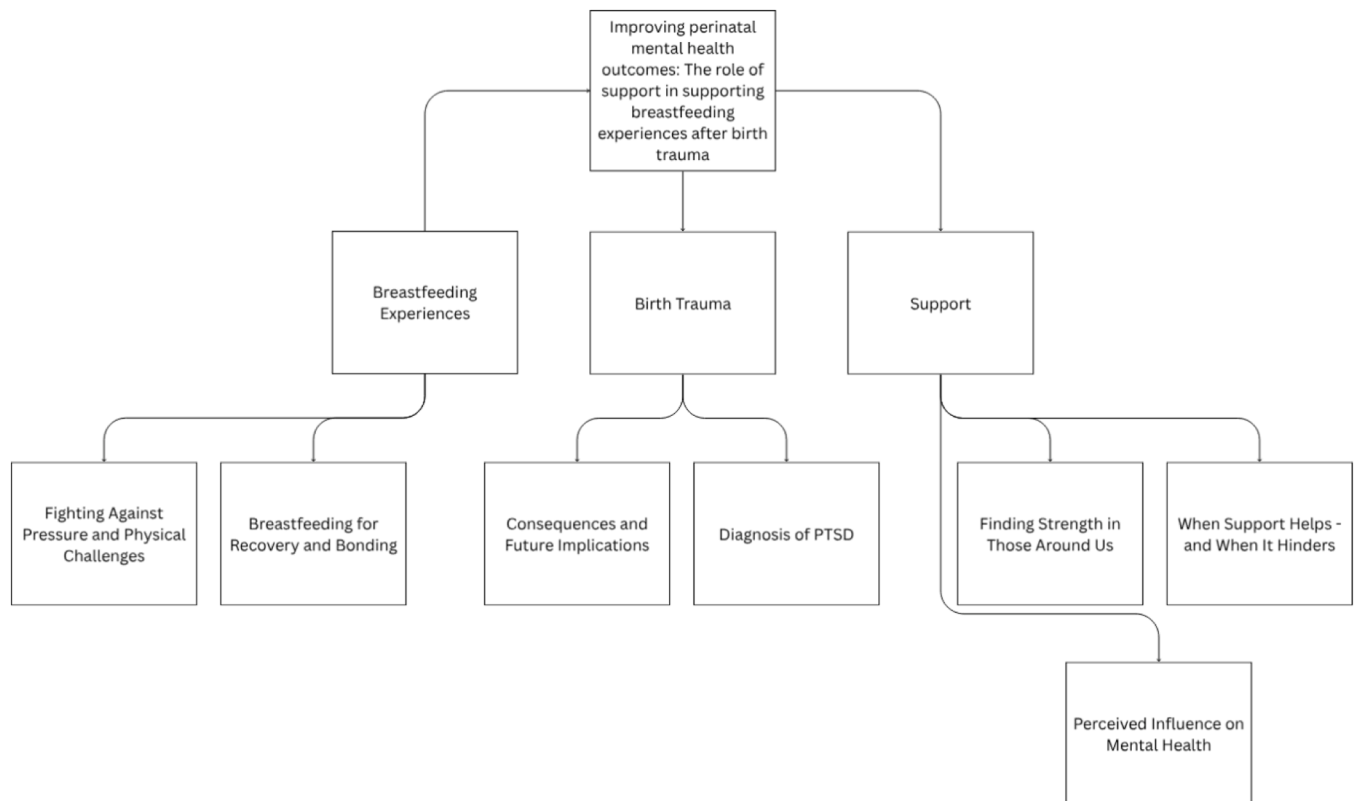


Fig. 1. A coding tree showing themes and sub-themes.

