Western Graduate&PostdoctoralStudies

Western University
Scholarship@Western

Electronic Thesis and Dissertation Repository

4-19-2018 9:00 AM

Post-Traumatic Growth and Pregnancy: Exploring the Experiences of Survivors of Child Sexual Abuse

Alexandra Canzonieri
The University of Western Ontario

Supervisor
Dr. Susan Rodger
The University of Western Ontario

Graduate Program in Education
A thesis submitted in partial fulfillment of the requirements for the degree in Master of Arts
© Alexandra Canzonieri 2018

Follow this and additional works at: https://ir.lib.uwo.ca/etd

Part of the Counseling Commons, and the Counseling Psychology Commons

Recommended Citation

Canzonieri, Alexandra, "Post-Traumatic Growth and Pregnancy: Exploring the Experiences of Survivors of Child Sexual Abuse" (2018). *Electronic Thesis and Dissertation Repository*. 5323.
https://ir.lib.uwo.ca/etd/5323

This Dissertation/Thesis is brought to you for free and open access by Scholarship@Western. It has been accepted for inclusion in Electronic Thesis and Dissertation Repository by an authorized administrator of Scholarship@Western. For more information, please contact wlswadmin@uwo.ca.

Abstract

Eighteen women in their second trimester of their first pregnancy who were survivors of childhood sexual abuse, and between the ages of 19 to 48 years old, were interviewed. Each participant was asked a series of questions including their thoughts about becoming a mother and how their lived experiences have changed their perception about raising a baby, their hopes for their baby and how their own beliefs have changed. A thematic analysis was conducted on 18 verbatim transcripts. Transcripts consisted of 120 statements that were coded into 4 major themes. The current research identified four major themes including Change in Perception, Personal Growth, Hope for Child and Spirituality and their subthemes. Results are framed using the Post Traumatic Growth Framework (Tedeschi & Calhoun, 2004). Implications for research and practice are offered.

Keywords: posttraumatic growth, trauma, pregnancy, child sexual abuse

Acknowledgments

Firstly, I'd like to thank Dr. Susan Rodger for all of your patience and guidance. Through your continuous support and wealth of knowledge, I've learned an immense amount throughout this process and appreciate every step of this journey with you.

I would also like to sincerely thank my thesis committee member, Dr. Jason Brown for devoting your time to this project. I am grateful for all of your feedback and for providing a fresh perspective.

I send out a special thank you to the courageous women who participated in this research. Your powerful words have resonated with me deeply and I will always remember your incredible strength and resilience.

Lastly, I would like to thank my support team for being there through thick and thin. Thanks mom and dad for your encouraging words and positive attitude throughout this academic journey. Your hard-work and dedication has kept me motivated to work through every challenge I've ever faced. I'd like to thank my counselling colleagues for all of the laughter, cries and support. I am so grateful to have formed such a strong bond to you and will never forget all the wonderful things that you've taught me. To my partner in crime, Gianluca, I owe you the world. Thank you for being there every step of the way and always showing me a new way to look at things.

Table of Contents

	Page
Abstract	i
Acknowledgment	ii
Table of Content	iii
List of Appendices	v
Chapter 1- Literature Review	
1. Introduction	
The Trauma Model	7
Post-traumatic Growth (PTG)	9
Women Sexual Assault Survivors and Passage of Time	12
Women CSA Survivors and Meaningful Milestones	15
Women CSA Survivors and Pregnancy	17
Next Steps Investigating Women CSA Survivors and PTG	20
Feminist Theory	20
Female Principles Concurrent with Present Study	21
Survivor Vs. Victim	22
Chapter 2- Method	
1. Method	
Grounded Theory	22
Secondary Data	23
Secondary Analysis	24
2. Participants	25
3. Procedure	25
4. Ethical Consideration	27
Chapter 3- Results	
1. Methodological Trustworthiness	28
2. Theme 1: Change in Perception	30
Subtheme 1: Relief and Acceptance	31
Subtheme 2: Finding New Meaning Through Tasks and Hobbies	32
Subtheme 3: Not Sweating the Small Stuff	32
Subtheme 4: Change in Attitude Towards Past Relationships	33
Closeness to Others	33
Anger Towards “Protective Figure” (Parent)	34
3. Theme 2: Personal Growth	34
Subtheme 1: Newfound Resilience	35

Subtheme 2: Self-confidence 36
Subtheme 3: Thinking of Self/Self-improvement 37
Subtheme 4: Confronting and Coping with the Trauma 37
4. Theme 3: Hope for the Child 38
Subtheme 1: Thinking of Future and Long-term Goals 39
Subtheme 2: Newfound Strength (Protection Towards Others) 40
Subtheme 3: Thinking and Loving Beyond Self 41

5. Theme 4: Spirituality 42
Subtheme 1: Deeper Connection to Faith 42
Subtheme 2: Divine Intervention 42

Chapter 4- Discussion

1. Theme 1: Change in Perception 47
Finding New Meaning Through Tasks and Hobbies 47
Change in Priorities 48
Change in Attitude Towards Past Relationships 48

2. Theme 2: Personal Growth 50
Newfound Resilience and Self-confidence 50
Confronting Past Trauma 52
3. Theme 3: Hope for the Child 55
Thinking of Future and Long-term Goals 55
4. Theme 4: Spirituality 57
Deeper Connection to Faith 57
5. Limitations 58
6. Strengths 59
7. Implications for Counselling 59
8. Implications for Research 60
9. Conclusion 61

References 62

Appendix 71

List of Appendices

Appendix	Title	Page
Appendix A	Ethical Approval	66
Appendix B	Four Major Themes Including Subthemes and Significance of Each One	68

Post-Traumatic Growth and Pregnancy: Exploring the Experiences of Survivors of Child Sexual Abuse

Child sexual abuse (CSA) is a significant issue that can affect the survivor's long-term psychological and physical outcome. Women survivors of child sexual abuse have been found to suffer more from psychological distress including post-traumatic stress and depression, as compared to men who have experienced CSA (Putnam, 2003). Although each individual responds to trauma differently, there is research suggesting that certain life events, such as pregnancy may be triggering for women survivors of CSA, given the invasiveness of pregnancy care and child labor (Yampolsky, Lev-Wiesel & Ben-Zion, 2010). There are some important connections between the experiences of childhood sexual abuse and transition to motherhood that will be explored here.

Despite much of the research focusing on the negative impact of CSA on women survivors, the unexpected outcomes of trauma can also lead to the potential experience of positive psychological changes known as post-traumatic growth (PTG). Given the research regarding the process of post-traumatic growth, as well as the high prevalence of mental health diagnoses among women survivors of childhood sexual abuse, it would be interesting to examine how the event of pregnancy and motherhood, a meaningful milestone for many women (Berman et al., 2014), can positively influence the processing of trauma.

Introduction

In 2012, the incidence of child sexual abuse was reported at the rate of 205 victims for every 100,000 people in Canada, with children and youth more frequently victims of sexual offences than adults (Statistics Canada, 2012). A province-wide health

survey of children aged 4 to 16 years in Ontario has found that females reported significantly more CSA (22.1%) than males (8.3%) (MacMillian, Tanaka, Duku, Vaillancourt & Boyle, 2013). According to the Canadian Incidence Study of Reported Child Abuse and Neglect (2008), child sexual abuse was identified as the primary maltreatment form in 3% of investigations. In 44% of these cases, emotional harm was sufficiently severe to require treatment, although it is likely that many more sexually abused children may have been harmed in a way that was not readily apparent (Trocme et al., 2008). The negative psychological and physical impacts of such experiences have been comprehensively examined in clinical and institutional populations and has found CSA to be a major risk factor for developing post-traumatic stress disorder (McElheran et al., 2012). Additionally, early studies have demonstrated evidence linking child sexual abuse to mood disorders. For example, Fergusson et al. (1996) followed a birth cohort of 1000 New Zealand children and found that compared with the non-abused children, children with a history of non-intercourse CSA had an increased odds ratio of 4.6 for major depression. Those with a history of child sexual abuse had an increased odds ratio of 8.1 for major depression and 11.8 for a suicide attempt. More recent studies have found CSA may result in symptoms of severe emotional distress followed by clinical diagnoses of post-traumatic stress disorder (PTSD) and major depression (Hahm, Lee, Ozonoff, & Van Wert, 2010).

Moreover, McElheran et al. (2012) have described other studies that have found numerous psychiatric difficulties in adulthood following CSA such as depression, anxiety, somatic complaints, social withdrawal as well as academic and cognitive difficulties (Molnar, Buka & Kessler, 2001; Margolin & Gordis, 2000). Recent research suggests that mental health diagnoses such as PTSD may serve as the mediating link

between mental health issues and physical health problems, as many of these problems co-occur (Zinzow et al., 2011). However, several other factors affect a survivor's experience with CSA, how these effects transfer into an individual's daily life and how one copes with the sequelae.

CSA may affect an individual's emotional well-being as some survivor's experience intense feelings of shame, guilt and self-blame. In fact Herman (2013) refers to it as the "shame diagnosis" given that these particular trauma experiences are based in a power imbalance of domination and submission (Munzer, Fegert, Goldbeck, 2016). The feeling of self-blame reported by survivors plays an essential function in coping with trauma as it provides survivors with a sense of control over the situation. Herman (2013) explains the purpose of self-blame as allowing the survivor to take control over the re-occurrence of future events. Rather than surrendering to the role of victim, a survivor will replay the scenario in her mind and find certain behaviors that she can change to prevent the event from happening again. This is important in understanding the persistence of self-guilt and the protective role it serves for a survivor following a sexual assault (Moor, 2007).

The power and use of language is noted here, and the importance of ascribing descriptive terms to people's lived experience is acknowledged. The terms 'survivor' and 'victim' are contested terms is both the practice and research literature; here, the words of participants themselves were used as the guide to include these terms within the current work. This is addressed more fully, later in the paper.

Rape in childhood goes beyond the definition of a physical assault; it is a violent infraction of a survivor's personal boundaries and dignity (Herman, 1992). Throughout childhood, the development of trusting relationships helps to establish a perception that the world is a trusting place in which people respect other people's boundaries and

appreciate one another's self-identities. However, this sudden intrusion into one's personal space shatters this positive worldview and threatens one's sense of autonomy and control over their body while creating a sense of constant vulnerability (Herman, 1992). By assessing the types of losses associated with CSA, Bourdon and Cook (1993) found that CSA survivors perceived loss of trust, self-love and self-identity attributed to the event to be the most difficult losses of CSA.

This sense of loss may have a significant impact on a woman's ability to cope with CSA later on in life, interfering with the development of a healthy sense of self-worth. For example, women survivors of CSA who have experienced a sense of loss may have a higher propensity to engage in avoidance coping (Murthi & Espelage, 2005). Avoidance coping can include social withdrawal and isolation from friends and family, ruminative thinking or self-destructive/ harmful behaviors (Cole & Lynn, 2011). Social isolation can be detrimental to the development of self-worth, as the validation and support from peers are essential for influencing an individual's perception of self (Murthi et al., 2005). Additionally, avoidance coping may lead to long-term feelings of anger, which may manifest into aggression towards peers or within other contexts such as driving or work life. (Estevez, Ozerinjauregi & Herrero-Fernandez, 2016). Displaced anger may arise from a child's inability to cope with anger, primarily from a lack of parental guidance or role model (Estevez et al., 2016). Although avoiding the negative emotions associated with trauma may temporarily reduce the negative psychological consequences, it may become problematic for long-term coping and development of self later on (Snyder & Pulvers, 2001) A low sense of self-worth may lead to further issues in

forming trusting relationships with others, becoming emotionally intimate with a partner and the ability to disclose the abuse to family, friends and therapists (Murthi et al., 2005).

