Exploring Factors of Traumatic Birth Experiences

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May 22, 2024

Abstract

Pregnancy and motherhood is a beautiful and joyous phase in life, but it is not without difficulties. The event of childbirth can be especially distressing due to various emotional, physical, and psychological factors leading to a phenomenon known as "birth trauma." Birth trauma has been on the rise over the past decades and can be damaging to the wellbeing of the mother and child. In order to gain insight, the current study explored birth trauma's relation to the mother's childhood trauma and postpartum maternal confidence/self-efficacy. Participants were 84 Albertan mothers (M = 31.19 years, *SD* = 5.873, range = 22 – 45; 3.6% Asian, 32.1% Black, 57.1% European/Caucasian, 2.4% Hispanic, 1,2% Indigenous, and 3.6% mixed) who completed self-report measures about birth trauma, childhood trauma, maternal confidence, and parenting self-efficacy. Results showed that childhood trauma was predictive of birth trauma and maternal confidence/ self-efficacy. Birth trauma had no significant relationship with maternal confidence/self-efficacy. The findings highlight that childhood experiences play a defining role in how a woman perceives her childbirth and her parenting. Addressing childhood trauma is critical in positively impacting the peripartum period.

Keywords: Birth trauma, childhood trauma, maternal confidence, parenting self-efficacy.

Exploring Factors of Traumatic Birth Experiences

Motherhood can be a pivotal part of a woman's life, and it is usually a stage life she looks forward to from a very young age. A predominant phase in this progress is the perinatal period, which is generally considered as a short period of time before labour to a few weeks after having given birth (Vogels-Broeke et al., 2021). Evidently, the event of childbirth is very definitive in this milestone, but a woman's perinatal period is far more than just childbirth and the events of care involved before, during, and after the birth. The concept of mother centered care related to the event of birth itself such as birthing plans and spousal connection and support during the postpartum period for several weeks after the birth has become more widespread in the past couple decades. However, transitioning to motherhood is affected by various dynamic physical, psychological, and social characteristics beyond popular care techniques such as support groups and classes that actively shape the mother and child's experience and well-being throughout the peripartum period (Larkin et al., 2009; Prinds et al., 2014; Seefat-van Teeffelen et al., 2011; Vogels-Broeke et al., 2021).

The perinatal period and the transition to motherhood also features many neurobiological changes that may be influential in the mother and child's wellbeing (Cárdenas et al., 2020). Environmental and psychosocial stressors that the mother experiences can be damaging to the overall pregnancy and labour, as well as the health of the mother and fetus, which provides basis to suggest that stress during the prenatal period can be consequential for the current and future generations (Coussons-Read, 2013). Some known stressors are the fear of childbirth, medical

interventions, interactions with healthcare professionals, as well as the experience of childhood trauma (Atzl et al., 2019; Bhatia & Jhannjee, 2012; Elmir et al., 2010; Reed et al., 2017).

Women who are affected by psychological, emotional, and/or physical stressors specifically during labour can be traumatized by childbirth, which is generally referred to as birth trauma (Watson et al., 2021). Mothers who have a traumatic birth experience are more likely to develop psychosocial difficulties during the postnatal period. Their mental health may be in a deteriorating state making them more susceptible to face issues with anxiety, post-traumatic stress disorder (PTSD), and maternal obsessive-compulsive disorder (OCD) (Ionio & DiBlasio, 2014; Molloy et al., 2021). Further negative impacts of birth trauma include extreme emotional responses, difficulty in communication, formation of maladaptive attachment styles, self-doubt, and low maternal confidence (Elmir et al., 2010; Molloy et al., 2021; Schwartz et al., 2015). Unfortunately, the subjective nature of birth trauma creates an obstacle in identification, diagnosis, and treatment (Beck, 2004b). There is a significant lack of acknowledgement and comprehension about birth trauma in society, which leads to the inability to fully recognize women's situations, provide consistent support, aid in recovery, and reform care and practice associated with the peripartum period (Watson et al., 2021).

When looking at the previous research in this field, as far as is known, there are has not yet been a study that considers both childhood trauma and maternal confidence in relation to the experience of birth trauma, particularly in the Canadian context. Thus, we aim to uncover how these three factors influence and interact with one another. Through this research, we will be able to provide insight into some of the broad patterns that underlie birth trauma and gain a better understanding of its predictive factors and negative impacts. In essence, the goal is to strengthen

and add to the literature in the field to improve the perinatal period and enhance wellbeing for the mother and the child.

Literature Review

Pregnancy is a special and significant part of a woman's life that can result in significant changes causing a need for physical, emotional, and/ or psychological adaptation (Atzl et al., 2019). The childbirth period is critical for the survival and wellbeing of the mother and the child, particularly in the case of complications (Rodríguez-Almagro et al., 2019). Although adverse effects of childbirth are not as common in developed countries (Rodríguez-Almagro et al., 2019), there are still many occurrences where an unpleasant childbirth experience can cause an otherwise joyous and rewarding event to become traumatic (Larkin et al., 2009).

Birth Trauma

A traumatic birth is generally defined as "the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature" (Greenfield et al., 2016, p. 265). However, there is not yet a consistent definition for birth trauma nor is there a way to assess the phenomenon systematically and the terms birth trauma and traumatic birth are used interchangeably in literature(Elmir et al., 2010). Hence, Beck (2004b, p. 28) refers to birth trauma as being in the 'eye of the beholder'. The subjective nature of birth trauma creates an obstacle in identification, diagnosis, and treatment.

For instance, when examining the statistics surrounding birth trauma, there are inconsistent reports. In one study, it was shown that around 30% of women have a traumatic birth experience around the world every year (Soet et al., 2003). However, a study from Boorman et al. (2014) found that 14.3% of women met criteria for a traumatic birth. While, in Canada, 9.3% of women reported a negative birth experience (Smarandache et al., 2016).

Finally, a more recent study shows that 40% of new mothers experience a traumatic birth (Beck et al., 2018). Furthermore, many mothers may demonstrate both types of traumatic stress responses after childbirth: birth trauma and PTSD (Ayers, 2004). This may mean that there has been an increase in birth trauma over the course of two decades or that there are unknown factors that are significantly influential to the experience, which makes this issue even more pressing.

Predictors of Birth Trauma

The complexity of understanding birth trauma arises from the vast numbers of factors that can cause it through interactions of neurobiological, environmental, psychosocial, physical, and emotional characteristics (Cárdenas et al., 2020; Coussons-Read, 2013). These variables all play a critical role in how the mother perceives her labour experience and whether she deems it to be traumatic. Some specific stressors that have been established through research in this field includes medical interventions, social interactions with healthcare staff, a pre-existing fear of giving birth, and experiences of trauma during childhood (Atzl et al., 2019; Bhatia & Jhannjee, 2012; Elmir et al., 2010; Jansen et al., 2013; Ma et al., 2023; Reed et al., 2017).