"I was diagnosed with PTSD about 5 months after my son's birth. I was having panic attacks and flashbacks. The panic attacks were triggered by hearing or seeing any references to birth, pregnancy or ultrasound scans." (Participant 24, 30 years old at the time of giving birth, vaginal assisted forceps delivery, exclusively breastfed for 2 weeks before formula feeding)

Another participant describes the debilitating nature of PTSD, preventing them from leaving the house and avoiding social situations:

"I was diagnosed with PTSD. I struggled to leave the house immediately after over fear of bleeding again. I found social interactions difficult as I didn't want to talk about my trauma and I was scared people would ask me about it." (Participant 12, 32 years old at the time of giving birth, vaginal birth with subsequent haemorrhage, mixed expressed and breastfed for 13 months)

A third participant details how PTSD led to challenges with bonding with her infant and how they became reliant on support from family:

"I developed PTSD which existed for 3 months, I struggled to bond with the baby. Suffering several prolapses and double incontinence meant I was unable to support myself and the baby for about 6 months so relied on family." (Participant 84, 32 years old at the time of giving birth, vaginal assisted ventouse delivery with tear and placental abruption, exclusively breastfed for 12 months)

Consequences and future implications

Some mothers felt put off having another baby for fear of going through the trauma again, 22 % of mothers in the study reported this. While these mothers' future decisions had been impacted, some did go on to have another pregnancy, while others didn't.

"I don't think I'll ever get over it, I'm trying so hard to keep my family together and be a positive role model for my son. I don't want to

pass any of my troubles on to him, because I was such a positive, fun person to be around before this happened to me. Never in a million years could I contemplate getting pregnant again; despite knowing how wonderful it could be to give my son another sibling." (Participant 58, 38 years old at the time of giving birth, emergency caesarean section delivery, mixed breast and express fed for 2.5 months)

The lasting consequences to mental wellbeing, following a traumatic birth, are evident. Many summarise that this is a key reason they are not considering having another child:

"Long term (9 months later) it still hugely affects my mental health - I suffer from flashbacks, I'm unable to talk about my birth without being extremely upset. I also feel I that I wouldn't be able to have any more children due to the trauma." (Participant 49, 28 years old at the time of giving birth, induced vaginal birth and haemorrhage, mix express breast and formula fed for 8.5 months)

One mother, who went on to have another child, describes how she was triggered when finding out she was pregnant again. Her second birth was not traumatic; despite this she still experiences triggers to her first traumatic birth:

"Very triggered when I found out I was pregnant again even though it was planned. Struggled through the pregnancy and how I would birth another baby. (Which I then managed successfully with 0 interventions or complications) however I still feel triggered in some situations." (Participant 33, 23 years old at the time of giving birth, vaginal assisted ventouse delivery with subsequent haemorrhage, exclusively breastfed for 22 months)

Breastfeeding experiences

This theme refers to positive and negative breastfeeding experiences. Some mothers reflected on aspects of their breastfeeding journey and the positive perceived influences this had on their mental health and bond

with their infant. Others reflected on the challenges they faced throughout their journey and the perceived negative impacts of this. Two key sub-themes emerged: Breastfeeding for Recovery and Bonding, and Fighting Against Pressure and Physical Difficulty.

Breastfeeding for recovery and bonding

20 % of mothers ($N = 10$) attributed being able to breastfeed successfully to supporting them to heal and bond with their baby following a traumatic birth, highlighting how breastfeeding support is crucial following traumatic birth experiences.

One mother detailed how breastfeeding was an integral part of her recovery after a traumatic birth and reflects on how this would have been challenging had breastfeeding not been successful:

“Breastfeeding my baby after a traumatic birth was a huge part of my recovery and helped with bonding, I am always grateful that I was able to breastfeed my baby as I feel an inability to do this would have further compounded my trauma and also impacted my early bonding and acceptance of my baby” (Participant 15, 33 years old at the time of giving birth, emergency caesarean section delivery with haemorrhage and failed epidural, mix breast and formula fed for 6 months)

Another mother explains her determination to breastfeed, caused by feelings of failure due to a traumatic birth. It supported her bond with her infant, and supported her to recover from her own trauma:

“My traumatic birth made me more determined to breast feed. I felt my body had failed me by haemorrhaging, so I really wanted it to almost redeem itself by being able to feed my baby. When I had to go to the hospital due to the haemorrhage, I had to leave my 3-week-old baby at home. It completely broke me and I felt so much guilt. When she was able to come to the hospital the next day to see me I felt like I had to work harder at our bond and breastfeeding was my way to do so. Having her with me and being the only one able to feed her was almost like my safety. It helped to keep me focused and take my mind off of the trauma a bit.” (Participant 12, 32 years old at the time of giving birth, vaginal birth with subsequent haemorrhage, mixed expressed and breastfed for 13 months)

Fighting against pressure and physical difficulty

Of the 50 participants, 62 % ($N = 31$) expressed challenges with breastfeeding and feeling pressured to feed a certain way. Challenges included pain, exhaustion, low milk supply, and latching difficulties. Pressure was felt from healthcare staff and was predominantly pressuring to formula feed, rather than supporting breastfeeding.