The emotional consequences of CSA associated with a sense of loss may also interfere with a survivor's ability to disclose their experience and actively seek support for coping with the trauma. Nondisclosure has been associated with negative psychological consequences as a result of ruminating on the event or actively ignoring emotional reactions to it (Ahrens, Stansell & Jennings, 2010). Seeking social support and connecting with others is important in maintaining a healthy self-esteem, thereby reducing a woman's sense of loss (Ahrens et al., 2010). Social support also provides a sense of reassurance for a survivor learning to trust again (Ahrens et al., 2010). Additionally, Ahrens et al. (2010) found that disclosure may mitigate the drain of the cognitive energy required to suppress thoughts and negative symptoms associated with trauma. Thus, disclosure and social support can mediate the psychological impact of CSA including symptoms of depression, PTSD and other psychiatric diagnoses related to CSA (Ahrens et al., 2010).

Another important sequealae and one of particular importance here, is the effect of CSA in women's emotional, psychological and reproductive health (Lemieux & Byers, 2008). Some studies have found an association between CSA and unsafe sexual behavior in women including consensual sex at an earlier age, a higher frequency of unprotected sex and a higher likelihood of contracting a sexually transmitted disease (Lacelle, Hebert, Lavoie, Vitaro & Tremblay, 2011). Early sexual behavior in CSA survivors may be attributed to a survivor's desire to establish control for her own sexuality and the feelings of abuse through the power of consent (Lacelle et al., 2011) Additionally, some women

who have experienced CSA may experience less pleasure from sex as well as more gynecological problems (Coker, 2007; Lemieux & Byers, 2008). Some women survivors of CSA learn to perceive their body image negatively and associate their body as an object to be used by others, and can develop a skewed perception of proper boundaries, appropriate sexual behavior and attitudes towards sex. A combination of feelings of low self-worth along with emotional vulnerability may explain why women survivors of CSA, compared to non-abused women, are twice as likely to get pregnant in young adulthood (Kilpatrick, Saunders & Smith, 2003).

Pregnancy, in general, is a significant life transition that constitutes a drastic psychological adjustment and is often related to high levels of stress (Elsenbruch et al., 2007). Pregnancy may entail a variety of emotions including ambivalence, fear of the inability to cope with the pregnancy as well as adapt to the changes associated with the progression of pregnancy (Chang, Chen & Huang, 2008). Anxiety may manifest itself through stress and is a predominant mood during pregnancy (Cox, 1994). It is important that women have psychosocial resources including stable social support to offset the negative impact of stress on emotional well-being (Glazier et al., 2004). Importantly, medical practitioners and others supporting women have an opportunity to provide resources to women that may be helpful during pregnancy (Berman et al., 2014). Thus, frameworks should be established to help practitioners and researchers understand the relationship between CSA, physical and reproductive health as well as mental health. Furthermore, rather than focusing solely on diagnoses and deficiencies, integrating strength-based approaches may be beneficial for fostering the relationship between women survivors and health care professionals (Berman et al., 2014).

The Trauma Model

Some children who are abused live in a constant fear of violence and helplessness. As described by Rodger and Leschied (2012), the long-term effects of child sexual abuse (CSA) are highly influenced by two factors: the frequency of victimization as well as relationship of the perpetrator to the survivor (cited in Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). If the perpetrator is someone in a position of trust, the survivor may have difficulties establishing open and trusting relationships in adulthood (Rodger & Leschied, 2012). Statistically, the majority of perpetrators are those familiar to the victim; in fact, 40% of the perpetrators of CSA are relatives of the child (Rodger & Leschied, 2012). The complexity of this form of trauma develops as the child attempts to silence the inner conflicts within, striving to form a trusting bond with the untrustworthy caretakers (Herman, 1992). Yearning for stability and safety, the child will try to convince him- or herself that the abuse did not occur in order to preserve the attachments to their abuser. Engaging in psychological defenses such as minimizing or suppressing the abuse, learning to ignore the severe pain, allows child survivors to dissociate themselves from the trauma (Herman, 1992).

Similarly, CSA survivors may develop pathological attachments to those who abuse them to protect their inner representations of dependable caretakers, even at the sacrifice of their own welfare. As stated earlier, children exposed to CSA are often engaged in finding ways to justify the situation to preserve their perception of having trustworthy parents or caregivers. In an effort to maintain a sense of safety, they may cling onto external sources of comfort, which may then include the abusive family member who is also a caregiver to the child. This may severely impact the child's

physical health as they attempt to maintain homeostasis in a chaotic environment (Herman, 1992).

Current research has found that CSA has variable effects on development depending on the age of abuse, and examining the developmental trajectory of CSA has been helpful for both research and practice (Andersen et al., 2008). Neurologically speaking, different sections of the brain may be altered at different sensitive periods, such as a reduction in hippocampal volume when CSA occurred between ages 3-5, and pre-frontal cortex changes when the abuse took place between 14-16 years old (Andersen et al., 2008). Therefore, depending on the age of child at the time of the abuse, the impacts and trajectories of this traumatic experience may vary.

Women, in particular, have a higher risk of developing mental health diagnoses including post-traumatic stress disorder (PTSD), and mood disorders such as depression and suicidal ideation than male survivors of CSA (Putnam, 2003). Research that has studied samples of women who are survivors of CSA have found that this connection may be attributed to difficulties regulating affect (Blalock et al., 2013), problems with interpersonal relating (leading to insecure adult attachments) (Grote et al., 2012) and negative assumptions regarding self (Blalock et al., 2013). Not only are women who have experienced CSA 3-5 times more likely to experience depression, the symptoms of depression differ from those who have not experienced CSA (Putnam, 2003). A study by Levitan et al. (1998) found that women who experienced CSA displayed symptoms of increased appetite and hypersomnia as compared to women without a history of CSA. Further, women who experienced CSA reported higher levels of psychological impairments, and were also twice as likely to report gastrointestinal issues such as nausea

and abdominal pain (Leserman, 2005) as well as disturbance of normal sleep patterns (Putnam, 2003).

Although the topic of pregnancy and CSA survivors will be discussed further in a subsequent section, it is important to recognize that CSA survivors experienced higher levels of distress and dissociation before, during and after childbirth than women who had not experienced this form of trauma (Lev-Wisel, Daphna-Tekoah & Hallak, 2009). Survivors of CSA may also experience emotion deregulation and experiential avoidance from dissociating (Polusny, Rosenthal, Aban & Follette, 2004). Higher levels of distress may be attributed to an increase in feelings of helplessness and lack of control during labor resulting in a longer delivery that is more physically and emotionally painful (Lev-Wisel, Daphna-Tekoah & Hallak, 2009). Thus, childbirth may trigger memories associated with CSA, by provoking fear and greater levels of anxiety throughout pregnancy (Lev-Wisel, Daphna-Tekoah & Hallak, 2009).

Post-traumatic Growth (PTG)

Tedeschi and Calhoun (2004) describe the concept of suffering possibly resulting in growth to be a major theme in ancient teachings and religions. For example, in the Christian faith, crucifixion of Jesus Christ symbolizes the power of his suffering to change others. Additionally, finding meaning through human suffering is a theme popular in philosophical discourses, scientific research and psychology (Tedeschi & Calhoun, 2004). Most recently, the focus on understanding how people can live meaningful and fulfilling lives despite major life crises has become a popular area of study with the emergence of positive psychology (Seligman & Csikszentmihalyi, 2000).

PTG refers to the positive psychological changes experienced following a struggle

with a crisis (Tedeschi & Calhoun, 2004). It is not a direct result of the trauma, but an individual's understanding and acceptance of their new reality. PTG can be described using factors included in Tedeschi & Calhoun's (1996) self-report measure, the Post-Traumatic Growth Inventory (PTGI). Increased appreciations for life, closer relationships with others, change in spiritual understanding, realizing new possibilities as well as a changed sense of what is important may occur. This may include a modification in priorities such that certain things that were taken for granted before, may have gained a newfound importance. Additionally, a more intimate bond with another person can also be part of the process of growth, as one may realize that certain relationships with people are now important. Another contributing factor to growth include the increased sense of personal strength or one's ability to recognize their internal strength to the point that issues considered a big deal in the past, are no longer an issue. Similarly, even individuals who are not religious can experience growth by engaging in existential questioning (Tedeschi & Calhoun, 2004).

PTG may be an ongoing process as various factors interact with eachother to influence the experience of growth; including personality characteristics, tools for managing emotions and having a strong circle of support may aid in the process of PTG (Tedeschi & Calhoun, 2004). Research using the PTGI has found that two personality traits: openness and extraversion correlated with PTG. Tedeschi & Calhoun (2004) explain that individuals with higher levels of these traits may be more receptive to positive emotions, even in the face of adversity. This in turn may help to process the event more effectively leading to a change in schema.

According to this framework cognitive restructuring resulting in change in

schemas is necessary for growth to occur. Following a major life crisis, individuals may try to identify ways to manage levels of distress. Although this process can be exhausting, it may lead to disengaging from previous goals and working towards new, more feasible ones (Tedeschi & Calhoun, 2004). Further, disclosure of the event to supportive others may also aid in cognitive restructuring (Tedeschi & Calhoun, 2004). Disclosing one's story can help shape the narrative about the different changes that have occurred and integrate this into one's schema. Additionally, disclosing and listening to other trauma survivors can provide new perspectives and find new meaning through these events (Tedeschi & Calhoun, 2004).

It is important to understand what the term *post-traumatic growth* captures that other relating concepts may not. Unlike terms such as "stress-related growth" that focuses on decreasing levels of stress, PTG refers to a psychological transformation following a trauma entailing more than symptoms of stress. Contrary to words such as *flourishing,* PTG describes the fundamental changes in one's self-concept and the ability to reorganize one's sense of self and worldview (Tedeschi & Calhoun, 2004). Likewise, it refers to one's personal development following a trauma that exceeds the changes present prior to experiencing the crisis. Unlike *resilience,* which refers to the ability to "bounce back" from an adverse event, PTG is not a return to baseline, but a profound transformation from it (Tedeschi & Calhoun, 2004). PTG is distinct from *optimism* as well, which is one's anticipation of positive outcomes. Although these may be traits conducive to experiencing PTG, they are not interchangeable terms. However, they may promote the willingness to transform and a capacity to cope with trauma (Tedeschi & Calhoun, 2004). Thus, PTG refers to the ability to deal with a trauma in a meaningful

manner and may constitute a variety of characteristics such as optimism and resilience to do so.

Additionally, it is important to recognize that PTG may be a construct more applicable to adults than to children, as PTG refers to the shattering of well-developed schemas to build new ones. Although traumatic experiences may shatter positive assumptions including a positive view of self or the perception of the world as a meaningful place, different factors following a trauma may help reorganize one's worldview to restore a positive perception (Shakespeare-Finch & Dassel, 2009). Specifically, young adults may report higher levels of growth, given their openness to change and to learning (Tedeschi & Calhoun, 2004).

Furthermore, current research in the area of CSA has not addressed the process of positive change following this form of trauma. The following review will discuss current literature examining the psychological consequences of CSA on women, different factors of post-traumatic growth (PTG), as well as identifying the next steps to investigate the positive growth in pregnant women who have experienced CSA. Given the evidence supporting the detrimental effects of child sexual abuse, specifically on women, research in the area of positive growth from trauma is imperative for a well-rounded treatment and for the prevention of several long-term physical and mental disorders.

Women Sexual Assault Survivors and Passage of Time

Grubaugh and Resick (2007) investigated how the passage of time after experiencing a trauma influences the longer-term effects and perceptions. This study used the Post-Traumatic Growth Inventory (PTGI) (Tedeschi & Calhoun 2006) to examine the relationship between growth outcomes and symptom severity. Researchers examined

perceived changes in the self such as increased self-worth, changed relationships with others, heightened awareness of new possibilities and greater appreciation of life in 100 female survivors of sexual and physical assault seeking treatment. Participants were included if they experienced the assault a minimum of three months before commencing the study. Grubaugh et al. (2007) administered the Posttraumatic Growth Inventory along with other self-report measures assessing PTSD, depressive symptoms and mood disorders. This study was non-experimental, with all interviews conducted in a controlled setting by a trained clinicians experienced in the field of mental health.