Medical Interventions

Childbirth is a process that has to be coordinated with medical expertise to ensure wellbeing of the mother and the child. Throughout the past decades we have seen a shift towards more technology and improvement in interventions related to the events of care surrounding childbirth; however, regardless of great advances, the procedures can still play an influential role in the overall labour experience (Jansen et al., 2013). Ranging from bedrest, anesthesia, medications, and caesarean sections, expectant mothers are faced with an overwhelming volume of medical procedures. Knowing that physical experiences related to labour can be determinant

of a traumatic experience (Elmir et al., 2010), it is important to acknowledge the invasive nature and distress that can occur as a result of giving birth.

A recent study done in China with women who had vaginal births showed that psychologically traumatic events such as a distressing labour experience, severe labour pain, premature delivery, possible separation between the mother and the child, as well as witnessing other women giving birth were significant risk factors that increased the likelihood of birth trauma (Hollander et al., 2017; Ma et al., 2023; Taghizadeh et al., 2014; Watson et al., 2021; Zhang et al., 2020). Pregnant women with low social support and/ or low family support also suffered with higher levels of pregnancy stress. Factors such as a lack in proper communication between the patient and the doctor, worries about one's health and that of the child, as well as sentiments of being forgotten or ignored have an impact on the prevalence of birth trauma. It is uncertain whether this study can be fully applicable to general populations, particularly in Canada. Canada's political and social climate, particularly universal healthcare, are vastly different from China, which may play a subtle but deep role in birth trauma. However, as mentioned, there is a substantial lack of research in the realm of birth trauma and no such study seems to have been conducted in Canadian nor western environments; thus, it is still valuable as it adds to the field and provides additional context. The study from Ma et al. (2023) also notably focuses on natural/ vaginal births, which may potentially be invalid across other procedures; this is pertinent, since it was found that a negative birth experience (subjective) and a surgical childbirth are significantly associated with postnatal PTSD and depression (Ayers et al., 2016; Rodríguez-Almagro et al., 2019).

Environmental Interactions

Along with the medical interventions involved with the birthing process, the mother's interactions with and perceived behaviour of healthcare professionals can also influence the

interpretation of the labour event, and whether it is thought to be traumatic (Elmir et al., 2010). In fact, one of the strongest predictors of developing PTSD in relation to the birth/ labour experience was interpersonal difficulties when interacting with care providers (Harris & Ayers, 2012). A more recent study from Reed et al. (2017) examined how recent mothers described their traumatic birth experience when considering the care providers that accompanied the process. The study highlighted several factors that were detrimental to these mother's labour. Care providers including obstetricians, midwives, and nurses were shown to prioritize their own agenda over and above the woman's care; mothers were merely seen as a tool to learn about a particular birthing experience. Participants also reported that their personal knowledge was disregarded; they felt that neither their own assessment own event nor the wellbeing of the child was valued or considered, leading to traumatic responses. The women in the study felt that, during the labour experience, they were being lied to, manipulated, coerced, or threatened into interventions that were unnecessary or excessive. Many women also felt violated and lacking in control, and described this particular factor as being similar to "sexual abuse" or "gang rape". Similar studies in the field have shown the importance of interpersonal interactions with care providers, since they play a critical role in determining the psychological outcomes that the mother faces during birth or post-natally (Elmir et al., 2010; McLachlan et al., 2016; Reed et al., 2017; Thomson & Downe., 2008). It is evident that healthcare professionals are influential in how mothers perceive themselves and the event of childbirth. The sensitivity of the subject requires professionals to be more supportive and empathetic of the situation rather than appearing emotionally detached in order to best avoid the possibility of birth trauma.

Childhood Trauma

Traumatic experiences during childhood can have long-term effects that persist into adulthood (Dye, 2018). These events can be distressing and overwhelming, leading to long-

lasting deficiencies mentally, emotionally, and physically, and have shown to be linked to many psychological disorders. Childhood trauma is examined through five domains: physical, emotional, and sexual abuse, and physical and emotional neglect (Burgermeister, 2007). Exposure to these experiences have a significant effect on mental and physical health (Atzl et al., 2019). Some direct effects include morbidity, diseases in the lung, heart, and kidney, poorer outcomes in life, anxiety, and social isolation (Howell & Sanchez, 2011; Özşahin, 2020; Wosu et al., 2015). It is inevitable that the negative impacts of childhood trauma are also present in pregnancy and labour (Özşahin, 2020; Wajid et al., 2019).

During pregnancy, experiences of childhood trauma have a likely potential of triggering certain psychological symptomology in those susceptible to developing psychopathology (Atzl et al., 2019). The emotional, physical, psychological, and cognitive stressors involved in pregnancy can be heightened by the experience of childhood trauma, since these memories arise as women reminisce about their entire childhood experience as they prepare themselves for motherhood (Atzl et al., 2019; Narayan et al., 2017). There were strong links found between the occurrence of childhood trauma and perinatal psychological disorders such as PTSD and depression (Choi & Sikkema, 2016). Atzl and colleagues (2017) researched the influence of childhood adversity and age on pregnancy related mental health issues. It was found that when childhood maltreatment was experienced at an early (0 to 5 years), it was significantly predictive of a perinatal-related PTSD diagnosis. There was no relationship found between middle or adolescent age childhood trauma and PTSD or depression. This finding is significant, because it highlights the critical nature of the early childhood period in shaping future outcomes in the stress response system and mental health, specifically during the peripartum period.

Previous research in this field has shown that women who have experienced childhood trauma and those who have the fear of childbirth express similar symptomology (Mancini et al., 1995; Spice et al. 2009); thus they are generally thought of as interchangeable. A study from Porthan et al. (2023) examined whether childhood trauma including its five domains influenced the fear of childbirth in pregnant women, which has been shown, as mentioned, to be a negative impact and predictor of birth trauma (Watson et al., 2021). The main findings showed that the experiences of emotional abuse, emotional neglect, and an extreme burden in childhood were significantly correlated with an increase in the risk of fear of childbirth and consequently birth trauma. The effects of emotional abuse were consistent in both women who were in their first pregnancy and those who were previously pregnant. Emotional neglect and extreme burden only predicted fear of childbirth in nulliparous women, who are women who have never given birth. These results can be explained by the fact that the experience of childhood trauma is associated with lower resilience in adulthood, which could play a role in fear in childbirth (Beutel et al., 2017; Nemeroff, 2004). Notably, this study found that there was no significant relationship between sexual abuse or physical abuse and the fear of childbirth, which contradicts previous research in the field. For example, in a study conducted by Montgomery, Pope, and Rogers (2015) that examined the birth experience in women who had experienced sexual abuse in their childhoods, it was found that it was very triggering. The way in which procedures were carried out by care providers, caused feelings of ‘loss of control’ to the extent that it felt like experiencing the abuse once again. For women who experienced this ‘violation’ during one pregnancy, it is likely to contribute to the fear or anxiety of experiencing it once more. The occurrence of childhood trauma can present as such a heavy psychological burden that it can be

detrimental to the mother's wellbeing and increase the likelihood of her experiencing trauma once again when giving birth.