One mother describes how she was pressured to produce milk, and when this failed, her baby was given formula instead of her being supported through this difficulty:

“So much pressure to ‘produce’ which caused more stress. Machine expressed on day 2 which was unsuccessful because of the stress. Baby was cup fed formula rather than supporting me to feed naturally.” (Participant 72, 33 years old at the time of giving birth, emergency caesarean section, mixed breast and formula fed for 2 years and 6 months)

Another participant highlights the physical challenges with breastfeeding, and how sometimes even with support, this can lead to an unsuccessful journey:

“Baby did not latch well, cracked bleeding nipples, multiple midwives tried to help, was suggested that we use a combination of formula and breast. Tried breastfeeding once nipples healed, but baby didn’t latch and got frustrated.” (Participant 48, 32 years old at the time of giving birth, assisted vaginal ventouse delivery with tear and episiotomy, mixed breast and formula fed for 6 weeks)

One mother explains how she had to fight for a tongue tie diagnosis, and then a snip to finally allow her baby to latch:

“Took a lot of requests from me to get proper support. Baby had a very clear tongue tie, I was in agony and baby losing weight rapidly. Also difficult to wake in feed without it just dripping out his mouth in anyway (with midwife support when requested we tried syringe, cup, bottle and breast feeding) took lots of times asking to get someone from infant feeding who assessed him and sent someone else up the next day who cut his tie next day.” (Participant 33, 23 years old at the time of giving birth, vaginal assisted ventouse delivery with subsequent haemorrhage, exclusively breastfed for 22 months)

Support

This theme provides an overview of the support mothers received, both positive and negative. The subthemes: Finding Strength in Those Around Us, When Support Helps – and When It Hinders, and Perceived Influence on Mental Health, encompass the wide range of areas that make up a mothers’ supporting network and how this affects their mental health. The support a mother receives can have a lasting impact on her breastfeeding journey following a traumatic birth.

Perceived influence on mental health

A total of 90 % of participants ($N = 45$) highlight how birth trauma and breastfeeding experiences have a perceived impact on their mental health outcomes. Mental health outcomes range from anxiety, postnatal depression (PND), and suicidal thoughts, often having long term negative impacts.

One mother describes reaching a breaking point and realising she needed help, this was due to her anxiety around her baby’s health and subsequent decline in her own wellbeing:

“I was scared my baby would die constantly that I wouldn’t sleep, I was extremely low, I had depressive episode and anxiety disorder and when I thought about driving into a wall I decided I need help.” (Participant 78, 33 years old at the time of giving birth, emergency caesarean section delivery, exclusively breastfed for 10 months)

Another participant details how her trauma impacted her milk supply, and this had a knock-on effect on her mental health:

“I was so traumatised I was only producing a tiny amount of breast milk and my mental health was suffering.” (Participant 4, 29 years old at the time of giving birth, emergency caesarean section delivery, mixed breast and formula fed for a few weeks)

The perceived impacts trauma had on mothers’ mental health was sometimes very significant, as one mother detailed worrying about hallucinations, suicidal ideation, and a relapse in a past mental health condition:

“That feeling of not knowing if my baby was real or not lasted a very long time. For the first year of their life I would be looking at other people’s faces to try and subtly check that they could also see my baby and I wasn’t hallucinating. I wanted to kill myself in the first year ish of my babies life. I had a big relapse of my eating disorder. I had post-partum depression. Looking back, I don’t know how I was functioning.” (Participant 36, 25 years old at the time of giving birth, emergency caesarean section delivery, combination feeding formula and breastmilk at the time of the study for 5 years)

When support helps – and when it hinders

82 %, or 41 of the 50 mothers, expressed positive support from healthcare staff and 64 % ($N = 32$) expressed a lack of support from healthcare staff. There is a stark contrast in the following quotes,

demonstrating the power of healthcare staff support and the opposing perceived impacts positive vs negative interactions can have on mental health outcomes.