Results indicated that symptoms of growth, as well as symptom severity, might be independent of one another, raising some interesting possibilities for their co-existence. Tedeschi and Calhoun (2004) describe posttraumatic growth as a process that arises from negative circumstances that elicit psychological distress. Individuals who face highly stressful events experience distressing emotions such as persistent anxiety (for long periods of time following the event), sadness (loss of something or someone important), irritability, guilt and/or anger. Events that threaten a person's physical well-being can lead to initial feelings of disbelief and intrusive thoughts. Rumination of intrusive and disturbing images may continue long-term after the event has occurred. The body may continue to experience high levels of stress as a result of prolonged activation of bodily systems. This may include muscle tension and pain, gastric and digestive issues and overall physical discomfort (Tedeschi & Calhoun, 2004). As the symptoms of trauma continue long after the event has occurred, dysfunctional patterns of thinking and psychological distress increase the risk of developing psychiatric problems (Tedeschi & Calhoun, 2004). Clinically speaking, trauma has been perceived as an experience that

results in psychological difficulties. However, suffering can lead to the possibility of positive change and the ability to cope with the crisis effectively (Tedeschi & Calhoun, 2004).

It is important to understand the processes of negative responses to highly stressful events in order to recognize the psychological processes involved in producing positive changes. Depending on the intensity and duration of a threat, anxious responses can persist for various lengths of time after. However, PTG occurs simultaneously with the attempts to adapt to stressful circumstances that trigger anxiety. The cognitive processing apparent in psychological disorders such as depression may actually be a component in post-traumatic growth as well. The difference however, lies in the survivor's reflection of past goals that may have been possibly attained in the past, but no longer viable in the present. Rather than focusing on one's failures or inability to accomplish goals created in the past (rumination in depressed individuals), a survivor will differentiate between feasible goals prior to the trauma and following it. By detaching from the unattainable goals from the past and realizing that life after the trauma cannot accommodate these goals and thus new goals must be formed, the survivor's worldview has changed (Tedeschi & Calhoun, 2004).

Current studies have supported the claim that processing the trauma through rumination can lead to PTG. A study involving 592 undergraduate students who completed a baseline survey as well as a follow-up survey 2 months later, aimed to examine pre-trauma psychological factors correlated with PTG. Consistent with the literature, researchers found that pre-trauma rumination affects PTG through cognitive processing (Su & Chen, 2015).

Although Grubaugh and Resick (2007) failed to mention how many years passed after the trauma occurred in this sample, results indicated that passage of time since the trauma happened might affect one's perception of the event in a positive way. Findings revealed that older individuals reported more growth from adverse experiences. Thus, the more time that passes since the event, the more likely the individual's memory and attitude towards the event will change (Grubaugh & Resick, 2007). However, passage of time does not necessarily determine that a positive change in perception will ensue, as individuals may also learn to perceive the event in a negative light by experiences following the trauma. Alternatively, research has found that individuals who have experienced a trauma between the ages of 10-30 years are more likely to incorporate these memories into their self-concept, as this is a crucial time for the development of self-identity (Sutherland & Bryant, 2005). Therefore, individuals who have experienced a trauma in childhood may be more likely to define themselves based on the trauma and focus on goals or expectations that revolve around the trauma. Thus, it is essential to examine events that happen following a trauma that are significant enough to shape the developing self into an identity separate from the trauma. Several events post-trauma may influence an individual's perception of the self, including positive or negative experiences, strong or weak social support (Putnam, 2003), attitude towards the perpetrator and event, development of coping mechanisms as well as meaningful life events (Tedeschi & Calhoun, 2004).

Women CSA Survivors and Meaningful Milestones

In psychotherapy, victims and survivors are often exposed to the memories of trauma in order to allow clients to process the incident, the feelings and emotions elicited

from the trauma and the aversive thoughts and images related to the traumatic information (Battern, Orsillo & Walser, 2005). In order to successfully move forward, an individual who has experienced a traumatic event must confront the painful reactions associated with the traumatic memory and learn to separate these unwanted thoughts of self-doubt, guilt and shame from their self-concept (Kashdan & Kane, 2010). Likewise, an individual must use psychological flexibility, which is the ability to adapt to fluctuating environmental changes and alter their perspective (Hayes et al., 2006). Contrary to psychological flexibility, experiential avoidance refers to the avoidance of triggering memories, feared thoughts and emotions associated with a trauma (Barlow, 2000). Using self-report measures, Kashdan and Kane (2010) compared how experiential avoidance and psychological flexibility in a sample of 176 college students who reported at least one traumatic event in their lives, would influence the development of PTG. The self-report measures examined number of traumatic events, post-traumatic distress, experiential avoidance, meaning in life and PTG.

The authors concluded that college students who used experiential avoidance to cope with a trauma reported post-traumatic distress not associated with PTG and higher well-being. Using regression analysis, they also found that individuals who reported greater distress and less experiential avoidance also reported the greatest growth and meaning in life (Kashdan & Kane, 2010). Thus, confronting stressful experiences and the negative thoughts and feelings associated with them may provide the opportunity for individuals to find meaningful interpretations of the event and integrate the changes into their personal framework resulting in growth (Lepore, Ragan & Jones, 2000). Likewise,

theories of development have acknowledged that some level of distress following a trauma is essential for restructuring one's sense of self (Tedeschi & Calhoun, 2004).

This awareness, openness and determination from a survivor to confront the issue, may also be motivated by the desire to move forward towards valuable goals (Kashdan & Kane, 2010). Nonetheless, it is important to consider populations other than well-adjusted college students in the study of post-traumatic growth and meaning. School may be a valuable goal for several individuals as well as an incentive to move forward and pursue this goal, but this may not be generalizable to the rest of the population. Despite this sample being limited to college students, varying forms of trauma experienced were reported (i.e., sudden death of a loved one, motor vehicle accident, witnessing violence in the home and natural disasters). The study used a measure to assess PTG (The Post-Traumatic Growth Inventory); however, there were no measures assessing different factors such as level of distress, spirituality, meaning of life, relationship with others, appreciation of life or other items in the PTGI prior to the traumatic event. Although growth cannot be adequately measured without the individual's baseline attitude prior to the trauma, the study did examine positive adjustment. Therefore, these findings provide support for current theoretical models that explain the role of experiential avoidance in diminishing well-being (Kashdan & Kane, 2010).

Women CSA Survivors and Pregnancy

Symptoms of CSA influence women's experiences of pregnancy and delivery. Seng et al. (2004) found that some participants demonstrated a higher tolerance to bodily changes associated with pregnancy than other women survivors. Participants presented a wide range of symptoms, each describing their own unique experience with re-

experiencing the trauma, hyperarousal symptoms, dissociation and interpersonal sensitivity. Additionally, another study by Smith et al. (2006) found that pregnant women who had experienced trauma reported less re-experiencing symptoms than non- pregnant trauma survivors. The researchers suggested there might be a biological basis to this, including fluctuating hormone levels throughout pregnancy, which may affect anxiety and memories of the event.

It is important to understand why some pregnant women who are survivors of child sexual abuse have reported higher levels of anxiety (Leeners,Richter-Appelt, Imthurn & Rath, 2006) as compared to their non-abused counterparts, as well as a higher intolerance towards prenatal care and examinations (Yampolsky, Lev-Wiesel & Ben-Zion, 2010). The high prevalence of depression in CSA survivors may affect a women's motivation to seek out support throughout pregnancy, attend appointments and properly nourish herself and her baby (Spinelli, 1997). Additionally, prenatal care such as vaginal examinations may trigger traumatic memories of sexual abuse. Thus, CSA survivors may be more reluctant to attend doctor appointments (Seng & Hassinger, 1998). Yampolsky et al. (2010) administered a self-report questionnaire consisting of five scales measuring CSA experiences, traumatic events, depressive symptoms, post-traumatic stress disorder symptom and demographics to 1835 Jewish women living in Israel. The sample was also divided into 3 groups: those who reported a history of CSA, those who experienced a trauma other than CSA and those that reported no trauma. Following the questionnaires, participants were invited for a one-hour interview. The researchers found those who suffered from CSA had fewer children than women who experienced other forms of trauma, and posited that this may have been related to the triggering effects of sexual intercourse, as well as lack of prenatal care. Additionally, results indicated that CSA

survivors were twice as likely to have high levels of post-traumatic stress and depressive symptoms as compared to the two other groups. Likewise, participants who suffered from CSA were more likely to dissociate from the experience by employing avoidance tactics such as skipping doctor appointments (Yampolsky et al., 2010).

It is important to consider limitations in the methodology of this study when interpreting the results. The sample size consisted solely of Jewish women in Israel, which may only be representative of this culture. Israel is a collectivist culture, which may hold a different attitude towards CSA from individualistic cultures. Research has shown that prevalence of CSA is lower in collectivist cultures, which has been attributed to an individual's avoidance of speaking out about their experience with CSA for fear of shaming the family (Stoltenborgh, Ijzendoorn, Euser & Bakermans-Kranenburg, 2011). Despite these differences, Israel's population is quite heterogeneous, and includes people from more than 70 countries and ethnicities (Yampolsky et al., 2010). The impressive sample size (unlike other studies that have used quantitative methods in this area of study) is important and allows for the between-group analyses. One of these groups included a control group that allowed the researchers to compare the experimental groups to a baseline in order to determine whether the variable in question really did have an effect on individuals.

This study confirms popular research in the area of CSA and women's health as well as emphasizes the importance of psychoeducation with healthcare professionals working with survivors of CSA. The present study found that pregnant survivors of CSA suffer high levels of distress increasing poor health and avoiding healthcare. Future studies may focus on the way healthcare professionals address the psychological state of pregnant CSA survivors, recognizing the unique concerns of women survivors and offering emotional support and assistance to pregnant CSA survivors exhibiting post-traumatic symptoms and avoidance.

Although the study was well controlled using a large sample size, mixed methods and highly valid and reliable self-report measures, not every child suffers detrimental consequences from CSA and may actually experience a positive transformation known as post-traumatic growth (PTG) (Tedeschi & Calhoun, 2004).

Next Steps Investigating Women CSA Survivors and PTG

Much of the research investigating the effects of CSA and PTG use quantitative self-report measures. This may be problematic for a number of reasons, including measurement issues, self-report biases and experimenter effects. Additionally, self-report questionnaires may not grasp the depth of each individual's journey from childhood trauma to post-traumatic growth, including meaningful events in between.

Likewise, exploring PTG in a limited sample, such as in participants from a specific culture or religion, may dismiss important aspects of the process of PTG. Although Lee Yampolsky et al. (2010) found that pregnant women in Israel who experienced CSA also had higher levels of avoidance symptoms, there is scarce research conducted on PTG in pregnant women who have experienced CSA and the factors associated with this process. The following research aims to understand the profound stories of pregnant women who are survivors of CSA and have developed meaning from their transition into motherhood resulting into PTG. Based in feminist principles, the current research examines the subjective and distinct experiences of each participant who have shared their journey from childhood up until their first pregnancy.

Feminist Theory

Feminist research has provided the opportunity for women to focus on producing explanations for the patterns of injustice manifested in gender specific ways (Ackerly & True, 2010) and related to ignoring women's voices in the realm of scientific research

which has place limitations on women's participation (Mason & Berman, 2014). Thus, feminist theory is based on the conditions of previous research, influenced by feminist psychology and challenging misogynist norms that belittled female qualities and potential for far too long (Ackerly & True, 2010). Feminist research seeks to respect and empower women by understanding their point of view. Likewise, feminist theory is based on the position that less powerful groups live in a culture of dominant groups. These individuals have a more realistic worldview due to their vulnerable position (Campbell et al., 2000). This is developed through one's conscious awareness of the oppression and learning to navigate society with these struggles.

