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Left on Delivered? An Argument in Defense of Postpartum Posttraumatic Stress Qualifying as A Sub-diagnosis of Complex Posttraumatic Stress Disorder

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Abstract

Postpartum-PTSD (PP-PTSD) is a mental disorder characterized by a traumatic childbirth experience in which mothers experience significant physical, psychological, and social distress. While typically viewed within the DSM-5's PTSD framework, it may be possible that the complexity of the disorder is not the best fit in terms of diagnosis and treatment of PP-PTSD. Sociocultural expectations of motherhood greatly impact the mother's self-identity, ability to self-regulate, and how she may interact in her relationships to others. Therefore, the present manuscript proposes PP-PTSD is viewed within the scope of Complex-PTSD's (C-PTSD) diagnostic criteria, as it encompasses the difficulties experienced beyond trauma that impact multiple domains of daily functioning. "Left on Delivered" shares a bleak, but realistic illustration of women struggling to come to terms with the traumatic experience that was promised to evoke profound happiness and gratitude.

Keywords: Postpartum-PTSD, Complex-PTSD, childbirth-related trauma

Posttraumatic stress disorder (PTSD) exists in both the DSM and ICD, characterized by a cluster of core symptoms following a traumatic event. Traumatic events are life-threatening in nature and are typically referred to as such when one encounters experiences of violence, car accidents, or sexual assault. Symptoms following a traumatic event such as experiences where one feels as though they are re-living the traumatic event (typically via nightmares or flashbacks), avoidance of stimuli that one perceives as similar to the traumatic event, and hypervigilance stemming from a need to be on high alert in potentially threatening situations (Cloitre, 2020) can greatly affect one's level of functioning and disturb her social, emotional, and physical wellbeing.

In 2018, the ICD-11 exclusively recognized a diagnosis beyond the core symptomology of PTSD named Complex-PTSD (C-PTSD; Cloitre, 2020). As stated in the ICD-11, this disorder extends beyond PTSD's diagnostic guidelines and is characterized by three core symptom patterns that arose when carefully considering patients who experienced more complex reactions to traumatic events (Cloitre, 2020). These patients typically struggle with regulating their emotions, experience disruptions within their self-identity, and encounter difficulties in cultivating meaningful connections with others (Cloitre, 2020). The main differentiation between PTSD and C-PTSD diagnoses is in relation to disorganization of the self (Brewin et al., 2017). C-PTSD has a more complicated impact on the individual in that the three core symptoms describe how the individual may see herself differently following her experience of trauma, thus affecting how she may act or connect with others. In sum, the implications of the complex trauma extend beyond the context that is similar to the traumatic event as with PTSD, affecting one's functioning pervasively in multiple settings (Brewin et al., 2017).

An important note to consider is that, within practice, it has become clear that although C-PTSD is typically diagnosed in individuals who have experienced repeated traumatic experiences such as childhood or domestic abuse, this is not always the case (Cloitre, 2020). In other words, it has been found within applied settings that clinicians encounter patients who experience one traumatic event, yet still display the complex response patterns characteristic of C-PTSD's symptomology. The converse exists as well: individuals who have endured persistent traumatic circumstances may only qualify for a PTSD diagnosis, but not C-PTSD (Cloitre, 2020). This distinction is important to recognize, as there may be a traumatic life event one may experience only once, and yet the individual could still experience C-PTSD's symptomology - not PTSD's. As stated by Brewin et al. (2017) in their review of PTSD and C-PTSD diagnostic guidelines, the nature of the traumatic event one experiences fails to determine what typology of symptoms an individual responds with following a traumatic event. In short, one's traumatic experiences do not discern what symptoms they will present with; while one individual may present with C-PTSD symptoms following a single traumatic event, another may fail to show any posttraumatic stress symptoms (PTSS) at all. According to Brewin et al. (2017), the traumatic event should be viewed as a risk factor in developing either disorder and should not be used as criteria for meeting either diagnosis.

C-PTSD was not adopted by the DSM-5, however. According to those who utilize this diagnostic manual, it is argued that the symptoms of C-PTSD are highly comorbid with other disorders that already exist within the DSM-IV, allowing questions to arise about the discriminative validity of C-PTSD (Sar, 2011). Specifically, the three hallmark symptoms characteristic of C-PTSD are very similar to that of borderline personality disorder and dissociative disorders (Sar, 2011). The main distinction between C-PTSD and these disorders is that C-PTSD's symptoms stem from one or more traumatic experiences (Sar, 2011). However, the DSM generally fails to account for etiology in the development of mental health disorders and, as a result, chooses not to recognize how developmental trauma may produce a multitude symptoms related to mental illness later on in life. Previous psychological literature has consistently shown that the development of borderline personality disorder and dissociative disorders are typically related to early developmental trauma, thus bringing into question the validity of these diagnoses (Sar et al., 2003; Sar, 2011). Many times, as stated by Sar (2011), patients present with symptoms of both borderline personality and dissociative disorders when receiving psychiatric treatment, and when both sets of symptoms are strongly correlated with developmental traumas, the validity of both disorders comes into question. Sar (2011), therefore, called on the DSM to recognize how trauma experienced early on in one's life may evoke interrelated consequences on the development of these mental disorders, and to reconsider the borderline personality and dissociative disorder diagnostic categories as a whole due to these symptoms being so similar. In the revised version of DSM-5, the borderline personality diagnostic category was reviewed and changed, but recognition of how developmental trauma may implicate this disorder was not included in its edits.