One positive example demonstrates how healthcare staff support can result in confidence and positive wellbeing outcomes, even following a traumatic birth:

“Health visitor a few days after birth, she made me feel like a rockstar when she observed a breastfeed. Gave me some tips to help with engorgement and kept telling me how great I was doing. After feeling like I had totally failed giving birth, I felt that I was finally doing something right for my baby” (Participant 37, 36 at the time of giving birth, assisted vaginal forceps delivery, exclusively breastfed for 19 months)

However, one negative example demonstrates how a lack of support can lead to mothers feeling unheard and how this can negatively impact mental health:

“I couldn’t tolerate anyone touching me for several months after my birth and still struggle to talk about it. I felt let down by the service and as if no one had listened to me. Communication was a big theme. My midwife was not supportive, and I felt manhandled. I felt low and anxious and recognise retrospectively that I over responded when I felt like medical staff weren’t listening to me. I was very protective over my baby and saw problems where I see now there were none.” (Participant 85, 32 years old at the time of giving birth, vaginal forceps assisted delivery and episiotomy, exclusively breastfed for 13 months)

Finding strength in those around us

There were 24 % of participants ($N = 12$) who expressed they had support from peers, which included support from family, friends and dedicated support groups/charities. These are the networks mothers rely on for day-to-day support and advice after they leave the healthcare setting.

One mother explains how she was able to access a support group, thanks to a supportive husband, and that she felt her mental health had been impacted by negative comments from health visitors:

“Little one was over 6 months old before I accessed a support group, which I was only able to do with my husband’s support due to how bad my mental health was - namely I didn’t want to go out anywhere as people felt overwhelming and I was in a constant state of panic over criticism thanks to the Health Visitors.” (Participant 23, 34 years of age at the time of giving birth, assisted vaginal forceps delivery with tear and haemorrhage, exclusively breastfed for 2 months and then combi fed breast and bottle for a further 2 months)

Familial support was a key positive:

“my sister was a great support” (Participant 38, 34 years old at the time of giving birth, emergency caesarean section delivery with blood loss and cord around baby’s neck, exclusively breastfed for 22 months)

One mother, who had support from a local charity, describes how the support was there but she needed this for longer to feel the benefits:

“I also had support from a local breastfeeding charity who came to visit us at home too, but I found it a bit stressful and frankly humiliating when it didn’t work, it was like I needed them to be there all day rather than just for half an hour or so.” (Participant 58, 38 years old at the time of giving birth, emergency caesarean section delivery, mixed breast and express fed for 2.5 months)

Discussion

This study demonstrates how trauma can be experienced in different ways and what support helps, or hinders, recovery. Mothers reported physical and emotional trauma during and after their birth, and there were 3 mothers who reported the death of a child. This is particularly poignant and had profound and lasting perceived impacts on their mental health. Trauma experienced during birth can often have lasting effects, with previous research reporting mothers being put off a subsequent pregnancy through fear of going through the same experiences again (Watson et al., 2020). Our findings support this idea.

Connecting birth trauma to breastfeeding, the current study’s findings reported that successful breastfeeding experiences could support mothers to heal and recover following birth trauma. This finding adds to similar prior research, which found successful breastfeeding experiences of mothers who have a perinatal mental health condition, were linked to the idea of healing and bonding with the infant, which our study also explored (Billings et al., 2024). The impact of these findings could be significant, if breastfeeding support were integrated with psychological support services, with a specific focus on supporting mothers following trauma, recovery could be accelerated. Previous research has also emphasised that successful breastfeeding can support birth trauma recovery, with Chen et al. (2022) finding a lowered risk of PTSD in mothers who exclusively breastfed. The role of exclusive breastfeeding and success could be considered in treatment following a traumatic birth to support recovery and reduce the risk of postnatal mental health conditions and PTSD. While some mothers may not be able to exclusively breastfeed, it is important to consider combining psychological support alongside breastfeeding support to help with trauma recovery.

The current findings also contribute to the idea of a positive cycle of breastfeeding (Wheeler et al., 2025) by demonstrating that successful breastfeeding experiences, following a traumatic birth, improve mothers’ mental wellbeing. The subtheme “Breastfeeding for Recovery and Bonding” highlights the importance of successful breastfeeding experiences in relation to recovering physically and emotionally following a traumatic birth, with many mothers describing their determination to breastfeed being increased by this. This also supports the use of emotion-focused approaches in supporting wellbeing in mothers who have experienced a traumatic birth (Gökçe İsbir et al., 2021). These findings lead to the recommendation for combining specialist breastfeeding support with trauma informed care, as this could greatly increase the number of positive mental health outcomes for mothers following birth trauma.