It is the occurrence and interaction of the aforementioned variables that cause extreme distress during the childbirth, leading to birth trauma and eventually further complications during the transition into motherhood.

Negative Impacts of Birth Trauma

Psychological Impacts

A negative birth experience may have an impact on the mother's mental health leading to consequences later in their parenting experience (Molloy et al., 2021). It is possible that the traumatic experience leads to perinatal mental health (PNMH) disorders such as post-traumatic stress disorder (PTSD), anxiety, maternal obsessive-compulsive disorder (OCD), and post-partum depression (Bener et al., 2012). Ionio and DiBlasio (2014) found that mothers with PTSD and post-partum depression have a significantly different method of interacting with their children opposed to mothers who had no postpartum symptoms. The study revealed that when mothers exhibited higher PTSD symptoms such as hypervigilance and hyperarousal, they showed more irritability and sensitivity towards their child two months after the birth. The effects of a traumatic birth experience can express themselves similarly to the trauma that rape survivors feel (Kitzinger, 2006), yet there is sparsity in the research impeding full understanding of the complications that entail birth trauma.

In fact, several studies show that the presence of PTSD after childbirth ranges from 1.5% to 6% in women (Ionio & Di Blasio, 2014; Alcorn et al., 2010; Beck, 2004a, 2004b; Edworthy et al., 2008). The rates of PTSD seem to lie in similar ranges in European studies as well. Around 33% perceive the birth to be traumatic and have PTSD symptomology 4 weeks after the delivery

(Ayers, 2004; Creedy et al., 2000; Soet et al., 2003). After 6 weeks, the incidence of birth trauma and PTSD ranges from 1% (Denis et al., 2011; Skari et al., 2002) to 9.9% (Czarnocka & Slade, 2000). There are many factors to consider from these studies, such as demographics and considering the time period for the development of PTSD, since it is not necessarily concurrent with the experience of a traumatic birth. Most notably, not all mothers that experience a traumatic birth are clinically diagnosable for PTSD (Molloy et al., 2021). Therefore, as shown by several studies, a substantial number of women are left without adequate support because they do not meet the threshold for a diagnosis, which can be detrimental to the mental wellbeing of the mother and the child. Simply not receiving a diagnosis does not mean that mothers are unaffected a traumatic birth experience, hence it is crucial that there is ample awareness and resources for mothers who may fall below the threshold.

Impacts in Relationships

Consistent with this, Fenech and Thompson (2014) conducted a meta-analysis on the psychological impacts of birth trauma on the mother particularly when it comes to relationships. They found vast research in the field which revealed that maternal well-being can be impacted through a sense of loss, intensely negative responses, and strained relationships with their partner and infants. It was also found that there is possibility in difficulty bonding with the baby along with nightmares, flashbacks, and feeling of anger and anxiety (Elmir et al., 2010); many women employed maladaptive coping mechanisms as a result of these effects. These effects also had the ability to influence future pregnancies, labours, and childbirths that the mother may experience. The implications of this experience led to women feeling “consumed by demons” and “tormented by ghosts” from their past, and it influenced them cognitively, socially, psychologically (Fenech & Thomspon, 2014).

Bonding

In a meta-ethnography synthesis by Elmir et al. (2010), many qualitative studies revolving around perceptions and experiences of birth trauma were considered. Overall, it was found that women who have had a traumatic birth experience felt invisible, as if they were out of control, and felt trapped in the recurrent nightmare of their trauma. Mothers in these studies were overwhelmed with their childbirth experience. Feelings of anger, loss, and disappointment as well as detailed memories of the event stayed with them for many years after the childbirth. These emotions and sentiments were able to, at times, hinder their childcare abilities, how they formed attachment with their child(ren), and the fulfilment of their maternal role. The strain in relationships also included their partner, as they lacked an interest in physical and sexual contact or intimacy. Feelings of depression, despair, and rare ideations of suicide also occurred in women who had experienced birth trauma.

In one particular qualitative study, 13 mothers were found to use defence mechanisms to ensure they protect themselves from reminders of the event, which negatively impacted their relationships (Fenech and Thompson, 2015). To cope with their difficult emotions, many women employed several functional and dysfunctional mechanisms unconsciously. The results identified ten defense mechanisms that were used to handle childbirth-related trauma. Mothers used ‘repression’ and ‘suppression’ either consciously or unconsciously to block out unwanted thoughts, and the used ‘avoidance’ in order to shield themselves from painful memories. To convince themselves and others that they are, in fact, good mothers, ‘sublimation’ and ‘undoing’ were used to change their negative impulses into more acceptable responses. The most outwardly negative effects of a traumatic childbirth experience were apparent through the use of the following maladaptive defence mechanisms: ‘displacement’, ‘somatisation’, ‘reaction

formation', 'turning against the self' and 'regression'. When these strategies were employed, mothers were angry, unpleasant and hostile towards themselves, their partners, their children, and others around them, which explains the strain in relationships due to birth trauma (Ionio & Di Blasio, 2014). When these mothers were observed at play with their children, they showed disorganization, withdrawal, disengagement, and an absence of vocalizations. Thus, the experiences of a traumatic birth may cause women to become the most emotionally distant from their infant for the majority of first year after the birth (Molloy et al., 2021). In essence, mothers were less interested in their surroundings and demonstrated avoidant behaviours, which could significantly worsen their bonding with the child and result in maladaptive attachment styles later (Elmir et al., 2010).

Maternal Confidence

Along with psychological and relationship-based impacts, birth trauma can be influential in the sense of self, which is established through maternal confidence, self-efficacy, and self-esteem. Maternal self-efficacy is defined as a mother's perception of her parenting ability and how she can successfully understand and tend to the baby's needs (Huang et al., 2022). Maternal confidence refers to a belief of competence in a maternal role (Crnec et al., 2010). Lastly, maternal self-esteem is how the mother feels about herself and sense of value. These factors can be pivotal in a successful transition to motherhood and forming a healthy bond with her child (Arante et al., 2020; Huang et al., 2022). It is important to note that although these terms appear to be distinct in literature, there is also research to support that the concepts do not hold a clear distinction in reality when it comes to the field maternal health, meaning that they may be interchangeable (Vance & Brandon, 2017).