Female Principles Concurrent with Present Study

Combined with feminist principles, the present study has allowed each woman to speak about her subjective experiences in order to represent the uniqueness of each woman's story (Berman et al., 2014). Additionally, it has provided the opportunity to introduce social justice issues into mainstream awareness, such as identifying patterns in women's oppression (Undurranga, 2010). The role of the researcher is to produce knowledge to contribute to information on gender equality as well as reduce injustice. The knowledge collected is through women describing their own lived experience from their own context, rather than from an outsider's representation of a problem (Undurranga, 2010). The events of each woman's life allow researchers and readers to critically reflect, as well as broaden their understanding of the social world (Campbell & Wasco, 2000). Using a feminist lens, the current study seeks to identify unequal power relationships through this non-authoritarian approach. This study aims to learn about the impact of trauma in a vulnerable population, as women speak out about their experience

with violence. The current study will examine: 1) how pregnancy can facilitate the process of post-traumatic growth in women survivors of CSA 2) what factors are necessary to experience PTG in this sample of CSA survivors.

Survivor Vs. Victim

The terms “rape survivor” and “rape victim” carry different connotations that may influence the identity and outcome of women who have been raped (Hockett & Saucier, 2015). Research has found that the label of “victim” may indicate that the sexual incident is the predominant focus in the individual’s life (McCarthy, 1986). The current study used the term “survivor” to describe women who have experienced CSA as it focused on the positive physical and psychological outcomes of CSA, while still acknowledging the negative outcomes rather than solely focusing on the negative short-term and long-term impact of CSA. The term “victim” may be associated with weakness, vulnerability or a direct focus on the impact of the sexual trauma rather than from the positive transformation following it. This study aimed to highlight the strengths of the participants and how they feel they’re grown since the trauma. Thus, we believed that the term survivor appropriately described the participants in this study.

Method

Grounded Theory

The following study used data that has been collected using grounded theory methodology based in feminist theories in order to allow participants to openly discuss their history with child sexual abuse and how these experiences shaped their attitude towards transitioning to motherhood (Berman et al., 2014). Grounded theory, a qualitative research approach created by Barney Glaser and Anselm Strauss (1967) entails a constant comparative method. Specifically, identifying codes, categories,

properties and other parts of the data that will be compared with the rest of the data collected (Hallberg, 2006). These ideas and categories grounded in the data are identified through observation, not through any preconceived ideas introduced by the researcher. The approach involves intensive interviewing to provide a profound examination of a topic, as well as allowing the participant to reflect on his or her own experience (Hallberg, 2006). The participant plays an active role in the process, discussing their experiences in detail while the researcher facilitates the interview through probing and encouragement. Once data is collected, the coding process begins involving line-by-line coding to determine themes. Once themes are identified, relationships between concepts are investigated and a core category emerges. This core category is central to integrating other categories into a framework (Hallberg, 2006).

Secondary Data

The present study used data collected from Berman et al.'s (2014) study, "Laboring to Mother in the Context of Past Trauma: The Transition to Motherhood". This research examined how past trauma impacted the lives of women as they embarked on their new journey to motherhood. Additionally, the study aimed to understand how systemic experiences and societal definitions of "good mothering" can influence a woman's perception of motherhood. The study was primarily composed of CSA survivors, however, researchers were interested in interviewing women with diverse experiences and included Aboriginal women as well as refugee women. These women revealed the hardships endured navigating daily life including poverty, social isolation, and challenges in their interpersonal relationships. Despite these challenges, mothers conveyed a hopeful attitude towards their future and working towards society's idea of

being a “good mother”. Although many women described using coping mechanisms deemed by research as “maladaptive”, they demonstrated an incredible amount of strength and resourcefulness as they navigated through the turmoil of life (Berman et al., 2014).

Secondary Analysis

Throughout the interviews, field notes were made to aid in the analytical decisions of the research team comprised of professionals in the field of nursing, psychology and psychiatry. Audit trails were used to examine themes and concepts of the interviews in order to generate explanations derived from the data (Berman et al., 2014).

The present study has used thematic analysis to identify recurring themes in the transcripts based on Tedeschi and Calhoun’s (2004) theory of five major domains of PTG. Applying the PTG Framework, the present study examined the data to explore CSA survivors’ accounts of newfound personal strength (self-reliance and independence), increased spirituality or changes in life philosophy, increased awareness of new possibilities during their new transition into motherhood, greater appreciation for life and a higher ability to relate with others, related to their pregnancy.

The current research utilized Creswell’s (2003) six generic steps for data analysis. The first step involved organizing and preparing the data for analysis. This included transcribing interviews and organizing the data. The second step involved reading the data to gain a general sense of the meaning and reflect on what participants said. Thirdly, the data or statements in the transcripts were coded into meaningful groups. These codes addressed a larger theoretical perspective of PTG found in the literature. Fourth, the coding process was used to generate themes. Themes are the major categories in the

research that entailed different perspectives and examples to form subthemes. Fifth, the description of themes was connected to the theoretical framework by using a discussion of several themes. Lastly, the data analyses were interpreted to capture the essence of the idea. This included a personal interpretation of the data based on my own experiences, as well as the findings from literature.

Participants

Participants from Ontario, Canada were recruited through advertisements posted on an online forum and on a list serve for women who were pregnant and marginalized because of citizenship status, inadequate housing and employment, and mental health and addictions challenges. Eligibility to participate in the study required women to be over the age of 18 years, in their second trimester of their first pregnancy (as this is typically a more stable time during the pregnancy) and to have disclosed an experience with CSA. Eighteen participants (*n=18*) who identified themselves as survivors of CSA were included in the study. The participants' ages ranged from 19 to 48 years and came from a variety of ethnic backgrounds. Three women identified themselves as refugees from Asia, Africa and Central America. (Berman et al., 2014).

Procedure

Before collection of data, ethics approval was obtained from the research ethics review board at the sponsoring university. Given the vulnerable nature of the study, research assistants who conducted the interviews were specially trained in different interview skills including building rapport with the participants, carefully listening to details, safety planning and responding to crisis (Berman et al., 2014).

Women who were interested in participating in the study emailed or used a toll free number to contact the research coordinator. Women who agreed to participate in the study were asked for a telephone number where they could be safely reached. Women were invited to complete a phone interview to determine eligibility. Subsequent to the preliminary phone screening, participants were invited for an in-person interview at a location chosen by the woman. The interviews were conducted in the preferred language of the women using translation procedures. Interview questions were changed according to responses from previous interviews. By looking at previous data, questions asked in proceeding interviews were directed towards saturating emerging concepts (Hallberg, 2006).

Once written consent was obtained from each participant, a semi-structured interview was conducted. The interview began by asking women their reasons for participating in this study to open up the dialogue regarding their past traumatic experiences. Questions focused on each woman's current physical and emotional well-being, their thoughts about becoming a mother, how they believed their experiences shaped their emotional states, goals for their baby and family, and their source(s) of resilience and strength. Each interview lasted approximately 2 hours and was digitally recorded. Each participant was provided financial compensation of $25 to offset costs of travel. Additionally, each participant was given a list of resources including contact information for free counselling services as well as 24-hour crisis lines in the event that they experienced distress following the interview. Data was collected until saturation of themes occurred and no new information was identified from additional interviews (Berman et al., 2014).

Ethical Considerations

When working with vulnerable populations, potential risks must be considered in order to protect the welfare of this population. As this study sample consists of pregnant women, potential harms and benefits were carefully assessed for the woman and for the fetus (Mason & Berman, 2014). Although the idea that participating in this form of research may lead to fetal harm is considered a risk, there is little empirical evidence to support this (American College of Obstetricians and Gynecologists, 2003). Using such rationales to exclude women from a study of this nature denies this population from receiving potential benefits through participation from this form of research (Mason & Berman, 2014). Similarly, current research has found that the majority of women survivors of interpersonal trauma who have participated in studies involving abuse have reported a positive and rewarding experience (Legerski & Bunnell, 2010). Other studies that have investigated the impact of trauma research on survivors well-being have found no harmful effects on those who participated in detailed psychological assessments. Furthermore, Schwerdtfeger (2009) found that trauma survivors who were asked to compare their preference between quantitative and qualitative approaches for this field of study, reported a preference for in-person, personal interviews. Newman et al. (2006) also found that trauma survivors perceived the opportunity to discuss their experience an empowering one that has aided in their sense of healing. Therefore, the current study aimed to provide women with the opportunity to reflect and speak out about their experience with violence as well as receive additional emotional support and realize that they are not alone in their journey (Mason & Berman, 2014).

Results

Methodological Trustworthiness

My experience with reading the transcripts of each woman's story was a humbling, yet informative, one. As I was not part of the interview or data collecting process, I did not have the opportunity to listen to how each survivor told her story. I was not privy to the facial expressions or tone of voice used to convey the emotions experienced by each woman. I could only envision how each interview was conducted and reflect on the emotions I felt while reading each transcript. Prior to writing notes throughout the transcripts, I read the transcripts from beginning to end in order to create an emotional context of how the stories were told. Some women described specific details of their experience with violence, which elicited feelings of shock and sadness. However, my overall impression of the transcripts was that they embodied power, strength, hope and resilience. The sadness I felt while reading the details of abuse quickly changed to relief and a sense of calm as women described how these events changed their attitude towards relationships with others and with themselves. Reading through the transcripts helped me to understand each woman's background and how their past has shaped their current attitude and thought processing. The resilience and honesty conveyed by the women helped me visualize the interviews as women narrating the details of the abuse confidently, acknowledging the pain they endured, yet feeling safe and comfortable enough to disclose specific aspects of their trauma. Additionally, I was reassured by the validating responses and sensitivity conveyed by the interviewers.

Reading the transcripts multiple times also helped me to grasp the strength of each woman's ability to cope with their past and fuel their desire to be a protective,

unconditionally loving mother to their baby. It also provided me with the opportunity to take frequent breaks and reflect on how these transcripts affected me. I was able to consult with my supervisor about my thoughts on these transcripts and appreciate the courage these women had to openly share their stories and convey a hopeful attitude for the future.

Working with qualitative data provided a profound understanding of how trauma can impact the body and mind. Each survivor spoke about her unique and complex journey from childhood to motherhood and how finding new meaning in life can positively change one's attitude towards the future. Likewise, it is important to attend to the validity, reliability and trustworthiness in qualitative work, and several measures were taken to ensure rigor in this study.

Next, in applying Guba's (1981) constructs for producing trustworthy results, I have spent a long period of time analyzing and reflecting on the data. My first read through of the transcripts consisted of becoming familiar with each woman's responses and tracking my thoughts, interpretations and reactions to the scripts. I read the transcripts several times to collect and combine similar quotes into groups and categorize each group. Throughout the process, I took notes and dissected each statement, to get a better understanding of what a response meant. I engaged in continuous assessment of statements to find similarities between each one. Additionally, I spent a significant amount of time creating new themes and omitting others.

The process of creating themes and sub-themes included checks by others, including my supervisor and a colleague from my program. I continuously consulted with my supervisor who provided me with guidance, feedback and confirmation of the validity

of the process of data analysis. This included regular discussions regarding the analytical process of this project and considering different perspectives about the themes. Themes were identified by examining the similar ways women described their ways of coping with the trauma and how they will use the strength they have gained from surviving the abuse to raise their baby. Reading the transcripts several times helped to identify common responses from women regarding how they will care for their baby, expectations they had for their child and how they will approach new and past relationships. Additionally, themes and sub-themes identified in the current research support past research discussing the process of PTG and the factors indicative of PTG.

Finally, my analysis was informed by Tedeschi and Calhoun's (2004) proposed factors of PTG including a changed sense of priorities, closeness to others, a greater sense of personal strength and spiritual development.