Support for breastfeeding mothers comes from a variety of sources, for example peer support is a source many mothers access, whether this be from dedicated peer support groups or from family and friends. Dedicated peer support groups have been found to have multiple positive impacts on mothers, peers who have breastfed their own infants are often able to empathise with mothers and provide emotional as well as practical support (Yang et al., 2024). Social support, such as that from family and friend groups is also vital in supporting mothers, particularly if they are experiencing perceived negative mental health impacts (Farrington and Woodward, 2024). Research has shown that social support from family and friends can increase mother’s self-efficacy when breastfeeding and reduce depressive symptoms (Mercan and Tari Selcuk, 2021). The current study adds valuable detail to this idea through qualitative accounts of mother’s experiences of support from peers. This vital support from family and friends is crucial to ensuring positive breastfeeding and wellbeing outcomes.

Support from healthcare staff is also crucial to a mother’s breastfeeding experience, positive and negative accounts were detailed by mothers in this research. Negatively, mothers expressed a lack of information around feeding and, in some cases, a lack of feeding support altogether. This has been demonstrated in previous research, which found mothers experienced a lack of support around combination feeding and expressing from healthcare professionals (Norman et al.,

2022). These negative experiences can impact not only a mother's ability to breastfeed but also have a detrimental effect on her mental health. The detailed personal accounts by mothers in this study emphasise the detriment a lack of trauma-informed breastfeeding support can have on maternal wellbeing. On the other hand, positive experiences can boost a mother's wellbeing and sense of autonomy and success, as reported by mothers in this study. This is a novel finding, especially where women have expressed feeling a sense of bodily failure over their birth experience, being supported to successfully breastfeed could support them to rediscover bodily autonomy and confidence, thus boosting mental health outcomes.

Being able to identify mothers who may be at higher risk of developing trauma-related symptoms after giving birth is a key starting point to ensuring and implementing trauma-informed care – this could include screening for past trauma, antenatal risk factors, and prenatal mental health conditions. Pidd et al. (2023) analysed 22 studies and found that identifying mothers with a traumatic history as early as possible is crucial. They found mothers need control and the ability to make decisions about their own care, they also need to trust and feel listened to by their care teams to have a chance at more positive experience. Supporting mothers' autonomy in this way, particularly with those who have experienced prior trauma, could be key in minimising trauma from a subsequent birth. The current study supports this idea by highlighting the positive impact of successful breastfeeding on recovery, after the feeling of having "failed" during the birth.

Once risk factors are identified, intervening in the birth process to minimise trauma, and identifying and diagnosing postnatal PTSD is key. The process for diagnosing PTSD require symptoms to last for at least 1 month, causing a delay in treating the condition – early detection is crucial to starting support promptly. There is emerging research highlighting the need for trauma informed care focusing on trauma prevention, intervention and treatment, and that this is key from the very start of the perinatal journey (Horsch et al., 2024). Being able to have a space to share or access specialist psychological support before birth or during the first few weeks, would complement any breastfeeding support for mothers who experience a traumatic birth. An integrated birth trauma clinic with psychological and breastfeeding support, could be an effective model of care for supporting symptoms of PTSD following childbirth (Williamson et al., 2021).

The findings from this study contribute to prior knowledge around birth trauma and the subsequent perceived impacts of this on maternal wellbeing and future implications. In addition, it adds novel qualitative exploration of the intersectionality between birth trauma, breastfeeding and the role of the maternal support network. There is a strong focus on mothers' voices, and key implications for trauma-informed care moving forwards.

Strengths and limitations

The chosen data analysis method, RTA, demonstrates a flexible approach and allows for the depth of analysis required to fully understand detailed experiences, a key strength of this method. Trustworthiness is enhanced by the researcher remaining reflexive throughout on how they influence the data analysis, increasing credibility of the analysis. Reflexivity was achieved through the lead researcher participating in regular supervisory meetings where it was reflected on how their background and assumptions could shape the interpretation of the data. However, it is important to note that RTA is a subjective interpretation of the participants experiences, there is therefore the potential for inconsistency in analysis, and this is recognised as a potential limitation. The researchers cannot draw a definitive reflection of the participants reality.