There are certain factors that can influence a mothers' self-efficacy such as socio-demographic and obstetric factors; however, much of this research yielded inconsistent data, being unable to establish strong relationships (Gemeda Gudeta et al., 2023). Ha and Kim (2013) did report low levels of self-esteem and self-confidence in motherhood was correlated with high childcare-related stress. It was found that parity and maternal attachment was predictive of maternal confidence; thus, women who had previous pregnancies/children and those that had a strong attachment to the current infant were more likely to be more confident in their parenting. Furthermore, expectant mothers who participated in prenatal classes reported higher levels of confidence compared to mother who did not, since it prepared them for delivery and helped boost confidence in the maternal role. It might help here to break down on pre vs post confidence and self-efficacy.

The event of childbirth also shapes how she views her capabilities in parenting and whether she views herself as a "good mother" (Molloy et al., 2021). Some mothers have noted that they feel that self-perception and self-knowledge of their own bodies and experiences is put into question or even dismissed during the labour experience; this can plant seeds of doubt in the mother's mind about her parenting abilities. A prominent relationship lies between low self-efficacy and the fear of childbirth (Effati Daryani et al., 2023), which is significant even when controlling for other factors (Schwartz et al., 2015); this is indicative of the role birth trauma may play.

When considering how childbirth experience influences the mother's overall self-esteem, Raudasja and colleagues (2022) were able to establish a significant predictive relationship. Looking at one year postpartum, it was found that a more positive labour increased self-esteem

and a more negative labour decreased levels of self-esteem. However, results were mixed for women who had mixed experiences, signifying that other factors contribute to self-esteem. When connecting to previously mentioned research, it is possible to understand that the birth experience has a crucial role in shaping how the mother views herself and perceives her parenting ability; however, there seem to be no studies that research the direct connection between low maternal confidence/ self-efficacy/self-esteem and the experience of a subjectively traumatic birth.

It is known that self-efficacy, in general, is developed predominantly in childhood and plays a role in overall psychological well-being (Orth & Robins, 2014). Thus, the experience of a traumatic childhood can lead to a decrease in self-esteem, confidence, and self-efficacy (Walter et al., 2010), which can negatively impact their resilience as well (Beutel et al., 2017). When considering pregnancy and motherhood, women who have faced adversity as children may have lower maternal confidence (Garon-Bissonnette et al., 2022). A study conducted by Kunseler et al. (2016) focused on resilience in terms of childbirth and parenting self-efficacy in mothers who had faced childhood neglect or abuse compared to those who have not. Participants were faced with a baseline task, an easy-to-soothe task, and a difficult-to-soothe task. Both groups presented no differences in resilience and self-efficacy when completing the baseline and easy-to-soothe task. The major finding is that mothers with experiences of childhood abuse had significant decreases in maternal confidence when faced with the difficult parenting task. The study highlights the critical nature of addressing and preparing mothers with childhood trauma to assist with better parenting outcomes. Furthermore, as far as is known, there is no research connecting the experience of childhood trauma and birth trauma and influences on maternal confidence. This

paper aims to shed light on these connections to expand the scientific understanding of birth trauma, in order to improve mental health and parenting outcomes.

Understanding that childhood trauma can influence birth trauma, we seek to expand this and determine whether certain domains are more or less related to birth trauma. It is also our goal to establish a relationship between birth trauma and maternal confidence/ self-efficacy. Since a majority of this field focuses on fear of childbirth, we aim to delve into these relationships in regard to birth trauma, as they are different – fear of childbirth is how a woman feels leading up to labor whereas birth trauma is how a woman perceives the labor experience. In addition, we want to ensure that we can replicate how those who experience childhood trauma are less confident in their parenting. We will further the field by looking at the entire relationship between childhood trauma and birth trauma and maternal confidence.

Method

Hypotheses

Derived from the literature review, the study is testing three hypotheses. First, childhood trauma is predictive of subjective birth trauma. Second, lower parenting self-efficacy or maternal confidence has a significant relationship with birth trauma. Lastly, childhood trauma has a significant relationship with lower maternal confidence/ parenting self-efficacy. As described previously, the literature in the field loosely supports the connections between one variable and the other. However, there has not yet been, as far as is known, a study regarding the intersection off all three variables. The primary goal of the study is to look at general tends between birth trauma, childhood trauma, and maternal confidence as an exploratory study.

Design

The current study utilized descriptive statistics, correlational analyses, and a linear regression to comprehend the self-report data from the survey participants. Due to the exploratory nature of the study, the aim was to understand predictive and risk factors relating to birth trauma while considering childhood trauma and maternal self-efficacy, as well as socioeconomic, geographic, and demographic characteristics.

Participants

The sample ($N = 84$) of participants consisted of 83 females and one demi-woman with a mean age of 31.19 years ($SD = 5.873$, range = 22 – 45). The participants consisted of the following ethnicities: 3.6% Asian, 32.1% Black, 57.1% European/Caucasian, 2.4% Hispanic, 1.2% Indigenous, and 3.6% mixed). All of the participants were Albertan residents at the time of participation, with 63.1% having given birth in a large urban population centre with a population of 100,000 and over. The majority of the participants (60.7%) had described experiences with their first child with 42.9% having had their first pregnancy. When considering the type of birth, 41.7% had an emergency c-section, 14.3% had an elective c-section, 17.9% had assisted vaginal births, 25.0% had normal vaginal births, and 1.2% did not answer. Participants' household income varied minimally with 8.3% making under $20,000 and 22.6% making $100,001 or over. Approximately half of the participants (45.1%) reported that their child had spent time in NICU, of which the average was 14.56 days.

Materials

Participants were given self-report scales and questionnaires and asked open-ended questions to assess and understand their retrospective accounts of birth trauma, childhood trauma, maternal confidence, and social support (refer to Appendix A for complete survey).

City Birth Trauma Scale. The City Birth Trauma Scale was used to understand the subjective traumatic birth experience of their most recent birth (Ayers et al., 2018). It assesses childbirth related PTSD according to DSM-5 criteria based on traumatic event during or immediately after the childbirth. The self-report scale consisted of 29 questions with four subscales: symptoms of re-experiencing, negative cognitions and mood, and hyperarousal. A higher score indicates more PTSD symptoms being present, which will represent a subjectively traumatic birth. This scale and its subscales have shown good internal consistency, with $\alpha = 0.92$ for the total scale.

Trauma and Distress Scale. Childhood trauma was assessed using the Trauma and Distress Scale (TADS; Patterson et al., 2002). It is a 43 question self-report scale which is used to measure childhood adversities in five different domains (emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse). There are 4 to 5 questions per domain, and all questions take age categories into account (0–6, 7–12, and 13–18 years). The TADS is a 5-point Likert Scale: 0 = never, 1 = rarely, 2 = sometimes, 3 = often, and 4 = almost always. The total score, which represents the complete burden of childhood adversities, is calculated as the combination of the scores from all five domains.