Theme 1: Change in Perception

In this section, mothers spoke about their acceptance with their past trauma and changing their attitude towards current negative events. Women spoke about the ability to cope with distressing thoughts, specifically past trauma and the relationship with their mother, as well as confronting future adverse events such as bad things happening to their baby. They also described the ways in which having a child can provide "peace and purity", by immediately changing how they felt as well as providing a distraction or "a way to get away". The language was optimistic as they spoke about their future with their child as well as coping with their childhood memories and poor relationship with family. Within this theme, women described various examples of their change in perception, divided into four subthemes of Relief and Acceptance, Finding New Meaning

Through Tasks and Hobbies, Not Sweating the Small Stuff and a Change in Attitude Towards Past Relationships.

Subtheme 1: Relief and acceptance.

Women survivors conveyed acceptance towards the past and acknowledged the current moment for what it is as well as perceiving the future in a positive manner: "The past is past. I decided to live with my present, and just look into the future. And there is no bad in the future for me; I know. I'm not going to experience that any more." Mothers also expressed acceptance towards their current goals reached, even if it did not necessarily meet their past expectations: "So I think I ... I met most of my goals. Maybe not in the exactly the order – cause I did say I wanted to be married first, but, I mean, the economy was a lot different at the time too. So ... it's going- in terms of my goal setting, it's gone pretty well ... to this point. And that's why I'm ... I'm pretty comfortable with it despite, you know, family is not exactly what I want it to be, and all of that stuff".

Subtheme 2: Finding new meaning through tasks and hobbies.

Mothers take up activities to help them remember events in a significant way: "Years ago when that first happened, I planted a rose bush in High Park. And I used to go back every year on the day. (pause) And I will be going back this year, but it will probably be the last time."

"Like the writing definitely helps and ... I even ... I had written a script, again before I found out I got- before I found out I was actually pregnant. Cause I was- like I was, like I say I was getting back into the film and stuff, cause I want to do independent film for my ... for myself, but ... I ended up putting it on hold because I didn't want this to

... be hindering rehearsal and stuff like that. So after the baby is born then I'll continue with it".

Additionally, mothers engaged in hobbies that may be meaningful to their child:

"I'm journaling right now for the baby. I'm wanting to build a really relationship with the child. Because when they're old enough to understand I want to give them the book and say 'Listen, this is I what I went through and I want you to see it".

Subtheme 3: Not sweating the small stuff.

Mothers expressed concern towards their baby's health and well-being, making it a priority over other things that may have seemed important in the past: "I just sat there and like ... all right. So what's next? (laughs) I didn't even get mad. I just kind of ... was like ... "All right. So you know, what's coming up next now? So ... al lright. Episode ... five million," Let's me just do the next show now, cause this is like a joke. You know? That these things just continue to happen, and I'm just like ... But still, with all of that, you know, end up in hospital and all this stuff, the baby is kicking like ... everything is A ok."

"So I just want him happy and healthy and safe. Anything else is a plus. He could be born deaf. If he was happy, healthy and safe, that would work for me." Others described their concern for the pregnancy and labor instead of the physical pain they had and will have to endure: "I've been stabbed a couple times. Like ... it was a accident, but ... Physical pain, I'm not really worried about. My worry is moreso ... I just don't want nothing to go wrong."

Subtheme 4: Change in attitude towards past relationships.

This subtheme was divided into two parts: Closeness to Others and Anger Towards "Protective Figure" (Parent):

Closeness to others.

Mothers described how specific relationships from the past had become more meaningful for them and their bond together had become stronger: "So the point is like we never. But now I don't understand how to be a mother; how she went through with me and my brother and my sister. So she's kind of understanding me; now for me and her to get along. So the baby kind of help us; get us close".

"Me and my mom have become ... way closer. Like she'll tell me more. I guess for her this is ... one of those ... places where I'm no longer just her child. You know, I become sort of like her equal. You know? So she'll disclose more about her life".

Others described a deeper connection, tolerance and level of respect towards their partner: "Yeah, one thing is just the importance of ... of parent ... of parenthood, and just working as a unit. How significant that is. Because one reason why relationships don't work is because it's people's personalities. I don't care what nobody says. You can be the most DIFFERENT people in the whole entire world. If you can- if you can find one common ground, you will make it work. And you have to."

"Because it's mostly you look at your circumstances and let it make you better. And I think it has. Right? [father's name], as a man, he's just a better person period. He was a good guy overall before. But I think he's more mature now."

Anger towards "protective figure" (parent).

Mothers reflected on past relationships (with mother or father) and expressed anger towards them for not protecting them and realizing errors in their parenting: "I don't know, probably moreso than even that trauma; maybe the issue with my dad. Cause it still ... it still go- Like I say, I don't like him. And ... not that I want him to die or something like that, but I don't really care for him too much, eh. And I don't feel like that about nobody. Not even the people who did what they did to me. I don't feel like that about them. But I do about my father"

"I'm so frustrated with her. Cause ... wants to take credit for my survival. You know? Meanwhile you should take credit for making me a little ... off the wall and having low self esteem and never being supportive of me. THAT, for THAT you can take credit for."

"And me being pregnant now, it makes me very angry cause ... I tried to protect her when she could have protected me. And I was so young. My relationship with my mom now is ... is hollow."

Others used the anger they had towards their mother as a motivation to be a better mother for their child: "But again I think everything that I've been through with my mom and with her boyfriend, it made me almost want to prove to her, or even to myself, that I could be ... a million times better mother than her".

Theme 2: Personal Growth

Mothers described having more strength and self-confidence as they take on their new roles as mothers and look for ways to care for their physical and emotional well-being in order to heal and take care of their baby. Some women attributed their

confidence to living independently and having respect for their body. They also acknowledged the importance of setting boundaries and limitations within their personal relationships. Women discussed feeling "stronger" and "confident" and that every experience leading up to their pregnancy had prepared them for future adverse events. Participants described every "bad" thing that had happened to them as an opportunity for building strength and protecting themselves from dangerous or unhealthy relationships and their babies from experiencing CSA. Mothers also described making changes and undertaking new roles because they wanted to, "not for anyone else". Additionally, mothers described accepting the past for what it was and not regretting anything that has happened. Women disclosed the desire to confront past trauma through counselling in order to feel "ready to be a mother". The language conveyed a sense of independence and trust within themselves as well as a welcoming attitude towards these changes. Mothers described four different ways of personal growth, including New Found Resilience, Self-Confidence, Thinking of Self/Self-Improvement and Confronting and Coping with the Trauma.

Subtheme 1: New Found resilience.

Mothers feel empowered as they transition into their new role of caring for a child. They described their pregnancy as a positive change from past experiences: "Yeah, like the pregnancy ... it's like another part of ME. It's really strange, and ... it's ... – I feel like I'm a warrior. I feel like I'm ... a new person".

"Some peace in my life, and some ... something that I can say where ... I went through all of this. All the ugliness that I went through came out ... something beautiful; something amazing"

Mothers also described the strength they have acquired from past events to overcome the potential loss of a child:

"I guess that if something is gonna happen to my baby, then EVERY thing, every trial, every negative experience in my life has been to prepare me for the moment of losing this child."

Subtheme 2: Self-confidence.

Mothers expressed self-assurance through their independence and the skills they have used to accomplish tasks: "I paid the rent. And my cell phone bill, and the cable and the internet, and the home phone, and HIS cell phone bill. And his insurance on his car. And I paid for everything, including groceries, so ... I know I can do it"

"Coming through, and going through a lot of stuff and surviving it, it was my OWN strength"

"Especially with the ... the amount of things I can do; I'm capable of doing. If you go in there you see ... you see a tool bench and a drafting table I built by myself. You know?"

Some mothers described a higher respect for themselves and their self-worth by demanding respect from others: "So you might as well just give it to them. I wouldn't have had that if I had started my healing journey earlier. And realized that ... 'You know something? I am valuable. I am worth something. And I do have the right to say no.' And it should be respected."

"Like I think my ambition and my drive for something has increased. Plus taking ... taking things from people, like in terms of like people treating us badly and stuff like that, I don't take that anymore. Because of the fact that ... he doesn't deserve to be

treated that way. Right? And so like I ... I really stand up for myself a lot more now ... than I did before".

Subtheme 3: Thinking of self/self-improvement

Mothers explained how this baby will benefit them and help them to change for the better: "He's made me want to be a better person ... because I don't want to screw up his life. And ... I know I'm doing it for the wrong reasons, becoming a better person for someone else."

"But the baby, it's like ... has made me a more, I guess, a more waken-up person; a more responsible person."

"I feel like things happen for a reason and I feel like because I've had him it's helping me cope. And I know that it sounds selfish. But in a way it's not because ... him helping me cope makes me a better mother for him."

"And the baby has made me a ... to be more wiser; more careful. More spiritually stronger."

Other mothers expressed a shift in emotions and ability to manage their emotions differently: "And that's why I'm trying not to get so angry. Try not to get so upset. I just want to be content REGARDLESS of the situation."

Subtheme 4: Confronting and coping with the trauma.

Mothers discussed their experience with getting support for their past trauma as well as expressing a desire to get help before the baby is due: "I do want to see a counselor, because I want to make sure that I'm prepared for when the baby is born. And that I don't have any hard feelings based on my past. I want to forget about it. Forgive and forget".

"And also since I've been ... going to the groups, I've felt a lot better about myself and ... I've met a lot of other mothers who are in similar situations. Or single parents who are in similar situations. So I'm ... I'm ... I'm ... I'm better. I'm feeling happier."

"I've been trying to help myself for MANY years. MANY years. More than 15 years. I do need ... – I think I do need help from outside. Especially now that we're going to have baby."

Others described mothers who have experienced sexual trauma to be at a disadvantage in comparison to mothers who had not: "people who haven't gone through trauma start on ... a seven on the scale of being ... ready to be a mother. And when you have gone through trauma you start on like a five. So you have to work through certain traumatic experiences, and then you're prepared to prepare to be a mother. You know? So ... there's so much more to do in a short period of time. And I mean it's not like I'm bound to be ready nine months. Have everything dealt with and everything figured out. No. It's still going to be a process."

Theme 3: Hope for the Child

Mothers expressed concern for their child's health and long-term well-being as well as future worries including their "financial, emotional and physical state" and living situation. Mothers were not concerned about having a boy or girl, but did place certain expectations and goals for their child including being well educated, learning about and having faith and learning different skills. They also conveyed optimism about the strong values they would like their child to have such as "respect for him/herself and for others". Mothers discussed protecting their children from harm, specifically, child abuse and preventing the same trauma they had experienced in their childhood from happening to

their child. Additionally, they described making sacrifices for their baby, prioritizing their baby's needs before their own and loving their baby unconditionally. The theme of Hope for Child was further divided into four subthemes including: Thinking of Future Self and Long-Term Goals, Newfound Strength, and Loving Beyond Self.

Subtheme 1: Thinking of future and long-term goals.

Some mothers described a desire to raise their children having positive characteristics, irrelevant to superficial traits: "Do you want a girl or a boy?' I was like 'I want him to be healthy. I want her to be healthy.' I want a healthy baby. I want him to be happy. I want him to be able to love themselves. I'm not the kind of person who will say I wish my baby becomes a doctor that has a great car and ... I want them to be happy."

"I hope that my baby will be healthy. And ... whole. And not go through ... any like really traumatic experiences. And that they'll aspire to be ... someone great. That's pretty much it. Oh, and I hope my baby will chose to be Christian."

"my child is going to learn how to respect adults, how to respect him or herself. Value him or herself. It's not going to be like other children where their parents are sleeping around, cheating, and hitting each other and ... oh god, you know whatever else. So ... it's going to be a child that's going to be SO different. You know, so completely different. And he's going to be very- a very strong child."

Others described characteristics they would want them to have if they were male: "If it's going to be a boy ... Uuum ... I think the most important thing about men, that they have to be smart. There is nothing ... disgusting as a stupid man. (laughing) So-

No. No matter if it's a girl or a boy, definitely university. Definitely high education. Definitely good ... - well educated person. With a good stand in ... in the life".