Further, the discriminative validity between C-PTSD and PTSD has been called into question following the ICD-11's adoption of the diagnosis (Cloitre, 2020; Brewin et al., 2017). Despite being characterized by two different core symptomology systems, criticism regarding its validity has grown in response to the recognition of this disorder. However, in a review of the literature discussing the two diagnoses, it is clear that two distinct systems of symptoms emerged (Brewin et al., 2017). Nine out of the 10 previous studies examined within Brewin et al.'s (2017) review distinguished the two symptom profiles of PTSD and C-PTSD, with C-PTSD being characterized by significant disturbances within one's self-organization. In other words, for those characterized by C-PTSD diagnostic profiles, these individuals reported more difficulties in their daily functioning beyond settings that reminded them of the traumatic event. The core symptoms of C-PTSD were found to impact multiple domains in a variety of settings, both physically and interpersonally.

Postpartum-PTSD

Within recent years, psychological and obstetric literature has highlighted numerous psychopathologies present during the postpartum period, including postpartum depression, postpartum anxiety, and postpartum psychosis. However, one diagnosis which has recently come into light is postpartum-PTSD (PP-PTSD).

Childbirth is typically identified as the traumatic event for women who experience PTSS (Posttraumatic Stress Symptoms) during the postpartum period. As stated by Waller et al. (2022), a traumatic childbirth experience can negatively impact women physically, emotionally, and psychologically (Greenfield et al., 2016). Across cultures, the experience of childbirth is viewed as particularly rewarding. The delivery experience itself invites a new chapter into a woman's life where she now assumes a maternal role in caring for her child. Typically illustrated as nurturing and attentive, a woman within a maternal role is expected to feel fulfilled by her duties and to be selfless in her love and care for her baby. However, there are instances in which childbirth may be perceived as a negative experience, which thus impacts the mother's experience postpartum both physically and mentally. Previous research has found that almost 30% of women characterize their childbirth experiences as traumatizing or threatening to their physical or emotional health (Ayers, 2004; as cited in Gründstrom et al., 2022). It has also been demonstrated that for women who endorse PTSS following a difficult childbirth experience, these

women are also likely to report lower scores on five quality of life dimensions, including how well they function in their emotional roles as mothers, energy and fatigue levels, their psychological well-being overall, their ability to function in social situations, physical pain following the childbirth, and their overall health (Gründstrom et al., 2022).

PP-PTSD is also typically viewed through the lens of PTSD symptomology. In other words, the core symptoms that the literature focuses on in assessing PTSS postpartum are heightened arousal, the re-experiencing of the traumatic childbirth, and the avoidance of stimuli that are perceived to be similar to those experienced within the context of the traumatic childbirth. Predictors pointing to the development of PP-PTSD have arisen within the literature, including fear of childbirth, a complicated delivery experience, preterm deliveries, and other stressors present during the childbirth experience, including the health of the baby (Grundström et al., 2022; Deninotti et al., 2020; Waller et al., 2022; Dekel et al., 2024).

In an effort to create a model to predict PP-PTSD for women with high-risk pregnancies, Polachek et al. (2016) revealed that women who experienced feelings of anxiousness or sadness during a past pregnancy or the childbirth experience itself, have a history of difficult childbirth experiences, prefer to have a cesarean section delivery for future childbirths, endured emotional crises during their high-risk pregnancy, report a severe fear of childbirth, or expect severe pain during their childbirth were more likely to endorse symptoms representing a partial or full PTSD diagnosis. These risk factors were found to compound on top of one another, meaning the more risk factors that are present during a woman's high-risk pregnancy, the more likely she is to report PTSS (Polachek et al., 2016). Interestingly, the two strongest risk factors identified were if both the presence of emotional crises during the high-risk pregnancy and the higher the woman's expectation of experiencing intense pain during childbirth, and the predictive power of developing PP-PTSD was found to increase 15-fold (Polachek et al., 2016).

Previous research has also suggested that a mother's negative perception of a childbirth experience may induce feelings such as anger, fear or sadness following delivery which, in turn, may negatively influence maternal satisfaction overall (Deninotti et al., 2020). The existence of PTSS postpartum suggests much worse outcomes in this domain, meaning if women perceive their childbirth experience as one that is negative and she reports PTSS postpartum, she may report lower levels of maternal satisfaction compared to those who do not experience PTSS following delivery. Deninotti et al. (2020) suggest that these women who endorse elevated levels of anger, sadness or fear after a difficult delivery experience may feel as though they were not successful in delivering their child vaginally, thus producing negative thoughts about their performance overall, and diminishing their self-esteem.

Evidence to suggest women of color are more likely to report traumatic childbirth experiences compared to white women has also been found within the literature (Waller et al., 2022). When comparing clinician reports of childbirth experiences to those of their patients, Waller et al. (2022) found more reports of traumatic childbirth experiences from black women compared to white women, regardless of the method of delivery utilized. This finding is of particular interest, as overall many clinicians reported these deliveries to be routine, but when compared to patient reports following their childbirth experiences, a different, more traumatizing picture is illustrated. This finding in particular is of significance, as the CDC reported maternal mortality rates for Black women in the United States are much higher compared to White, Hispanic, and Asian women (Hoyert, 2025). For Black women in the United States, it is stated that 50.3 maternal deaths occur for every 100,000 live births, whereas the other ethnicities' rates that were observed are less than 15, respectively (Hoyert, 2025).

Waller et al. (2022) also draw attention to differences between two common delivery methods: cesarean sections and vaginal delivery. Via post hoc analyses, it was discovered that both cesarean and vaginal deliveries produced elevated levels of patient-reported trauma following childbirth when the mother experienced more blood loss (Waller et al., 2022). The researchers estimated that women who lost over 1,000 ml during cesarean section deliveries and women who lost over 400 ml during vaginal deliveries were more likely to view their childbirth experiences as more traumatic, which then posed them at greater risk for developing postpartum psychopathologies.