Perceived Maternal Parenting Self-Efficacy Scale. Maternal self-efficacy was assessed using the Perceived Maternal Parenting Self-Efficacy scale (PMP-S-E; Barnes & Adamson-Macedo, 2007). The questionnaire examines a mother's beliefs about their ability to be successful as a maternal figure and in their parenting role. This scale has 20 items as a 4-point Likert scale (1 – Strongly disagree, 2 Disagree, 3 – Agree, 4 – Strongly agree) with four subscales: care taking procedures, evoking behaviour(s), reading behaviour(s) or signalling, and

situational beliefs. The scale has strong internal consistency reliability and external reliability (α = 0.91, α = 0.96), as well as good validity.

Maternal Confidence Questionnaire. Lastly, maternal confidence was measured with the Maternal Confidence Questionnaire (MCQ; Parker & Zahr, 1985). This 14 item 5-point Likert scale (1 – Never, 2 – Seldom, 3 – Some, 4 – Often, 5 – A great deal) quantifies maternal confidence in parenting skills and the ability to recognize their infant's needs. The questionnaire has also been shown to have good flexibility, reliability, and validity.

Procedure

The sample for the study was chosen through self-selection, where Alberta residents over 18 years of age subjectively identified themselves as having experienced a traumatic birth in the past five years. The self-report survey was sent to various community resources, such as women's clinics, through which participants had access. The incentive for participation was a $15 online gift card. The research was approved by the Red Deer Polytechnic Research Ethics Board (REB) (Red Deer Polytechnic, 2024). Participants were provided a consent form at the outset of the survey, which provided information on the survey. Within the consent form participants were provided with a list of community resources due to the sensitive topic. Participants then completed 21 demographic questions which asked about socioeconomics, geographics, mental health, parenting, etc., then completed the scales. Responses from the participants were anonymous and collected through Simple Survey. For data analysis, IBM SPSS, a statistics software, was used. It took participants 32 minutes to complete on average.

Results

Descriptives

Of the 84 participating women, 72.7% reported experiencing complications during pregnancy, 35.7% were diagnosed with psychological disorder related to the birth, and 26.2% were diagnosed with psychological disorder unrelated to the birth, as seen in Table 1, which shows participants characteristics. It was found that 30% of the participants were found to have high levels of birth trauma related PTSD, as shown in Table 2, which focuses on relative levels of variables that were assessed by splitting the responses into three groups (low, medium, and high).

Table 1

Demographics of participants

Variable	%
Mother's age	
< 30 years	47.6
≥ 31 years	52.4
Religious	
Yes	52.4
No	21.4
Relationship status	
Single	11.9
In a relationship	88.1
Level of education	
No post-secondary education	3.6
Some post-secondary education	96.4
Household income	
≤ $60,000	46.8
> $60,000	53.2
People in household	
≤ 3	62.2
> 3	37.8
First child	
Yes	61.4
No	38.6
Gender of child	
Male	57.8
Female	42.2
Complications during pregnancy	

Yes	71.5
No	21.4
Child in NICU	
Yes	45.1
No	54.9
Diagnosed with psychological disorder related to birth	
Yes	35.7
No	63.1
Diagnosed with psychological disorder unrelated to birth	
Yes	26.2
No	73.8
Level of childcare experience	
Moderate to high	64.3
Low to none	35.7

Table 2

Levels of each variable measured in participants

Variable	n (%)
Birth-related PTSD	
Low	22 (26)
Medium	37 (44)
High	25 (30)
Childhood Trauma	
Low	38 (45)
Medium	42 (50)
High	4 (5)
Maternal Confidence	
Low	3 (4)
Medium	64 (76)
High	17 (20)
Maternal Self-efficacy	
Low	0 (0)
Medium	21 (25)
High	63 (75)

H1: Childhood trauma is predictive of subjective birth trauma.

In order to test the first hypothesis of the study, a Pearson's correlation was conducted between the Birth trauma-related PTSD subscale in the City Birth Trauma scale and the total

childhood trauma subscale in the TADS. A significant positive correlation was found, $r = .342$, $p < .001$. Further analyses showed that birth trauma related PTSD was significantly correlated with childhood emotional abuse ($r = .397$, $p < .001$), childhood physical abuse ($r = .323$, $p < .003$), and childhood sexual abuse ($r = .299$, $p < .006$). A linear regression was conducted with total childhood trauma as the predictor and the analysis yielded a significant regression, $b = .162$, $t(83) = 3.30$, $p = .001$, meaning that childhood trauma was predictive of birth trauma. It also accounted for significant variance in birth trauma related PTSD, $R^2 = .117$, $F(1, 82) = 10.89$, $p = .001$.

H2: Lower childbirth self-efficacy or maternal confidence has a significant relationship with birth trauma.

For the second hypothesis, two Pearson's correlations were computed comparing birth trauma related PTSD with maternal confidence and parenting self-efficacy. Neither correlation was significant since birth trauma related PTSD and maternal confidence yielded $r = .012$, $p = .917$ and birth trauma related PTSD and parenting self-efficacy yielded $r = .142$, $p = .198$, which shows that there were no correlational relationships between the variables. It is important to note that the correlation between maternal confidence questionnaire and parenting self-efficacy was $r = .762$, $p < .001$. Thus, linear regression analyses with these variables were computed as a total of MCQ and PMP-S-E scores. A significant regression was not found when considering total confidence/self-efficacy from birth trauma related PTSD, $b = .164$, $t(83) = .791$, $p = .431$; therefore, birth trauma is not predictive of maternal confidence or self-efficacy. Birth trauma related PTSD did not account for any variance in total maternal confidence and self-efficacy $R^2 = .008$, $F(1, 82) = 0.63$, $p = .431$.

H3: Childhood trauma will have a significant relationship with lower maternal confidence.

When testing the third hypothesis, two Pearson's correlations were computed. Both yielded significantly negative correlations between maternal self-confidence and total childhood trauma (r = -.509, p < .001) and between parenting self-efficacy and total childhood trauma (r = -.297, p < .006). Furthermore, a linear regression with total childhood trauma as the predictor of total confidence/self-efficacy was computed, which found b = -0.374, $t(83)$ = -4.20, p < .001; Thus, total childhood trauma is significantly predictive of maternal confidence and self-efficacy. Total childhood trauma also accounts for significant variance in total maternal confidence and self-efficacy, R^2 = .177, $F(1, 82)$ = 17.64, p < .001. Notably, total childhood trauma accounts for more variance when predicting maternal confidence/self-efficacy than birth trauma related PTSD.

Table 3

Correlational Analyses among participants scores for birth trauma related PTSD, total childhood trauma, maternal confidence, and parenting self-efficacy

Variables	1. Birth trauma related PTSD	2. Total Childhood Trauma	3. Maternal Confidence	4. Parenting Self-efficacy
1. Birth trauma related PTSD	1.00	.342**	.012	.142
2. Total Childhood Trauma	.342**	1.00	-.509**	-.297*
3. Maternal Confidence	.012	-.509**	1.00	.762**
4. Parenting Self-efficacy	.142	-.297*	.762**	1.00

Note. *p < .01. **p < .001.