"I need him to be man enough to fight the fight when he needs to, but also to- fighting means walking away sometimes."

Others discussed their future as parents to their child: "I will take care of my kid and ... do EVERYTHING that he needs and he doesn't have to suffer for everything- anything. I'll be a very good mom".

"my husband is more laid back he's probably going to say 'Go ask your mom.' But I also want to be that friend. Be that, you know, like ... someone close to my kids. I want ... I want ... to talk to my kids, you know, just to ... to know what's going on with them."

Subtheme 2: Newfound strength (protection towards others).

Mothers expressed concern and anger towards anyone who may hurt their child as well as a desire to protect them no matter the consequences: "so I wouldn't have to deal with the outcome. I was always worried that if I had a girl and she ever came to me and told me any of the things that happened to her, like happened to me, I'd kill somebody. So that has always stopped me."

"If anything were to happen to my son I would want him to tell me. And if I found out, I would never let anyone get away with that. So it was ... You know, it really did affect me because I thought that's ... that's ... that's why, as you can see, with everything I'm telling you I do everything- And I know every mother does. I do anything in my power to protect him even if it means I'm getting hurt"

"I'm going to be protective, which I won't be pawning my child off with anybody, like what was done to me. And ... and we're really ... family oriented".

Subtheme 3: Thinking and loving beyond self.

Mothers discussed their unconditional love for their baby and doing things they may not enjoy doing or giving up certain habits to keep their baby healthy: "Like I said, my baby is growing inside me, and I feel him kick, and I love him to bits. So I'm not gonna go and like screw him up by smoking a cigarette."

"I hate vegetables. I hate carrots and orange. Now I has to eat it. In the beginning it was really hard for me to eat it cause I would puke it; I would just threw it up. And it was like certain food I never ate. If my family or anyone maked (sic) it for me I would never eat it. So now I HAVE to eat it for the health of my baby. Not for me; just it was everything for the baby."

"I feel my baby kick and I'm totally in love with my baby. (very emotional voice) I think I've gone for like nine ultrasounds cause I love seeing my baby."

"But I never ... felt comfortable with somebody like ... – woman or man – going down there and like all up in my ... stuff, you know. So I'd always avoided it. But it's kind of like how automatically like once you find out that you're going to be a mother, it's like ... although you're scared, you're like 'Ok, so this is in the best interest of my baby. So I have to do this."

"Like drink two glasses of milk a day. I don't normally ... normally drink milk, but, you know, I keep thinking of like ... it's good for the baby. I even take fish oil, which is gross and ... you know, stuff like that."

Theme 4: Spirituality

Mothers described a deeper connection with their faith and attributed certain events to the workings of a higher power. Mothers discussed their relationship with a higher power, as well as how their baby had helped strengthen the connection between them and their God. The language used conveyed a sense of appreciation for their baby and a healthy dependency on faith. Women use accepting and grateful language to describe their relationship with God, focusing on the positive events in their life rather than the negative ones. The theme of Spirituality is divided into two subthemes: a Deeper Connection to Faith and Divine Intervention.

Subtheme 1: Deeper connection to faith.

Pregnancy was an event that helped mothers form a stronger bond with a higher power: "The baby ... has brought me closer to God. But even before the baby I was reading my Bible even."

Subtheme 2: Divine intervention.

Mothers explained their belief in God and attributed their pregnancy as a gift from a higher power: "And this was not a planned pregnancy, but ... someone had it planned. God had it planned".

"Just go through with it and see where it goes. You know? Because like ... it's a blessing from God, and like, you know ... I should just ... It's not the child's ... you know, it's not the child's fault. So just have him."

Some women described having a relationship with a higher power: "Just ... the almighty, the Lord. Whatever name you're going to use. I have my own relationship ... with this creator" and this higher being sending specific and empowering messages to

mothers to provide comfort: “And I really think that’s what probably what, you know, what ... what God’s trying to tell me. His spirit is trying to tell me stop TAKING on the whole world. Cause understand, like the whole world ... is going to be there regardless, right? So ... just do ... do what I can. And I feel like I can do GREAT things.”

Discussion

The current study examined interview data from eighteen women survivors of CSA in the second trimester of their first pregnancy. Through semi-structured interviews each woman was given the opportunity to share her experience with past trauma in the form of childhood sexual abuse (CSA) and provide a detailed account of her life leading up to motherhood. Each participant described how she developed meaning from her transition into motherhood and how this significant event had changed her worldview. Women described the positive changes during their pregnancy, and their accounts of these changes were examined using both a feminist lens and the Post-Traumatic Growth framework.

Tedeschi and Calhoun (1999) describe PTG as positive changes following an individual’s struggle with trauma. In their theory of PTG, they describe five ways in which people are transformed as a result of traumatic experience: through an increased appreciation for life, closer relationships with others, changes in spiritual understanding, realizing new possibilities and a changed sense of what is important (Tedeschi et al., 1996). Although the literature has explored these five factors of PTG in various populations, most of the research has used self-report measures to identify these factors. Additionally, there is scarce research into the positive effects of pregnancy in CSA survivors. Thus, the current research used qualitative analysis to understand the profound

stories of pregnant women who are survivors of CSA and have developed meaning from their transition into motherhood resulting in PTG.

It is important to investigate the impact of CSA in women survivors, given the high prevalence of sexual abuse among girls. Research suggests that 1 in 3 girls in Canada experience an unwanted sexual act (Statistics Canada, 2015). The literature outlines the adverse effects of child sexual abuse that may foster the development of mental health diagnoses such as PTSD (Munzer, Fegert & Goldbeck, 2016) and depression (Molnar et al., 2001) as well as physical health issues (Zinzow et al., 2011). Additionally, women who have experienced violent upbringings are at a high-risk of encountering challenges throughout their development. (Berman et al., 2014).

Often times, symptoms of trauma are concealed throughout adulthood and not addressed. These symptoms may be triggered throughout different life cycles, including pregnancy and the transition into motherhood (Berman et al., 2014). Pregnancy in the health care system is an intrusive experience that is not guided by trauma-informed principles. Workers in this field may not have an understanding of how CSA impacts patients who are pregnant, thereby ignoring critical symptoms and denying them proper care (Elliot et al., 2005). Examining the profound effects and changes experienced by survivors of abuse can equip health care professionals with essential tools to properly address trauma and enhance patient care. Knowing how to identify the symptoms of trauma and using sensitive approaches to treatment can be critical in the development of trust between patient and the health care system.

Additionally, understanding the impact of trauma can be helpful in the therapeutic setting. The literature explains the high risk of experiencing detrimental symptoms

following CSA and the many mental health issues associated with it (McElheran et al., 2012). However, research suggests that neglecting the negative emotions correlated with the trauma to be maladaptive to long-term coping and in the formation of self (Snyder et al., 2001). Disclosure can be a powerful tool for mitigating symptoms of psychiatric disorders following trauma (Ahrens et al., 2010). Confronting distressing memories in a safe space, such as with the counsellor, provides the survivor with an opportunity to find meaning of the event through their story (Lepore et al., 2010). It allows survivors to gain control over the event, by narrating their story in the way they choose to (Herman, 1992). Likewise, confronting past trauma can lead survivors to interpret the event differently and incorporate these changes into their worldview (Lepore et al., 2010). Although the majority of people who have experienced CSA suffer major disruptions throughout their life, there are some who undergo a positive transformation following distressing life events. Women in this study have demonstrated a way of coping with the trauma that opposes research suggesting a high prevalence of psychological and developmental issues following CSA. This research aimed to demonstrate the different forms of growth following the struggle with trauma.

The current research provided women the opportunity to speak out about their experience with violence. Historically, women's participation in scientific research was not valued and their voices were excluded from the scientific process (Mason et al., 2014). As women began engaging in research, providing new insight into the inequity and oppression of women, new issues came to light (Ackerly & True, 2010). The current research used feminist principles to allow each woman to break the silence. Each survivor was given the chance to speak out about her experience with injustice and the strength

required to grow from it. This research used a qualitative approach in order to understand the meaning behind each woman survivor's thought processing and behaviours following trauma. In doing so, each woman demonstrated her experience with PTG as she took on a new role as a mother.

Tedeschi and Calhoun (1999) describe the phenomenon of PTG as positive changes including a change in relationships with others, change in sense of self and change in philosophy of life. Additionally, the concept expanded to include more factors such as a greater appreciation for life and changed sense of priorities, warmer, more intimate relationships with others, a greater sense of personal strength, recognition of new possibilities or paths for one's life, and spiritual development (Tedeschi & Calhoun, 2004). However, PTG is multifaceted and may depend on several factors including the influence of other people and the continuous challenges faced in adulthood (Tedeschi & Calhoun, 2004). Similar to Woodward and Joseph's (2003) research who have found through each participant's narrative that certain aspects in their lives have allowed trauma survivors to reflect on their traumatic events and experience PTG, the current research has demonstrated the importance of significant milestones, such as pregnancy as a vehicle for change.

Research on the impact of pregnancy on women survivors of CSA is limited but previous research has suggested a link between PTG and the transition into motherhood (Berman et al. 2014). The current research supports Tedeschi and Calhoun's (2004) findings on PTG in trauma survivors but also provides additional domains within the definition of PTG. Likewise, this research demonstrates how these additional domains may be attributed to the occurrence of meaningful circumstances following complex

trauma. By using thematic analysis, the current research has identified four major themes including: change in perception, personal growth, hope for child, and spirituality as well as fourteen subthemes.

Theme 1: Change in Perception

Change in perception included a shift in the mother's attitude towards her past trauma, current hobbies, situations that may have been distressing in the past and past relationships. Change in Perception includes 4 subthemes: Relief and Acceptance, Finding New Meaning Through Tasks and Hobbies, Not Sweating the Small Stuff (Change in Priorities) and a Change in Attitude towards Past Relationships.

Finding new meaning through tasks and hobbies.

Mothers shared how they have taken up new hobbies and creative activities to express their emotions and document their journeys. Many women discussed engaging in these new activities in the hopes of showing it to their child in the future. By doing so, mothers were able to create new meaning in this next stage of their lives as well as document these memories. Likewise, this demonstrates taking a new direction in life as well as a newfound appreciation within this stage. Tedeschi and Calhoun (2004) discuss the domain of an increased appreciation with life including a changed sense of what is important. For example, things that may have had little meaning in the past begin to have increased importance. As mothers change their thoughts and attitudes, they shift towards new ideas and interests. The process of cognitive flexibility is associated with creativity, as the mind becomes more receptive to greater options, stimulated by positive affect (Pavani, Vigouroux, Kop, Congard & Dauvier, 2015).

Change in priorities.

This current research suggests a shift in priorities in which mothers discussed their baby's health and well-being to be of primary importance. This research also supports the literature by demonstrating that those who have experienced PTG appreciate the current moment as well as the simple things in life. Focus on the "here and now" may be attributed to reappraisal of past behaviour also prompted by a desire to change negative thoughts/behaviours/regrets (Pavani et al., 2015).

Positive reappraisal may be fostered by the ability to broaden one's cognitive mechanism by disengaging from old thought patterns and focusing on something new (Pavani et al., 2015). This does not mean that PTG is void of distressing thoughts, but through rumination, positive thoughts and emotions arise (Pavani et al., 2015). Tedeschi et al. (2004) describe PTG as a consequence of the attempts of psychological survival, which can coexist with the distress of the trauma. Mothers described their experience with abuse, but also shifted their focus towards their baby and their future with a child.

Change in attitude towards past relationships.

Additionally, mothers in this study suggested a change in attitude towards relationships. Specifically, a shift in how they viewed their parents or "protective figure". Many of the women suggested a change in perception of past relationships: from viewing their parent in a positive light to a negative one as they transition into motherhood. Comparing their perception of what it means to be a "good" parent to the parenting they were exposed to growing up helped them realize that they were not sufficiently protected as a child when the abuse occurred. Participants developed

awareness that it was the perpetrators who committed the abuse who were at fault, shifting the blame onto them.