PP-PTSD and Its Comorbidities

It is common for comorbid psychopathologies to arise during the postpartum period, specifically postpartum depression and PP-PTSD, also referred to as childbirth-related PTSD (CB-PTSD; Dekel et al., 2024). As is also present in discourse that attempts to parse whether comorbid conditions such as PTSD and depression are reflective of a single construct as opposed to two distinct diagnostic profiles, Dekel et al. (2024) aimed to distinguish if CB-PTSD and postpartum depression symptomology represent a single construct related to a negative childbirth experience. Participants ($N = 685$) in their analysis were postpartum women and were assessed using surveys, including the PCL-5 which measures PTSS frequency via self-report and is based on DSM-5 diagnostic criteria, a Brief Symptom Inventory (BSI) to measure the mother's general distress following childbirth, a sub-scale from within the BSI that assesses depression symptoms following the childbirth experience, the Peritraumatic Distress Inventory (PDI) and Peritraumatic Dissociative Experiences Questionnaire (PDEQ) to measure acute traumatic reactions pertaining to distress and dissociation respectively following childbirth, and the Life Events Checklist for DSM-5 (LEC-5) to

assess previous trauma history (Dekel et al., 2024). Within the sample, analyses found that 18% of the postpartum women could be classified under a CB-PTSD diagnosis and 57% of postpartum women experienced high levels of postpartum depression. However, in terms of comorbidity, 90% of the postpartum women classified with a CB-PTSD diagnosis also experienced heightened levels of postpartum depression, while one-third of those who were classified as experiencing postpartum depression (n = 123) additionally experienced symptoms of CB-PTSD (Dekel et al., 2024). Researchers concluded that women who gave birth to their child earlier than their expected due date were more likely to experience comorbid symptoms of both disorders than women who gave birth at term. Other predictive factors indicating postpartum comorbidity are if the mother is younger, has a previous history of ill mental health, had to have an emergency cesarean section to preserve the health of the mother or baby, experienced elevated levels of peritraumatic and postpartum distress, and if the delivery experience was long in duration (Dekel et al., 2024).

Dekel et al. (2024), however, make a point to state that although the disorders can co-occur during the postpartum period and that it is a common phenomenon, the two disorders were significantly related to different sets of risk factors, indicating two distinct diagnostic categories for postpartum depression and CB-PTSD. In other words, women who experienced postpartum depression were subjected to different predictive risk variables than those who experienced CB-PTSD. Specifically, postpartum women were more likely to be classified with comorbid disorders compared to only postpartum depression when the mother had one or more offspring before this specific childbirth experience and experienced obstetric complications during the delivery (Dekel et al., 2024).

Further, previous research has highlighted that some women may develop a fear of childbirth after a complicated delivery experience, ranging from a low fear of childbirth to a phobic fear of childbirth, which was found to be a strong predictor of elevated frequencies of PTSS postpartum (Grundström et al., 2022). In short, if a woman has developed a severe to phobic level of fear related to childbirth, she is more likely to experience more PTSS postpartum. According to Gründstrom et al. (2022), severe and phobic levels of fear related to childbirth negatively impact multiple domains of a woman's life, including emotionally, socially, and professionally, and may encourage the woman to either postpone future pregnancies or decide to not become pregnant again in the future (Wijma & Wijma, 2017). Grundström et al. (2022) also found that fear of childbirth during the postpartum period was correlated with lower quality of life on behalf of the mother. The researchers conducted a cross-sectional study to examine the implications of fear of childbirth on PTSS and quality of life among eight dimensions: physical role functioning, emotional role functioning, energy and fatigue, emotional well-being, social functioning, pain, and general health (Grundström et al., 2022). Using a sample of women (N = 76) who underwent a complicated childbirth within the previous one to three months, multiple measures were analyzed and relied on self-reported measurements. Specifically, using the Short Form Health Survey-36 (SF-36) to measure the mother's psychological wellbeing and quality of life via eight dimensions. Grundström et al. (2022) found evidence suggesting women who had elevated levels of fear related to childbirth were more likely to experience disruptions in their emotional role functioning, energy and fatigue, emotional wellbeing, social functioning, pain, and general health. To summarize, women who develop fear related to childbirth were more likely to report lower quality of life in multiple domains, as well as experience elevated levels of PTSS.

PP-PTSD Beneath a C-PTSD Lens

Across the literature, it appears quite common to measure the symptomology of PP-PTSD within the scope of PTSD's diagnostic criteria. However, it may be of benefit to examine the experience of PP-PTSD via the context of C-PTSD's core guidelines due to the complexity of the trauma experienced, as well as the symptoms many mothers report following the changing of their social roles to one that is more maternal. The present paper aims to examine PP-PTSD diagnoses through a C-PTSD lens and compare the presentation of the core symptoms that emerge among both diagnoses. Through this comparison, an argument will be made in favor of PP-PTSD being screened via C-PTSD diagnostic guidelines.

PP-PTSD Beneath a C-PTSD Lens: Difficulty in Emotional Regulation Processes

One core symptom characteristic of C-PTSD is one's difficulty in regulating her emotions. Regulating one's emotions can be described as a process in which an individual utilizes her social skillset to influence the expression of her emotions, including how and when they are expressed, as well as what emotions she will experience (Gross, 1998). Difficulties in emotional regulation processes have also been found to emerge within other psychiatric diagnoses, particularly in individuals who are experiencing a major depressive episode or are diagnosed with generalized anxiety disorder (D'Avanzato et al., 2013).