Discussion

The purpose of this study was to improve the general understanding of birth trauma. Specifically, the aim was to comprehend the relationships that underlie birth trauma, childhood trauma, and post-natal maternal confidence. Among the study participants, it was found that 30% experienced severe birth trauma related PTSD and 44% experienced a moderate level, which matches consistent reports that 30% of women globally have a traumatic birth experience (Soet et al., 2003). In fact, this is more than the 9.3% prevalence rate that Smarandache et al. (2016) had found among Canadian women; hence, the data further supports the need for increased awareness surrounding this phenomenon.

The first hypothesis was established showing that if a woman had experienced traumatic experiences in her childhood, then she had an increased likelihood of experiencing a traumatic birth as well, which is supported by vast research in the field. Experiences of trauma, regardless of the domain, has been shown to decrease resilience and heighten sensitivity to triggering situations (Atzl et al., 2019; Beutel et al., 2017). Furthermore, women are likely to recall traumatic memories from their childhood during the labour period, making them more susceptible to experience trauma. These factors come into play during labour, which is a very demanding situation, causing women to feel more distressed and, eventually, leading to PTSD symptomology (Choi & Sikkema, 2016). The results of the study do slightly contradict the research presented by Porthan and colleagues (2023), which states that emotional abuse and emotional neglect have the strongest relationship as opposed to our findings that rather showed that it is emotional, physical, and sexual abuse are correlational. However, their study focused on fear of childbirth rather than directly looking at birth trauma. This may be indicative of the difference between these two phenomena and provide reasoning for the need to consider them as

distinct. Although they are both influential components of childbirth, they seem to be influenced by different aspects of childhood trauma; fear of childbirth is heavily related to emotional trauma, whereas birth trauma is predicted by childhood abuse. Clearly, emotional abuse is t a critical component and may be more influential than any other domain of childhood trauma, since it, in most cases, underlies the other domains of trauma (Dye, 2022; Hart et al., 1996). There is minimal focus on the five domains of childhood trauma separately in relation to birth trauma; perhaps, further research can shed light on the details regarding this phenomenon.

The current study did not find any significant relationship between birth trauma related PTSD and maternal confidence or parenting self-efficacy; it was neither correlational nor predictive. This contradicts past research which has found that when mothers experience a traumatic birth experience, particularly when linked to negative interactions with healthcare professionals, they have shown increased self-doubt and doubted their knowledge about parenting, resulting in lower maternal confidence (Molloy et al., 2021). Raudasoja et al. (2022) also demonstrated that it was possible to predict maternal self-efficacy from birth trauma; however, it can yield mixed results. Specifically, the predictive relationship only holds true in extreme case such as a very positive or very negative birth experience. Furthermore, they concluded that there were other factors that influenced maternal confidence, not just birth trauma. Taking that into light with the current study, it is important to consider that there were relatively low reports of low maternal confidence or parenting self-efficacy (Table 2). Furthermore, there may have been an influence of social desirability bias. Since the scales focused on parenting skills and confidence/ self-efficacy, there may have been a difficulty in admitting shortcomings in fear of being considered a “bad mother”, resulting in such high numbers. Thus, the data provided should be interpreted with caution as it may be impacts by sub-

conscious factors. Utilizing a social desirability scale in the survey may have been helpful to understand the extent to which participants were influenced by this bias.

The third hypothesis was supported; experiencing childhood trauma decreased the confidence or self-efficacy that mothers felt after giving birth. As mentioned, the experience of childhood trauma can have detrimental effects on one's resilience, confidence, and self-efficacy (Walter et al., 2010; Beutel et al., 2017). These feelings are escalated during the stressful postpartum period, possibly leading to low maternal confidence, particularly for first time mothers (Garon-Bissonnette et al., 2022). Low maternal confidence can influence parenting outcomes and result in complications when bonding with the child and in forming a secure attachment (Goto et al., 2010; Huang et al., 2022; Kojra et al., 2012). Traumatic childhood experiences of the mother were able to predict higher levels of maladaptive socioemotional behaviour in the child (McDonnell & Valentino, 2016); this may possibly result in intergenerational trauma since the level of trauma in mothers was linked to similar levels of trauma in the child. It is important to consider this relationship very carefully in terms of parenting because it has the potential to perpetuate continuously.

Limitations

There are some limitations in this study that may be addressed in future studies. First, this study used a cross-sectional design by asking mothers to provide a retrospective account of their childhood trauma and birth experience. Although it is a much easier method of data collection, retrospective studies are likely to be influenced by recall bias, particularly when considering trauma, which has been shown to sometimes cause memory loss (Molloy et al., 2020). Future studies may consider a hybrid approach in which they acquire retrospective accounts of childhood trauma, while testing for birth trauma shortly after birth and maternal confidence

sometime in the postpartum window; this would provide a more complete outlook to gain data on the variables.

As mentioned, there were very little reports of low maternal confidence and self-efficacy. It may have been difficult for mothers to either acknowledge or have awareness of their lack in confidence when it comes to parenting. The low variability in the scores seem to have influenced the results found in the study, particularly in terms of statistical relationships with birth trauma. Perhaps, including a social desirability scale could help to account for influences on the self-report data. Another limitation of this study is that it may not be generalizable to populations that differ heavily from Canadians. As mentioned, the medical aspect of childbirth is influential to birth trauma; the healthcare system is a definite area of differentiation in factors such as wait times, monetary factors, and interactions with healthcare professionals. Since the participant pool consisted of Canadian residents, the results may not apply to those who reside in countries with a vastly different approach to health.

Future Directions

There are several ways in which this study can be modified to account for different aspects of the peripartum period that play a role in birth trauma. This study focused on maternal confidence after labour, which may be influenced by the birth experience. It is possible to consider childbirth self-efficacy next, which is how well an expecting mother is able to handle labour (Gemeda Gudeta et al., 2023); this can be influential to how she perceives the birth to be, traumatic or not. For example, a very early study by Manning and Wright (1983) was able to show a strong relationship between high childbirth self-efficacy and lower perception of pain and medicine usage. Essentially, high confidence may protect mothers from a traumatic birth experience. Psychological factors of childbirth self-efficacy have much more research and

statistics to support them. Lower childbirth self-efficacy in pregnant women has shown links to fear, anxiety, and PTSD, increasing the likelihood for birth trauma (Schwartz et al., 2015). Even though there is more literature on this topic, there is no research considering childbirth self-efficacy, childhood trauma, and birth trauma. Understanding self-efficacy prenatally while also considering childhood trauma may provide insight into how predictive factors interact with noe another and help to shed light on the complexities that surround birth trauma.