By only analysing the 50 participants who scored 32 or above on the PCL-5 and who self-described a traumatic birth, there could be an ethical concern around collecting data which is not intended for analysis. This is justified by using a validated screening tool (PCL-5) to ensure that those

who met the criteria for a traumatic birth were not over or underestimating their experiences, thus giving the study greater validity. The PCL-5 is designed to measure current PTSD symptoms and therefore, due to some participants being several years postnatal, the measure may not fully capture the full impact of distress on these mothers. Future research should therefore incorporate a longer-term measure for exploring postnatal populations.

In retrospect, further participant demographic information could have been collected to fully demonstrate the wider context of the participant experiences. Due to this limitation, the study is unable to evaluate the length of time between giving birth and completing the survey, which could have an impact on recollection of events, for example and could have led to further analysis and comparison. The age of the infant at the time of participation is a factor that could influence both the perception of birth trauma and subsequent feeding experiences. The omission limits the ability to explore how specific temporal factors may have shaped the patterns observed. Future studies could include this variable to strengthen interpretation of results.

While specific birth-related factors such as mode of delivery, medical interventions, and complications were recorded, these were not explicitly analysed as contributing factors, where they may have had a meaningful impact on trauma symptoms. Therefore, future research could evaluate the role of these specific factors in the trauma responses and breastfeeding experiences of participants.

Conclusion

Overall, this study demonstrates that there are several factors determining a positive or negative breastfeeding experience following birth trauma, including emotional and practical support, the nature of healthcare staff responses, and the mother's self-perception. Participants described how dismissive or negative comments increased distress and impacted feeding negatives, whereas positive reinforcement and encouragement fostered confidence and supported breastfeeding continuation. Based on these findings, in future prompt trauma-informed care along with integrated psychological support could negate some of the risk of negative mental health outcomes, reduce the development of PTSD symptoms by supporting breastfeeding experiences after a traumatic birth, and improve mental health outcomes.

Future research should further examine the differences between mothers who intended to breastfeed, verses those who did not. Additionally, a comparison of those who perceived their birth to be traumatic verses those who did not could be conducted to explore the differences in support received and breastfeeding outcomes. This study's dataset could be further analysed to explore some of these patterns in more depth.

Ethics statement

All data was anonymised from submission of the questionnaire and kept in accordance with GDPR and Bournemouth University regulations. Participants were given the right to withdraw, regardless of reason, if they felt they could not continue. Participants were notified that they could withdraw up to the point of submission and after this their data would be anonymised. All participants gave written informed consent to participate in this study as part of the online survey.

To mitigate any potential participant distress, the questions were developed with support from birth trauma organisations (Make Birth Better and Birth Trauma Association) to ensure sensitivity, participants were also signposted to contacts for support in case of any distress. The study was granted ethical approval by Bournemouth University Research Ethics Panel, Ethics ID: 52358.

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CRediT authorship contribution statement

Abigail Wheeler: Writing – review & editing, Writing – original draft, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Fay Sweeting:** Writing – review & editing, Supervision. **Andrew Mayers:** Writing – review & editing, Supervision. **Amy Brown:** Writing – review & editing, Supervision. **Shanti Farrington:** Writing – review & editing, Supervision.

Appendices

Appendix A

Questions exploring participant demographic information and experiences.

Where was your baby born?
Which of these experiences describe your birth?
Did you experience any complications relating to the birth? For example, a tear or haemorrhage.
Was your baby premature?
How old were you (when your baby was born)?
Was your baby admitted to a neonatal unit?
How did you feed your baby?
How long did you breastfeed this baby for? If you are still breastfeeding, for how long have you breastfed this baby so far? (Breastfeeding referring to exclusively and mixed breast/bottle)
If you have stopped breastfeeding this baby, why did you do so? (Breastfeeding referring to exclusively and mixed breast/bottle)
What support did you receive in hospital immediately after birth?
What support did you receive later and from whom?
If you had a traumatic birth, how has it affected your mental health, both immediately after birth and as time has passed?
If you had a traumatic birth, how did it affect your experience of breastfeeding?

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