Emotional regulation processes are typically divided into two categories of strategies: disengagement and engagement (Sheppes et al., 2014). A disengagement strategy is employed when an individual stops processing emotional stimuli altogether or chooses to focus on other stimuli in order to inhibit mental emotional processing (Mehta et al., 2024). Oppositely, engagement strategies encourage the processing of emotional stimuli (Mehta et al., 2024).

One facet of emotional regulation that has received attention within the field is alexithymia. Alexithymia is defined by three dimensions in relation to emotional processing: difficulty with identifying emotions, difficulty in describing emotions, and externally oriented thinking patterns (Taylor, 1984; Ahrnberg et al., 2022). Externally oriented thinking is often illustrated as when an individual chooses to disengage from processing emotional experiences. Interestingly, these difficulties can be seen not only in reference to one's own emotions but also to others. Generally speaking, individuals who report elevated levels of alexithymia also report more intense negative emotions (Mehta et al., 2024). Specifically, the intensity of negative emotions has been found to mediate the relationship between two dimensions of alexithymia and the utilization of disengagement emotional regulation strategies when experiencing daily life stressors (Mehta et al., 2024). Individuals who report difficulties with identifying or describing their own or others' emotions in particular may be more likely to report more intense negative emotions, which thus may elevate their usage of disengagement strategies to self-regulate (Mehta et al., 2024).

Deninotti et al. (2020) explored how two emotional regulation strategies, specifically cognitive reappraisal, and expressive suppression, manifest in women experiencing PTSS and postpartum depression. While cognitive reappraisal, an engagement strategy, was hypothesized to be more beneficial to mothers by reducing the emergence and severity of anger and sadness following a difficult childbirth experience, expressive suppression was thought to have a more negative influence on the mother following a difficult childbirth experience (Deninotti et al., 2020). Expressive suppression can be seen as advantageous in the sense that it may decrease the behavioral response associated with emotional expression. However, it may also decrease the likelihood of other, more positive emotional expressions, which may inadvertently elevate anxiety and depression for the mother (Deninotti et al., 2020). This strategy, in comparison to the previous, would be considered a disengagement strategy. The researchers theorized that women who utilize the former emotional regulation strategy may feel different inwardly than how they present outwardly. In other words, these women may feel they are being inauthentic to their true feelings following a difficult childbirth experience, which may negatively impact their emotional well-being in the long term. To determine if an association exists between maternal satisfaction, emotion regulation strategies, and psychological outcomes, Deninotti et al. (2020) utilized a sample of 50 women who underwent emergency cesarean sections during their childbirth experiences. Correlational analyses revealed that the emotional regulation strategy utilized by the mother, as well as her satisfaction with the experience, were associated with experiencing PTSS postpartum (Deninotti et al., 2020). The participants who tended to employ an expressive suppression strategy reported lower levels of satisfaction regarding their childbirth experience, which then impacted their reports of PTSS. Mothers who reported higher levels of PTSS reported lower maternal satisfaction scores (Deninotti et al., 2020).

Further, in a sample of 56 Swiss mothers to children aged 12 to 42 months old, mothers who reported severe symptoms related to Interpersonal Violence Related-PTSD (IPV-PTSD; Schechter et al., 2015) experienced more difficulty with identifying others' emotions. Schechter et al. (2015) note this particular dimension of alexithymia was strongly correlated to the severity and frequency of dissociative symptoms and hyperarousal. Despite the traumatic event specified in this case being in relation to experiences of violence as opposed to the experience of childbirth, this finding is of particular importance as other research suggests these difficulties can be present within regular, everyday caregiving experiences between the mother and child (Ahrnberg et al., 2022). Particularly within playful interactions between a mother and child, research has hypothesized that emotional regulation strategies are utilized and depended upon (Ahrnberg et al., 2022). If the traumatic event which catalyzed the emergence of PTSS is in relation to a childbirth experience, it may suggest more negative outcomes early on in the postpartum period. In other words, because the period immediately following childbirth is one that is often considered to be an extremely sensitive and vulnerable developmental stage for both the mother and child (Çankaya & Ataş, 2022), mothers may experience great difficulties cultivating strong bonds with her newborn.

Within the beginning of the postpartum period, many mothers choose to breastfeed their children as a way to establish close connections with their infant (Çankaya & Ataş, 2022). Following a sample of 325 Turkish mothers, Çankaya and Ataş (2022) aimed to examine potential associations between the mothers' self-efficacy in breastfeeding experiences, their psychological wellbeing, and their emotional regulation skills. Results following a series of in-person interviews displayed positive correlations between a mother's breastfeeding self-efficacy, her psychological wellbeing, and the use of adaptive emotional regulation strategies (Çankaya & Ataş, 2022). When mothers were more likely to employ regulatory emotional engagement strategies such as positive refocusing, reassessing breastfeeding plans, positive cognitive reappraisal, and often putting their breastfeeding experiences into perspective in a positive manner, the mothers reported elevated levels of psychological wellbeing, indicating better outcomes emotionally (Çankaya & Ataş, 2022). This finding, in turn, positively impacted breastfeeding self-efficacy, as the women were more likely to present more confidently when breastfeeding, as well as be more successful in the experience overall (Çankaya & Ataş, 2022). Conversely, the opposite was apparent within the results of this study: negative associations surfaced within the data between breastfeeding self-efficacy and four emotional regulation strategies that are considered to be maladaptive (Çankaya & Ataş, 2022). Specifically, mothers who utilized strategies involving

blaming themselves for the success (or lack thereof) of breastfeeding outcomes, ruminated over unsuccessful breastfeeding experiences, catastrophized, or blamed others for poor breastfeeding experiences were more likely to report lower self-efficacy scores (Çankaya & Ataş, 2022). Via multiple linear regression analyses, Çankaya and Ataş (2022) concluded psychological wellbeing, the use of self-blame, not using cognitive reappraisal strategies, and the use of formula during breastfeeding experiences were risk factors predicting lower breastfeeding self-efficacy outcomes.