Another major factor that plays a role with birth trauma is the fear of childbirth. Although fear of childbirth is natural, when it becomes excessive and debilitating, then it is known scientifically as tokophobia, and can cause women to avoid pregnancy (Bhatia & Jhannjee, 2012). There are two types of tokophobia that a woman can experience. Primary tokophobia is described as an overwhelming fear of childbirth in a nulliparous woman, who does not have a previous experience of pregnancy. Secondary tokophobia occurs as a result of previous experience of a traumatic birth or pregnancy. Furthermore, women who experience tokophobia expect their birth experience to be traumatic, leading to an increase in the possibility of actually experiencing birth trauma (Goutaudier et al., 2019). Some factors that can contribute to tokophobia include fear of pain, harm or death to one or one's child, belief of incompetence, the loss of control, and not trusting care providers (Porthan et al., 2023; Sjögren 1997; Slade et al. 2019). Due to the dual faceted nature of tokophobia, the fear of childbirth is both a negative effect and predictive factor of birth trauma (Watson et al., 2021). Bringing in tokophobia into a study of this nature could demonstrate comorbidity and potentially highlight interaction effects when considering maternal confidence.

This study focused on predictive factors and negative outcomes, but a possible future study could also consider protective factors. Since it was established that childhood trauma can

predict birth trauma and maternal confidence/ self-efficacy, it would be beneficial to study components that could potentially lessen the impacts that childhood trauma has on the peripartum period. For example, there are factors that can protect against the experience of a traumatic birth such as skin-to-skin contact immediately after the birth, a reliable birth plan, continuous care, and a significant level of post-natal care (Ayers et al., 2015; Hernández-Martínez et al., 2019). Focusing on the support that the mother has may also shed light into some possible benefits. Sobczak et al. (2023) highlighted that support may be key to lessening negative impacts for both the mother and child. Specifically, they synthesized research in the field regarding doulas, which showed that they helped towards reducing anxiety and stress and producing positive birthing and parenting outcomes.

Conclusion

Birth trauma is a pressing matter that more and more women are facing, yet there is minimal research on the topic. This study helps to provide insight into the broad patterns surrounding birth trauma and its predictive factors and negative impacts, while focusing on the mother's childhood and her experience in parenting. Childhood trauma, particularly abuse, increases the distress of the event and is predictive of how a mother negatively reacts to childbirth. Similarly, childhood experiences actively shape the mother's perception of her parenting ability and impacts her bonding with the infant. It is evident that the predictive nature of traumatic childhood experiences is the crux of the issue and is significant in the peripartum experience, influencing the likelihood of both birth trauma and low maternal confidence. Thus, helping mothers deal with their childhood experiences would be ideal to reduce the impact of these consequences. Not only does this shed light on factors related to birth trauma, it also

provides an avenue for targeted maternal care in order to enhance the wellbeing of the mother and child.

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Appenndix

Survey Questionnaire

Demographics

Please fill in the blanks or check your response.

1. What is your age? _____

2. What gender do you identify as? _____

3. What is your racial origin/lineage? What race would you identify yourself as? Check all that apply

Asian
Black
European/White
Hispanic
Indigenous (please specify)_____
Pacific Islander
Don't know
Prefer not to answer

4. Are you affiliated with any particular religion/ faith? If yes, please elaborate _____

5. What is your relationship status?

Single
Married
Living with significant other
Partner but not living together
Separated
Divorced
Prefer not to answer

6. What is your highest Level of Education completed?

Below 12th grade
High school diploma
Technical School
Some college or technical school
Bachelors Degree
Masters Degree
Professional Degree
Doctorate Degree
Other
Prefer not to answer

7. What is your Household Income?

Under $20,000

$20,001 – $40,000
$40,001 – $60,000
$60,001 – $80,000
$80,001 – $100,000
$100,001 or over
Prefer not to answer

8. What city do you live in? _____

9. How many people live in your household? _____.
Please elaborate (e.g., me, partner, grandparent, 3 children).
10. Is this your first child? ____ Yes ____ No
If no, how many children do you have? _____

11. How many pregnancies have you had?

12. What is the birth month and year of your most recent child? _____

13. What is your child's gender? _____

14. What type of birth did you have for your most recent child?
Emergency C/S
Elective C/S
assisted vaginal
normal vaginal

15. Did you experience any complications during your most recent pregnancy?

16. Did your child end up spending anytime in the NICU?
If yes, how many days of care?

17. Have you been diagnosed with any psychological disorders related to the birth of your child?
If yes, please elaborate _____

18. Have you been diagnosed with any psychological disorders not related to the birth of your child?
If yes, please elaborate _____

Please check the statement that best describes your childcare experience prior to having your baby, (e.g. babysat for infants and small children often).
19. Before my baby was born, I had _____ childcare experience.
_____ 1. a great deal of
_____ 2. some
_____ 3. very little
_____ 4. No

20. Please describe your recent birth experience and what made it traumatic. Please give as much or as little detail as you feel comfortable providing.

21. If you have other children, were any of those birth experiences traumatic? Please give as much or as little detail as you feel comfortable providing.

City Birth Trauma Scale (29 questions)
This questionnaire asks about your experience during the birth of your most recent baby. It asks about potential traumatic events during (or immediately after) the labour and birth, and whether you are experiencing symptoms that are reported by some women after birth. Please tick the responses closest to your experience.

During the labour, birth and immediately afterwards:
Did you believe you or your baby would be seriously injured? Yes No
Did you believe you or your baby would die? Yes No

The next questions ask about symptoms that you might have experienced. Please indicate how often you have experienced the following symptoms in the last week:
Symptoms about the birth*

* Although these questions refer to the birth, many women have symptoms about events that happened just before or after birth. If this is the case for you, and the events were related to pregnancy, birth or the baby then please answer for these events.

Responses: NOT AT ALL; ONCE; 2 - 4 TIMES; 5 OR MORE TIMES
Recurrent unwanted memories of the birth (or parts of the birth) that you can't control
Bad dreams or nightmares about the birth (or related to the birth)
Flashbacks to the birth and/or reliving the experience
Getting upset when reminded of the birth
Feeling tense or anxious when reminded of the birth
Trying to avoid thinking about the birth
Trying to avoid things that remind me of the birth (e.g. people, places, TV programs)
Not able to remember details of the birth
Blaming myself or others for what happened during the birth
Feeling strong negative emotions about the birth (e.g. fear, anger, shame)

Symptoms that began or got worse since the birth:
Responses: NOT AT ALL; ONCE; 2 - 4 TIMES; 5 OR MORE TIMES

Feeling negative about myself or thinking something awful will happen
Lost interest in activities that were important to me
Feeling detached from other people
Not able to feel positive emotions (e.g. happy, excited)
Feeling irritable or aggressive