Interestingly, this opposes betrayal trauma theory (Freyd, 1996), which suggests that trauma survivors cope with the trauma by denying the betrayal perpetrated. This can be adaptive for remaining attached in other relationships. However, this can also lead to re-victimization, as the ability to detect trustworthiness is impaired (Gobin & Freyd, 2014). Research suggests that early betrayal trauma, such as CSA can lead to high levels of distrust in others. This may be a result from damage to cognitive mechanisms, which can skew a survivor's perception of trustworthiness. Mothers in this study have spoken openly about their childhood abuse and how they continued to be victimized in later relationships. Some conveyed reluctance to trust others judgments, such as those made by friends. This may support previous research that suggests that survivors have lower propensity to trust (Gobin & Freyd, 2014). In turn, women may have learned to trust their own intuitions and decisions, especially as they transition to a new role in their lives. However, some mothers spoke honestly about their perpetrators and developed a lack of trust towards that specific relationship, as well as with another parental figure that failed to protect them. Thus, survivors may create stronger barriers that build resiliency when faced with future adverse events, but also as a way to protect themselves in future relationships. Research suggests that trust difficulties may be mitigated by situations where strong and safe relationships exist (Kia-Keating, Sorsoli & Grossman, 2010). Similar to Calhoun & Tedeschi's (2000) study involving PTG in bereaved families, mothers in this study not only cut out certain relationships, but fostered the development of new and old ones. The bond between mother and child may have also led mothers to

develop closer relationships with other people as part of their experience with PTG (Tedeschi et al., 2004).

Theme 2: Personal Growth

Personal Growth includes each mother's ability to recover from traumatic experiences and build strength and courage. Mothers also expressed changes within themselves including higher self-confidence, self-worth and resilience as well as a desire to confront and cope with their past trauma.

Newfound resilience and self-confidence.

In this current study, women indicated a greater sense of strength transitioning into motherhood. Self-confidence is defined as believing that the self is capable of success and competence (RMIT University, 2009). On the other hand, resilience is the process of developing survival strategies to cope with hardships (RMIT University, 2009). Mothers demonstrated how a higher sense of confidence and determination also indicated greater resilience (Krosch & Shakespeare-Finch, 2017). Resiliency is a key trait of PTG as it is defined as the adaptation to the stresses of traumatic experiences (Ashkay & Magyar-Russell, 2009). Resilient people also show several personality traits such as curiosity, optimism and being open to new experiences (Askay et al., 2009), which seemed apparent in the responses of the mothers in this study. Women expressed feeling stronger and being able to cope with future adverse events despite being unable to control past events. Women survivors of CSA discussed the motivation to fight for other life challenges. Questions asked throughout the interview highlighted strengths and skills,

helping mothers identify new skills and qualities that have developed from the trauma, as they acquire the new role of mother. The confidence and strength to grow and overcome future stressors also demonstrates a strong sense of self-efficacy. Social cognitive theory posits that self-efficacy is a person's confidence in their ability to perform a task or behaviour successfully (Bandura, 1997). Research has found that an individual may be more likely to perform a behaviour or task if they believe they can perform it successfully (Locke & Sadler, 2007). Findings by Harville et al. (2009) indicate that those who show high levels of self efficacy and more effective emotion regulation management may experience more positive affect that could foster PTG. Additionally, positive affect has been correlated with building skill, counteracting negative emotions and thought processing and foster psychological and physical well-being (Fredrickson, 2001).

In relation to the subtheme "change in attitude towards past relationships" mothers conveyed a strong sense of independence rather than dependence on relationships. Some mothers spoke about having discrepancies or differences in opinions with their friends, but trusting their gut instinct. Mothers felt confident about their choices, despite external pressures they may have experienced. Research has emphasized the importance of social support in providing an opportunity for trauma survivors to feel heard and for also offering a new perspective (Tedeschi et al., 2004). Moreover, support from those who have experienced trauma may also influence trauma survivors to incorporate new schemas. Additionally, revealing the emotional aspects of an experience as survivors retell their story to others can also lead to strong bonds forming (Tedeschi et al., 2004). Although research suggests the importance of social support with trauma survivors, mothers in this study spoke about changes with past relationships rather than

forming new ones for support. Women who emphasized the importance of independence, self-confidence and self-efficacy may have learned to place higher trust in themselves rather than on distrusting past relationships. As mothers expressed anger towards individuals in their life who had betrayed their trust, mothers may have learned the importance of relying on themselves.

Tedeschi et al. (2004) describe an increase in personal strength as part of the process of PTG, which also correlates with the sense of being vulnerable. As women convey an attitude of feeling unstoppable or that they can overcome anything, they also accept the possibility that bad things may happen to them again and that their past experience with trauma may not be their last. However, their past traumatic experiences have also prepared them for the possibility of future traumas, which some women described as something bad happening to their child. An earthquake is used by Tedeschi et al. (2004) to describe the process of significant trauma and PTG. A traumatic event can shake one's worldview, challenge one's understanding of the world as a safe place and deteriorate one's sense of safety and trust in the world. These unexpected threats to one's assumptive world can result in serious psychological distress. Rebuilding these walls of safety and protection takes time as our minds incorporate the trauma and reveals an altered reality. These new schemas also integrate potential threats in the future, creating stronger walls, more resistant to adverse events (Tedeschi et al., 2004).

Confronting past trauma.

Some mothers discussed their experience with confronting their trauma by going to counselling. Others expressed a desire to go to counselling to prepare for the birth of

their baby and some mothers discussed their experience and thought processing regarding the trauma. Helgeson, Reynolds and Tomich (2006) found in a meta-analysis that distress and intrusive thoughts were associated with growth. As demonstrated using the PTGI in Chopko's study (2000) involving police officers and PTG, intrusive thoughts were associated with cognitive processing and contemplation of a stressor in order for growth to occur. Research in effective coping has found that acceptance and active coping leads to better long-term outcomes (Folkman & Lazarus, 1980). Although this study did not look at different coping strategies used by participants, women described the desire to work directly on the stressor and accept that the trauma did occur.

Acceptance coping is associated with better psychological adjustment following trauma versus avoidant coping (Jensen, Thoresen & Dyb, 2015). Avoidant coping, which uses distractions as a tool to direct attention away from the trauma and negative emotions associated with it, may be adaptive during the trauma but not afterwards (Jensen, Thoresen & Dyb, 2015). Although the effects of trauma may persist for years following the abuse, exacerbated by situational factors, mothers in this study openly spoke about their experiences and confronting/accepting the past. Research has found that survivors of trauma who use distraction tactics to ignore the past and who recovered from trauma quickly, were less likely to have a changed worldview as less time was devoted to cognitive restructuring (Helgeson et al., 2006).

It is important to recognize that PTG is not solely an intellectual process void of emotion. Participants conveyed their feelings towards the trauma, underlying fears transitioning to motherhood as well as hope and joy for their baby's future. Tedeschi et

al. (2004) describe the emotional element part of the psychological processing in PTG, which helps to reinforce lessons learned from the trauma. This is distinct from other developmental processes because one's assumptive view is disrupted so quickly, the body must learn to survive again. By telling these stories to others, the emotional aspects of past events are revealed and survivors of trauma are forced to confront doubts of meaning and purpose as well as create a new definition of meaning (Tedeschi et al., 2004). Thus, the more that one confronts the trauma and engages in cognitive rebuilding, the higher the likelihood that the trauma is appreciated (Tedeschi et al., 2004). Likewise, Herman (1992) discusses the importance of "telling the story" in a safe and trusting relationship. Flooding is a technique used in therapy that allows the individual to relive the experience in a controlled environment, while managing anxiety through relaxation techniques. Individuals develop detailed scripts of each trauma experienced and choose which one to narrate. It has been found that this may provide a transformation in the way the trauma is processed psychologically and provide a relief towards symptoms associated with trauma (Herman, 1992). In this study, mothers described their past experience with trauma and how it would affect their new role as a mother. For some, this was the first opportunity they had to discuss their story in a caring, safe and trusting environment. In doing so, women were given the opportunity to openly tell their stories from their point of view, while also helping them see purpose in their lives as they discussed their future with their child.

Pregnancy may have influenced the mother's worldview and provided new possibilities to regain control over their lives, seeing their child as an opportunity for a new chance of life. Cognitively processing trauma can occur in several ways. Rumination

can involve replaying the trauma in one's mind in an attempt to figure out how the trauma may have been avoided. This form of thinking often leads to feelings of regret, guilt, shame and self-blame (Tedeschi et al., 2004). Similarly, thoughts of "who am I?" following a trauma may lead to a destructive path of self-doubt. However, it may also pave the way for the potential to develop and understand one's self. Mothers in the present study described their cognitive processing to involve setting new goals for themselves and for their babies. Accepting that certain goals created prior to experiencing trauma may need to be changed following a trauma allows for the ability to move forward (Tedeschi et al., 2004). Failure to acknowledge a new reality following trauma can impede in cognitive structuring and destructive rumination.

Theme 3: Hope for Child

Mothers discussed setting future expectations for their child pertaining to their well-being and success. Theme 3 entails 3 subthemes: Thinking long-term/future goals, newfound strength and protection towards others and thinking and loving beyond self.

Thinking long-term/ future goals.

Mothers identified with their new role of raising a child, which may have provided a new sense of direction for them. Women discussed the changes in their lives since learning about their pregnancy and how most of their decisions were now centered around their baby. Some mentioned the many sacrifices they had made for the well-being of their child. Many of these changes were centred on hope for giving their child a happy life, distinct from their own childhood.

Adding purpose to an event may have helped the women find meaning from their trauma and with their pregnancy. Hope acts as a precursor for change and overcoming emotional difficulties (Levi, Liechtentritt & Savya, 2012). It can provide a new perspective and realization of dreams as well as provide the motivation to act towards achieving those dreams (Levi, Liechtentritt & Savya, 2012). This attitude of hope and optimism is similar to Viktor Frankl's theory on Logotherapy, which he describes as a way to "transform tragedy into triumph" (Southwick et al., 2006). Following a traumatic event, an individual will suffer from psychological distress in an attempt to process the event. This state of shock can also open different avenues for finding meaning (Addington, Tedeschi & Calhoun, 2016)). The search and discovery of meaning is essential for PTG to occur, focusing on one's strengths as opposed to psychopathology (Southwick et al., 2006). According to Frankl (1958), the discovery of meaning can be made through a deed, work or love. Women in this study described their unconditional love for their baby-to-be, indicating a love greater than any other bond they have ever had. As mothers prepare for the birth of their babies, they convey a hopeful attitude towards their relationship with their child, as well as aspirations they have for their child in the future. Rather than focusing on the negative effects of trauma, many of which continue to impact a trauma survivor's life, mothers focused on the new opportunities their babies would have. They shifted focus away from the horrendous abuse within their childhood, to the privileged and loving childhood their babies will have. This does not indicate that their past is forgotten, nor is the baby distracting away from their history of suffering.

Theme 4: Spirituality

Some mothers expressed holding sacred beliefs and referring to a higher power. Theme 4 entails 2 subthemes: Deeper connection to faith and divine intervention.

Deeper connection to faith.

Spirituality, broader than religiosity, has shown to play a large part in well-being and an adaptive resource for those who have experienced traumatic events. Gesselman et al. (2015) found that cancer patients with spiritual belief showed lower levels of stress, decreased depressive symptoms and greater mood stability. Spiritual experiences may also promote adaptive adjustment to trauma through different pathways such as providing opportunity for positive emotions. The ability for spirituality to buffer against the psychological impact of trauma could be attributed to how trauma may be conceptualized as part of bigger plan, as though the experience may have happened for a reason (Gesselman et al., 2015). Likewise, confronting trauma can lead to existential questioning related to meaning and purpose (Tedeschi et al., 2004).