PP-PTSD Beneath a C-PTSD Lens: Disruptions of Self-Identity

Identity as a construct is both multidimensional and multifaceted (Hyland et al., 2023). Research suggests that, generally speaking, people hold multiple self-identities at once (Hyland et al., 2023). While normal identity development encourages positive evaluations of oneself, disruptions in identity development have been linked with more negative evaluations, where one may perceive oneself as a bad, worthless, or vulnerable person (Hyland et al., 2023). Typically, negative self-evaluations of one's identity point to mismatches between how one thinks she should be versus who she really thinks she is (Hyland et al., 2023). These disruptions are considered to be a hallmark of C-PTSD diagnoses.

Hyland et al. (2023) review the role of both memory and identity in the presentation of C-PTSD via the memory and identity theory. Within this theory, it is posited that an individual's experience of one or multiple traumatic life events interacts with her existing vulnerabilities to produce memories of trauma and negative self-concepts, thus encouraging PTSS (Hyland et al., 2023). Previous research has highlighted the profound role of negative identities in the development of C-PTSD, stating these disruptions are directly associated with all clusters of C-PTSD's symptomology (Hyland et al., 2023). For individuals with C-PTSD diagnoses, it is common that they perceive themselves to have little self-worth, to feel fragmented or broken, or even nonexistent (Hyland et al., 2023). As C-PTSD is evoked with one or multiple experiences of trauma, exposure to such events has been seen to conflict with positive evaluations of one's identity, strengthen negative evaluations, or create new identities with poorer expectations for the future (Hyland et al., 2023). While individuals with C-PTSD diagnoses who view themselves as worthless are found to engage in self-blaming tendencies at higher frequencies than others when they reexperience sensations that remind them of traumatic events, those who characterize their identity as nonexistent struggle more with emotional regulation overall (Hyland et al., 2023).

Seeing as pregnancy and the postpartum period have been identified as significant developmental stages in a woman's life, there is little doubt that changes do not occur within a woman's self-concept during this time. During pregnancy and following childbirth, mothers move towards adopting maternal roles. Oftentimes, these roles are informed by ideals present within sociocultural norms (Collins, 2021). Characterized by Collins (2021), some sociocultural norms shared by mothers are the expectation to prioritize childcare above all else and the notion of a maternal instinct in which once giving birth, a mother will innately know exactly how to care for her child in the correct way. However, these expectations of what a mother should be or how a mother should act are often unrealistic compared to everyday experiences. Many women experience disruptions within their identity as a woman when adopting a maternal role, which has been found to bring upon psychological distress. Within Collins' (2021) analysis, these disruptions may occur when a woman feels like a bad mother for considering her own needs instead of prioritizing her child, not inherently knowing how to soothe and care for her child, and struggling to undertake the role of serving as the main caregiver for her child.

Via interpretative phenomenological analysis, Collins (2021) sought to illustrate the everyday emotional experiences that six British white mothers faced by conducting semi-structured interviews. All six women had at least one child who was under the age of five years old, and all women reported varying degrees of psychological distress in relation to performing their maternal role (Collins, 2021). When the women shared what they thought motherhood would entail, many assumed it would be both enjoyable and full of love, as evidenced by their idealized versions of the maternal role (Collins, 2021). However, when their everyday experiences conflicted with these highly positive expectations, the women expressed feelings of psychological distress (Collins, 2021). Instead of reaching out to family or friends for support with these emotional conflicts, the women turned inwardly within themselves and did not ask for support. Two women plainly stated they assumed that they would be rejected by others for sharing how their actual experiences during early motherhood were mismatched with ideal sociocultural representations of it (Collins, 2021). Here, these women detailed fearfulness regarding how others would react and perceive them if they found out about their true feelings, and also mentioned how they assumed other mothers did not feel similarly (Collins, 2021).

Beyond comparing themselves to other mothers, these women also described how a lack of "maternal instinct" distressed them greatly (Collins, 2021). Collins (2021) recognizes that it is communicated to women socioculturally that there is an assumption within Western societies, in particular, that women possess an innate knowledge of how to raise and care for children. However, these women expressed a great deal of guilt when they did not know how to provide and care for their child in the right way. Some women went further, detailing feelings of inadequacy, failure, helplessness, and resentment (Collins,

2021). Inherent within their feelings of failure, the mothers felt they themselves were not capable of being competent mothers to their children, which was found to be deeply entrenched within their senses of self-worth (Collins, 2021). The mothers also felt as though they should completely devote every sense of themselves into their maternal roles but found that as a result of prioritizing care for their child, they stopped caring for themselves (Collins, 2021). Many of the woman shared experiences of neglecting their own basic necessities, including sleep. One woman openly questioned if she had made the right choice in having children due to feeling conflicted with prioritizing if she should engage in self-care or care for her child (Collins, 2021). Another woman expressed how she thought her child would be better off having a different mother than herself because she did not think she was prioritizing her child's care in the way she should have been (Collins, 2021).

A sub-theme emerged within the qualitative data, with many women describing feelings of how it seemed as though they lost themselves entirely because of their prioritization of the maternal role. Two women in particular equated motherhood to feeling as though they themselves have died (Collins, 2021). By having to give up their careers and futures through the prioritization of motherhood and childcare, these women experienced great resentment and grief over the loss of their self-concept, expressing feelings of brokenness (Collins, 2021).