Feeling self-destructive or acting recklessly
Feeling tense and on edge
Feeling jumpy or easily startled
Problems concentrating
Not sleeping well because of things that are not due to the baby's sleep pattern
Feeling detached or as if you are in a dream
Feeling things are distorted or not real

If you have any of these symptoms:
When did these symptoms start?
Before the birth
In the first 6 months after birth
More than 6 months after birth
Not applicable (I have no symptoms)

How long have these symptoms lasted?
Less than 1 month
1 to 3 months
3 months or more
Not applicable (I have no symptoms)

Do these symptoms cause you a lot of distress? Yes No Sometimes
Do they prevent you doing things you usually do (e.g. socialising, daily activities)? Yes No Sometimes
Could any of these symptoms be due to medication, alcohol, drugs, or physical illness? Yes No Maybe

Trauma and Distress Scale - TADS (43 questions)

Instructions
These questions ask about personal experiences you may have had in your life so far.
Many questions refer to 'when you were young': this means the period of your life when you were growing up and before you left school. When we talk about 'parents' this means the adults who had the main responsibility for your upbringing as a child and teenager.
If your parents behaved differently, please answer the questions thinking about the parent whose behaviour was worse.

Read each item carefully and pick the response that most accurately describes the experience from your point of view. Please answer all the questions as honestly as you can.

Scale:
0 never
1 rarely
2 sometimes
3 often
4 nearly always

*1. When I was young, I felt safe and protected by somebody.
2. When I was young, I was often hungry.
3. I was bullied at school.
4. I often had to wear ragged or dirty clothes to school.
*5. When I was young, I felt valued or important.
6. My parents / caregivers were often drunk, stoned or wasted.
7. I have been bullied at work.
*8. My family were emotionally warm and loving.
9. When I was young, I was hit so hard that it left marks, cuts or bruises.
10. I felt rejected by my parents / caregivers.
*11. When I was young, there was an adult I could confide in.
12. When I was young, I was humiliated by people in my family.
*13. When I was young, my family looked after each other.
14. I believe that I am a bad person.
15. I believe that somebody died because of me.
16. I have experienced serious physical assault.
17. Adults (like teachers, doctors or nurses) noticed cuts, bruises or marks from when I was beaten.
*18. My childhood was perfect.
19. I am bothered by a very shameful secret.
20. I think I was physically abused when I was young.
*21. I respect myself.
22. When I was young, someone touched me or tried to make me touch them in a sexual way.
23. I have had experiences that I feel very guilty about.
24. I have been involved in life-threatening situations.
25. I was forced to keep secrets about someone sexually interfering with me when I was young.
26. When I was young, I felt hated by a member or members of my family.
*27. My family was the greatest ever.
28. Other people have acted badly because of me.
29. When I was young, I felt like the odd one out in my family.
30. I have experienced sexual assault.
*31. If I needed treatment someone would always take me to see a doctor or nurse when I was young.
32. I feel that I was put down, criticized and made to feel inferior when I was young.
33. Someone sexually molested me when I was young.
34. I feel responsible for harm or injury to another person.
*35. When I was young, I had friends I could talk to about personal problems.
36. I have experienced harassment / persecution from other ethnic groups.
*37. I did well at school.
38. I have experienced the loss of somebody who was very important to me.
39. I believe that I do not deserve to do well in life.
*40. My family was supportive and encouraging when I was young.
41. I believe that I was sexually used when I was young.
42. I felt afraid of someone in my family.
*43. When I was young I could make friends easily

Postpartum Social Support Screening Tool (12 questions)
The following questions are about how much support you can count on from people around you. How often is each of the following kinds of support available to you if you need it?

Pick one option for each question.
None of the time
A little of the time
Some of the time
Most of the time
All of the time

1. Someone you can count on to listen to you when you need to talk
2. Someone to give you good advice about a problem
3. Someone to take you or your child to the doctor if needed
4. Someone you can laugh or just relax with
5. Someone to help you get information or help you to solve a problem
6. Someone to help you with chores or with taking care of the child
7. Someone to share your most private worries and fears with
8. Someone to do something enjoyable with
9. Someone to love you and make you feel special

Who helps you the most with the practical things (feeding your child, folding laundry, grocery store)?
Spouse
Community Health Worker
Other family members
Friends
Paid helper
Doctor
Nurse
Case manager
No one
Other (please specify) _____

With whom do you feel most comfortable sharing your feelings or talking about something that is worrying you?
Spouse
Community Health Worker
Other family members
Friends
Paid helper
Doctor
Nurse
Case manager
No one

Other (please specify) _____

Who has helped you the most with the transition to parenthood?
Spouse
Community Health Worker
Other family members
Friends
Paid helper
Doctor
Nurse
Case manager
No one
Other (please specify) _____

Perceived Maternal Parenting Self-Efficacy (PMP S-E) (20 questions)
Strongly disagree
Disagree
Agree
Strongly agree

Please rate whether you strongly disagree, disagree, agree, or strongly agree to these statements about your parenting.

1 I believe that I can tell when my child is tired and needs to sleep
2 I believe that I have control over my child
3 I can tell when my child is sick
4 I can read my child's cues
5 I can make my child happy
6 I believe that my child responds well to me
7 I believe that my child and I have a good interaction with each other
8 I can make my child calm when he/she has been crying
9 I am good at soothing my child when he/she becomes upset
10 I am good at soothing my child when he/she becomes fussy
11 I am good at soothing my child when he/she continually cries
12 I am good at soothing my child when he/she becomes more restless
13 I am good at understanding what my child wants
14 I am good at getting my child's attention
15 I am good at knowing what activities my child does not enjoy
16 I am good at keeping my child occupied
17 I am good at feeding my child
18 I am good at changing my child
19 I am good at bathing my child
20 I can show affection to my child

Maternal Confidence Questionnaire – MCQ (14 questions)

Although the following questions are similar to the ones you just responded to, they are part of another questionnaire.

How confident do you feel in your parenting role?
Never
Seldom
Some
Often
A great deal

1. I know when my child wants me to play with him/her. 1 2 3 4 5
2. I know how to take care of my child better than anyone else. 1 2 3 4 5
3. When my child is cranky, I know the reason. 1 2 3 4 5
4. I can tell when my child is tired and needs to sleep. 1 2 3 4 5
5. I know what makes my child happy. 1 2 3 4 5
6. I can give my child a bath. 1 2 3 4 5
7. I can feed my child adequately. 1 2 3 4 5
8. I can hold my child properly. 1 2 3 4 5
9. I can tell when my child is sick. 1 2 3 4 5
10. I feel frustrated taking care of my child. 1 2 3 4 5
11. I would be good at helping other mothers learn how to take care of their children. 1 2 3 4 5
12. Being a parent is demanding and unrewarding. 1 2 3 4 5
13. I have all the skills needed to be a good parent. 1 2 3 4 5
14. I am satisfied with my role as a parent. 1 2 3 4 5