Within Collins' (2021) analysis, it becomes clear that these mothers experienced profound disruptions within their self-identities following the adoption of maternal roles. Although these women did not express PTSS specifically, it is evident that the women's conceptual representations of the maternal role itself conflicted with their everyday experiences of motherhood, resulting in elevated psychological distress and disruptions related to who they felt they were. Although the sample Collins (2021) utilized lacked diversity and thus may not be generalized to other populations of mothers, it may be safe to assume that mothers from other ethnic backgrounds may experience similar distress. Generally speaking, previous research has found support to suggest black women are more likely than other races to report more traumatic childbirth experiences, resulting in the increased emergence of PTSS (Waller et al., 2022). This finding is compounded when considering Black women experience significantly higher maternal mortality rates compared to other ethnicities within the United States (Hoyert, 2025). Following this line of thinking, it may be apparent that black women who underwent experiences of trauma during delivery may experience similar disruptions within their self-identities into the postpartum period. However, this has not been captured within the literature as of yet.

Through Odunsi and Hosek's (2024) work though, a clearer illustration has been painted to identify how Nigerian mothers reconstruct their self-identities when performing maternal roles. A common custom utilized within Nigerian cultures is the use of motherhood-indicative labels, signifying to both the mother herself as well as to her community, her change in social status (Odunsi & Hosek, 2024). These labels are compromised by combining titles such as "mother" or "mommy" with a woman's first-born child's first name (i.e. "Mommy James"; Odunsi & Hosek, 2024), even if she has more than one child. There are social and cultural implications that emerge from the use of these labels, as they are typically used by family members or other members of the community (Odunsi & Hosek, 2024). Not only are these labels representations of how mothers are expected to behave within Nigerian communities, perpetuating a "motherhood myth" that details expectations of the maternal role as one must act selflessly and is solely responsible for her child's wellbeing in multiple domains (Constantinou et al., 2021, p. 853), but also influence how mothers view their own unique identities (Odunsi & Hosek, 2024). When Nigerian mothers find themselves struggling with the maternal role, oftentimes the use of these labels creates more disruptions in her self-identity rather than integration. Some participants within Odunsi and Hosek's (2024) qualitative analysis explained they rejected the use of these labels as identifiers of themselves for a long time, ultimately choosing not to respond when being referred to in this way. Often, these women found such labels to be constant reminders of who they no longer were due to them no longer being called by their names and instead being called by an integration of their social role and child's name (Odunsi & Hosek, 2024).

Many women experience rumination following traumatic events in which their bodies are impacted (Odunsi & Hosek, 2024). For women who experience traumatic childbirth experiences, it may be common for these mothers to ruminate over their physical changes and compare their postpartum bodies to their bodies before pregnancy, which may influence one's self-perception. The Nigerian mothers in Odunsi and Hosek's study (2024) seemed to focus heavily on the physical toll pregnancy had on their bodies, viewing their postpartum bodies as "contorted" or even referred to them as "worksites" that were responsible for homecare, childcare, and also professional work all at the same time (Odunsi & Hosek, 2024). Participants found it difficult to integrate or find balance with their multiple identities, with one woman expressing devastation with the fact that she had lost many clients for her business because many assumed she was no longer working after having a child and stopped calling her (Odunsi & Hosek, 2024). This woman shared she found it difficult being labelled as she was, as it negatively impacted her business and distracted her from attracting new clients due to feeling so poorly. Another woman reflected on her body postpartum, sharing that while she breastfed her breasts became enlarged, and she was referred to as the "big breasted lady" by others in her community (Odunsi & Hosek, 2024). Reflecting on this experience, this participant expressed feeling

bad about herself and appearance despite acknowledging her experience was reflective of what naturally comes alongside motherhood (Odunsi & Hosek, 2024). The researchers also highlighted how the women detailed experiences of demonstrating elasticity within their new identities, explaining how Nigerian mothers are expected to be extremely flexible in accommodating the needs of her children (Odunsi & Hosek, 2024). However, when their postpartum identities were tied to labels that conflicted with how they personally viewed themselves, participants shared they felt as though these labels were reminders of how past versions of themselves were lost (Odunsi & Hosek, 2024). For Nigerian women who experience symptoms of postpartum depression, the authors suggest that the use of motherhood-indicative labels may have a more profound impact on these women at the detriment of their emotional wellbeing. Specifically, such labels may serve as reminders and messages that women hold onto to represent difficult periods of their lives, or lost selves (Odunsi & Hosek, 2024).

Seeing as a movement towards a maternal role seems to conflict with many women's self-identities, particularly when physical, social, and professional changes occur, one may conclude these disruptions can be seen as a source of psychological distress to mothers. The change in a woman's self-identity appears characteristic of the motherhood experience and thus cannot be ignored when considering the impact of psychological distress. Many women across cultures equated the adoption of her maternal role to the death of her previous self, indicating that some level of grief over losing previous self-concepts exists. This argument, however, is not in favor of over-medicalizing women's difficulties with integrating their identities as mothers with their perceived self-identities. Rather, when this mismatch evokes difficulties that extend beyond herself and impact her daily functioning, it is of importance to consider.

For women with severe to phobic levels of fear related to childbirth, previous research indicated that these women scored much lower in measures assessing their physical, emotional, and social role functioning (Gründstrom et al., 2022). Gründstrom et al. (2022) also revealed severe and phobic levels of fear related to childbirth were associated with increased PTSS. With these findings in mind, it can be concluded that these women experienced significant disruptions in performing their maternal roles in multiple domains, which coincided with higher frequencies of reported PTSS. This finding could be a result of these women not being able to reconcile with the traumatic experience due to their intense fear related to the childbirth, which thus impacted how they functioned as a maternal figure to their child. Although not directly linked to their identities in this study, one's performance of social roles she feels she should be competent enough to complete, as outlined by societal and cultural conceptualizations of idealized mothers, but still not able to perform as adequately as she may have hoped as a result of increased PTSS and fear following the experience, it can be assumed that she would experience great distress and question if motherhood was the right choice for her. Severe fear of childbirth alone has been seen to increase a woman's reluctance to become pregnant again (Wijma & Wijma, 2017). When compounded by a traumatic childbirth experience, PTSS, and an inability to perform her maternal role, one can assume this may negatively impact her self-concept, and she may see herself as an inadequate mother. In other words, these women may have created a new, negative self-identity of themselves as a mother characterized by inadequacy as a result of their trauma. Again, as trauma may influence the production of new identities via negative self-evaluations (Hyland et al., 2023), these mothers may be displaying a clear hallmark symptom of C-PTSD.

Further, when considering how some mothers shared internal conflicts about who they once were and who they were as mothers, these women experienced feelings of grief and equated their past selves to have passed (Collins, 2021; Odunsi & Hosek, 2024). When comparing these findings to the experience of those diagnosed with C-PTSD and their expressions of how they felt their identities were nonexistent (Hyland et al., 2023), it is clear to see that these illustrations are very similar.

As stated previously, those diagnosed with C-PTSD have been found to generate new identities with poorer expectations for the future following a traumatic event (Hyland et al., 2023). This conclusion is of particular interest when compared to the women within Polachek et al.'s (2016) model, demonstrating that many of the women who endorsed symptoms of PTSD representative of partial or full diagnosis reported no desire for having children in the future or wished to postpone plans to expand their families because of their traumatic experience. It may be possible here that the traumatic childbirth experience induced a negative self-identity within these women that could be characterized by feelings of inadequacy or incompetence. Thus, when looking ahead to the future in terms of their family planning, these women may have decided to reassess them within the context of these negative evaluations of the experience as a whole. Considering Polachek et al.'s (2016) model was based on women with high-risk pregnancies, these women may have also experienced changes to their physical body following childbirth, which may have also encouraged the creation of negative self-identities. Future research in this area is needed however in order to determine associations between self-identity, PTSS and future family planning.

PP-PTSD Beneath a C-PTSD Lens: Difficulty Maintaining Relationships

Individuals with C-PTSD diagnoses typically struggle with maintaining and cultivating meaningful connections with others. Following a traumatic event, individuals who possess fewer social supports are at an increased vulnerability for being unable to reconcile with the effects resulting from the trauma and thus are posed with a greater risk of developing C-PTSD (Hyland et

al., 2023). The memory and identity theory posits that individuals who create identities that are related to feelings of being betrayed by others, abandoned or alienated experience stronger disturbances in their abilities to maintain relationships (Hyland et al., 2023). This finding may, in part, be due to these individuals negative self-identities potentially being validated by the traumatic experience and having fewer supports to challenge or address this with. In support of this assumption, research has found evidence that women who maintain severe fears of childbirth, and thus increased PTSS, have been found to report poorer scores related to their social functioning (Gründstrom et al., 2022).

In line with the evidence suggesting the protective power of social support on the development of C-PTSD, social support has been found to produce similar effects on PP-PTSD symptoms. Noyman-Veksler et al. (2014) investigated social support's role in the development of PTSS for women who had emergency and elective cesarean sections. Through a longitudinal design, mothers were measured two times, at six weeks postpartum (Time 1) and 12 weeks postpartum (Time 2), to investigate differences in postpartum psychological symptoms following potentially traumatic childbirth experiences. For women who perceived that they had low levels of social support at Time 1 and also had emergency cesarean sections to deliver their child, elevated levels of PTSS emerged from the data (Noyman-Veksler et al., 2014). However, these PTSS elevations were not replicated for women with the same method of delivery but perceived higher levels of social support (Noyman-Veksler et al., 2014). This evidence has been supported by Deninotti et al. (2020) as well: when women's birthing partners were present during childbirth, her satisfaction with the experience overall greatly increased. Further, Deninotti et al. (2020) also found that the presence of a midwife during both pregnancy and the delivery had a profound impact on the presence of PTSS. Under the supervision of a midwife, these women reported significantly less PTSS than those who did not have a midwife present (Deninotti et al., 2020). It may be suggested that midwives provided reassurance and support during the experience, which may have protected the mother from experiencing PTSS following the difficult childbirth.

Although not explicitly linked with PP-PTSD, previous research has recognized an association between a mother's postpartum depressive and postpartum anxiety symptoms with early postpartum bonding with her infant (Ahrnberg et al., 2022). During infancy, mothers are responsible for caring for their children and interpreting their necessities via interpretations of their infants' behaviors. Because infants are physically unable to vocalize their needs, correct interpretations of behavior are crucial in assuring that the infants' needs are met. Typically, infants express their needs to caregivers through crying or facial expressions (Maupin et al., 2019). However, evidence suggests women who experience alexithymia create weaker bonds with their children (Ahrnberg et al., 2022). Through the utilization of a longitudinal design, Ahrnberg et al. (2022) followed 1,766 Finnish mothers from three months postpartum to six months postpartum. Findings revealed that mothers who were more likely to report difficulties in identifying their own as well as their infants' emotions had deteriorated bonds with their infants during this period (Ahrnberg et al., 2022). In other words, when mothers struggled to identify their infants' emotions, it was difficult for them to conceptualize why their infant was crying so they could respond appropriately. As previously stated, postpartum depression is highly comorbid with symptoms of PTSS (Dekel et al., 2020). Because postpartum depression has been found to be commonly expressed alongside symptoms of PP-PTSD, future research may wish to directly explore the impact of PTSS on maternal bonding experiences postpartum, as well as if there are associations present between PP-PTSD and alexithymia.

Another facet of social relationships that has been examined within the literature is the role of maternal attachment styles on mother-infant bonding (Hairston et al., 2018). Utilizing a sample of 114 women, mothers 4 to 12 weeks postpartum were measured on their attachment styles, as well as symptoms of postpartum depression and PP-PTSD (Hairston et al., 2018). Evidence emerged that women who endorsed PP-PTSD symptoms were more likely to engage in avoidant attachment styles, resulting in elevated scores related to rejection and anger (Hairston et al., 2018). Avoidant attachment styles are characterized by individuals who act independently of others and devalue the importance of social relationships (Hairston et al., 2018). Further, individuals who engage in avoidant attachment behaviors typically maintain negative evaluations of others and deactivate their own attachment behaviors (Hairston et al., 2018). In the context of Hairston et al.'s (2018) study, mothers employing this attachment style may have felt rejected and distant from their infants, as they find it difficult to conceptualize the value their bond holds. These mothers were theorized to also experience elevated levels of anger and discomfort when their infants vocalized distress, thus increasing the distance in their bond (Hairston et al., 2018).

As seen within the literature, mothers who report psychopathological symptoms during the postpartum period struggle to cultivate meaningful bonds with their infants. Social support appears to predict similar outcomes for both PP-PTSD and C-PTSD, providing protective buffers for the development of PTSS following a traumatic life event, such as a difficult childbirth. Because the nature of the maternal role is one that is highly social, as evidenced by the importance of the mother-infant bond early on in the postpartum period, a mother who struggles with maintaining and creating supportive bonds with others may have poorer psychological outcomes similar to those with C-PTSD diagnoses.

Conclusions

Within the present paper, PP-PTSD outcomes have been viewed within the scope of C-PTSD's diagnostic guidelines, as outlined within the ICD-11 (Cloitre, 2020). Through this comparison, it is clear that the complexities of motherhood following traumatic childbirth experiences are best captured through these guidelines. Much of the postpartum research utilizes diagnostic criteria from the DSM and focuses on postpartum depression as opposed to PP-PTSD, however there is much room to grow in this area of interest. By utilizing ICD-11 diagnostic guidelines, there is the potential to obtain a clearer understanding of women's experiences with PP-PTSD, which is oftentimes complicated by social, cultural, physical, and emotional changes characteristic of motherhood.

Motherhood in itself is a profound developmental period characterized by intense changes within the mother's internal and external worlds. When compounded by negative, particularly traumatic, childbirth experiences, mothers may experience symptoms related to PTSS, signifying lower emotional and physical well-being. These negative outcomes hold significant implications for not only the mother's self-identity, but also the development of the bond with her child and her other interpersonal relationships. However, this area of research is now only gaining the attention it requires. The phrase "Left on Delivered" illustrates a clear picture: women, after giving birth, hold sociocultural expectations of themselves as mothers that they must uphold in order to be seen as a "good mother." The "good mother" is instinctively nurturing, prioritizes her child above everyone and everything else, and devotes all of herself to her maternal role. If a woman experiences a traumatic delivery of her child and subsequently looks down on herself for not succeeding in her maternal role from the very beginning, it may be likely that she may view herself differently from this image of the "good mother." This realization alone can be distressing for her. By comparing herself to an unrealistic expectation of the "good mother," it is likely she may experience a disruption in her maternal identity, which may have a snowballing effect on her psychological and physical well-being. With this in mind, she may not be equipped to effectively tackle her role as a mother as a result of her comparison to an unrealistic standard. In line with C-PTSD, individuals with these diagnoses typically experience their symptoms in a variety of settings. This is also true of a mother's struggle to handle her maternal role, especially when she holds a negative self-identity. Mothers often adjust to their maternal role amongst juggling professional obligations, other interpersonal connections beyond the bond with her child, and her own physical health following a traumatic childbirth. As a result, it may be possible that she may find herself struggling in domains outside of her internal experience. In other words, within her interpersonal and professional settings, her lack of self-esteem and disorganized self-identity may hold significant implications in her ability to maintain the meaningful relationships that are important to her, as well as keep up with the responsibilities expected of her in the professional realm. Many mothers, when coming to the realization that they are struggling to juggle multiple identities and, particularly, are struggling to come into the "good mother" expectation they hold dear, may isolate themselves from their social support system. These mothers may feel guilty, inadequate, and not fit for the maternal role. "Left on Delivered" suggests this isolation from her social supports, disorganization of the self, and difficulty with coming to terms with the traumatic experience that was meant to be one of profound happiness. The phrase illustrates the bleak reality these women face when coming to terms with the complicated, difficult, and isolating role that is a mother who does not perceive herself fitting the "good mother" mold.

It is through this understanding that better support can be provided to mothers who experience traumatic deliveries of their children. Seeing as PTSS have drastic implications in multiple dimensions of a woman's life, it is crucial to understand how these symptoms manifest within the context of traumatic childbirths and how the intensity of these symptoms can be mitigated. There has been a spotlight on PP-PTSD within psychological research in recent years, and the diagnosis has been garnering more attention worldwide. Therefore, this is the perfect time to reconsider the diagnostic criteria of PP-PTSD, along with its complexities and effects that carry across multiple domains, including her relationship with her infant and her other social supports. The recognition of PP-PTSD within a lens that is representative of its social, psychological and physical complexities is crucial to supporting mothers during the pivotal and vulnerable stage that is the postpartum period. Without a clear picture of all of the factors that compound and aggravate the fallout following the experience of trauma, it is impossible to identify the resources necessary to support these women.

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