Consequently, challenges may arise if survivors cannot make sense of the trauma and cannot fit their experience into their spiritual belief systems. However, by working through conflicts, survivors can revise their belief systems by assimilating their experiences into the cognitive processing of meaning-making (Kurian et al., 2016). Although women did not disclose being apart of a spiritual community, they did express engaging in religious activities such as reading the bible. Research has found that spiritual coping can be helpful for those involved with an organized group such as church

or a religious organization (Calhoun & Tedeschi, 1999). A connection with a higher power can provide a source of support and comfort for those who have experienced loss (Wiechman & Magyar-Russell, 2009).

Limitations

The purpose of this study was to understand the individual experiences of pregnancy for women survivors of CSA. Each woman described how her transition into motherhood has helped her develop a new sense of purpose and meaning following her struggle with trauma. The study is of a small-scale examining the stories of eighteen women survivors. Thus, results may not be generalized to other women who have experienced CSA. Likewise, the study only focused on women survivors of CSA not the experience of male survivors. Therefore, these results may not extend to non-female survivors who are transitioning into parenthood (i.e., how fatherhood can provide meaning to a CSA survivor).

Additionally, the data was originally collected for a study aimed to understand how trauma has impacted a survivor's perception of motherhood. There may have been a biasing effect in which participants came to the interviews with a certain expectation to focus on the positive changes following their trauma. Likewise, questions from the interview focused on each woman's source of strength, resilience and hopes and dreams for their baby, which may have reinforced the positive aspects of each woman's life. Nonetheless, questions did also focus on the negative aspects of trauma such as the participant's experience with the health care system as well as how trauma has impacted their physical and emotional states.

Strengths

Although the sample size in this study is not large according to the suggestion of Morse (1994), there is no specific sample size required or deemed appropriate in qualitative research. Thus, the validity and credibility of this data does not lie in its quantity but in the meaning of the data. Adding more participants to the sample would likely not have increased the number of themes. Furthermore, by using Creswell's (2003) 6 steps for thematic analysis as well as Guba's (1981) constructs for producing trustworthy results, it was possible to analyze the data in depth.

This study provided the opportunity for each participant to share her narrative in detail. Many women told their story for the first time in these interviews, allowing each one to speak out about her experience with sexual violence and share her journey of hope and resilience. The empowering nature of qualitative analysis can give researchers a more profound look into the mechanisms of coping with sexual violence, especially in mothers-to-be. Additionally, the interviewing process did not dismiss information or restrict participants to responding to specific questions without explanation. This study analyzed all data gathered to better understand each factor related to the process of PTG.

Implications for Counselling

The current research demonstrates the importance of providing a safe space for women survivors of CSA to share their stories in a trauma-informed setting. There is a need to address and understand the impact of trauma and the ways it influences child-rearing practices. Not only does this promote the need for education about trauma, but

can demonstrate the necessity of ongoing support for mother survivors of trauma. As mentioned previously, trauma can manifest into several symptoms. Although it is invisible to the eye, acknowledging trauma in health-care/counselling practices provides a crucial step towards healing and recovery (Berman et al., 2014). Ethically, counsellors have an obligation to minimize the likelihood of harm in practice. Thus, providing a comfortable atmosphere, establishing safety and recognizing the signs and symptoms of trauma can empower women to break the silence regarding sexual violence. As women speak out about their experience, they may gain control of their narrative and identify strengths to cope with these symptoms. This is especially important for mother survivors and the need to reduce intergenerational trauma.

Implications for Research

This study aimed to elucidate the importance of understanding trauma in the health care system and identifying meaningful factors for coping and recovery. Allowing women to share their experience with violence may provide insight into the processes involved in trauma recovery. Likewise, this research examined the possibility of PTG in survivors of childhood abuse and the possibility of healing and growth following complex trauma. Past research focuses on the negative, long-term impact of trauma. However, this research examined a different path of trauma by focusing on women's strengths and identifying factors that may be helpful in coping with trauma, rather than on psychopathology. Further research may examine the impact of daily stressors, such as poverty, abuse, substance abuse, and homelessness that may exacerbate symptoms of trauma and impede in the process of PTG. Additionally, the research was based in

feminist principles and provided an opportunity for women survivors to describe their stories. However, future research may consider examining the impact of CSA in other vulnerable populations and how finding meaning can facilitate PTG.

Conclusion

Pregnancy, a meaningful milestone for women was investigated as a driving force behind PTG for survivors of CSA. Using qualitative analysis, women survivors of CSA in their second trimester of pregnancy completed face-to-face interviews. Four themes were identified: Change in Perception, Personal Growth, Hope for Child and Spirituality. Supporting research in the area of counselling and trauma, mothers described factors that facilitated growth including confronting and coping with their past trauma and changing their priorities. Contrary to research based in the medical or deficit model, mothers in this study demonstrated positive changes following their experiences with trauma and the strength and confidence to be dedicated mothers to their babies-to-be.

References

ACOG Committee Opinion. Number 290, November 2003. (2003). *Obstetrics & Gynecology, 102*(5, Part 1), 1107-1113.

Ackerly, B., & True, J. (2010). Back to the future: Feminist theory, activism, and doing feminist research in an age of globalization. *Women's Studies International Forum, 33*(5), 464-472.

Addington, E. L., Tedeschi, R. G., & Calhoun, L. G. (2016). A growth perspective on post-traumatic stress. In A. M. Wood, & J. Johnson (Eds.), *The wiley handbook of positive clinical psychology; the wiley handbook of positive clinical psychology* (pp. 223-231, Chapter xx, 485 Pages) Wiley-Blackwell.

Ahrens, C. E., Stansell, J., & Jennings, A. (2010). To tell or not to tell: The impact of disclosure on sexual assault survivors' recovery. *Violence and victims*, *25*(5), 631-648.

Andersen, S. L., Tomada, A., Vincow, E. S., Valente, E., Polcari, A., & Teicher, M. H. (2008). Preliminary evidence for the sensitive periods in the effect of childhood sexual abuse on regional brain development. *The Journal of Neuropsychiatry and Clinical Neurosciences, 20*(3), 292-301

Askay, S. W., & Magyar-Russell, G. (2009). Post-traumatic growth and spirituality in burn recovery. *International Review of Psychiatry, 21*(6), 570-579.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55*(11), 1247-1263

Batten, S. V., Orsillo, S. M., & Walser, R. D. (n.d.). Acceptance and mindfulness-based approaches to the treatment of posttraumatic stress disorder. *Acceptance and Mindfulness-Based Approaches to Anxiety Series in Anxiety and Related Disorders,* 241-269.

Berman, H., Mason, R., Hall, J., Rodger, S., Classen, C. C., Evans, M. K., . . . Al-Zoubi, F. (2014). Laboring to mother in the context of past trauma: The transition to motherhood. *Qualitative Health Research, 24*(9), 1253-1264.

Births: final data for 2003. *National vital statistics reports*, *54*(2), 1-116.

Bourdon, L. S., & Cook, A. S. (1993). Losses associated with sexual abuse: Therapist and client perceptions. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 2*(4), 69-82

Braje, S. E., Eddy, J. M., & Hall, G. C. (2015). A Comparison of Two Models of Risky

Sexual Behavior During Late Adolescence. *Archives of Sexual Behavior, 45*(1), 73-83.

Campbell, R., & Wasco, S. M. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology, 28*(6), 773-791

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*(3), 225-246.

Canada, G. O. (2015, November 30). Police-reported sexual offences against children and youth in Canada, 2012.

Chang, M., Chen, C., & Huang, K. (2008). Effects of music therapy on psychological health of women during pregnancy. *Journal of Clinical Nursing, 17*(19), 2580-2587.

Chopko, B. A. (2010). Posttraumatic distress and growth: An empirical study of police officers. *American Journal of Psychotherapy, 64*(1), 55-72.

Coker, A. L. (2007). Does Physical Intimate Partner Violence Affect Sexual Health? *Trauma, Violence, & Abuse, 8*(2), 149-177.

Cole, A. S., & Lynn, S. J. (2010). Adjustment of sexual assault survivors: Hardiness and acceptance coping in posttraumatic growth. *Imagination, Cognition and Personality, 30*(1), 111-127.

Cox, J. (1994). Perinatal psychiatry: East is East and West is West. *British Journal of Psychiatry, 164*(3), 420-420.

Creswell, J. W. (2003). *Research Design* (2nd ed.). Sage.

Elliott, Denise E., Paula Bjelajac, Roger D. Fallot, Laurie S. Markoff, and Beth Glover Reed. 2005. Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of community psychology* 33, (4) (07): 461-477

Elsenbruch, S., Benson, S., Rucke, M., Rose, M., Dudenhausen, J., Pincus-Knackstedt, M., . . . Arck, P. (2006). Social support during pregnancy: effects on maternal depressive symptoms, smoking and pregnancy outcome. *Human Reproduction, 22*(3), 869-877.

Estévez, A., Ozerinjauregi, N., Herrero-Fernández, D., & Jauregui, P. (2016). The Mediator Role of Early Maladaptive Schemas Between Childhood Sexual Abuse and Impulsive Symptoms in Female Survivors of CSA. *Journal of Interpersonal Violence,* 088626051664581

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: II. psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(10), 1365-1374.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior, 21*(3), 219-239.

Frankl, V. E. (1958). The will to meaning. *Journal of Pastoral Care, 12*, 82-88.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56*(3), 218-226.

Freyd, J. J. (1996). *Betrayal trauma: the logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.

Gesselman, A. N., Bigatti, S. M., Garcia, J. R., Coe, K., Cella, D., & Champion, V. L. (2017). Spirituality, emotional distress, and post-traumatic growth in breast cancer survivors and their partners: An actor–partner interdependence modeling approach.

Glaser, B. G., Strauss, A. L., & Strutzel, E. (1968). The discovery of grounded theory; strategies for qualitative research. *Nursing Research, 17*(4), 364.

Glazier, R., Elgar, F., Goel, V., & Holzapfel, S. (2004). Stress, social support, and emotional distress in a community sample of pregnant women. *Journal of Psychosomatic Obstetrics & Gynecology, 25*(3-4), 247-255.

Gobin, Robyn L., and Jennifer J. Freyd. 2014. The impact of betrayal trauma on the tendency to trust. *Psychological Trauma: Theory, Research, Practice, and Policy* 6, (5) (09): 505-511.

Grote, N. K., Spieker, S. J., Lohr, M. J., Geibel, S. L., Swartz, H. A., Frank, E., . . . Katon, W. (2012). Impact of childhood trauma on the outcomes of a perinatal depression trial. *Depression and Anxiety, 29*(7), 563-573

Grubaugh, A. L., & Resick, P. A. (2007). Posttraumatic growth in treatment-seeking female assault victims. *Psychiatric Quarterly, 78*(2), 145-155.

Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational technology research and development, 29 (2), 75-91.

Hahm, H. C., Lee, Y., Ozonoff, A., & Van Wert, M. J. (2010). The impact of multiple types of child maltreatment on subsequent risk behaviors among women during

the transition from adolescence to young adulthood. Journal of Youth and Adolescence, 39(5), 528–540.

Hallberg, L. R. (2006). The "core category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-being, 1*(3), 141-148.

Harville, E. W., Xiong, X., Buekens, P., Pridjian, G., & Elkind-Hirsch, K. (2010). Resilience after hurricane katrina among pregnant and postpartum women. *Women's Health Issues, 20*(1), 20-27.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1-25.

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology, 74*(5), 797-816.

Herman, J. L. (1992). *Trauma and Recovery: The Aftermath of Violence*. New York: Basic Books.

Herman, J. L. (2013, June). PTSD as a shame disorder. Keynote address, XIII ESTSS CONFERENCE: "Trauma and its clinical pathways: PTSD and beyond", Bologna. European Journal of Psychotraumatology 2013, 4, 21270.

Hockett, J. M., & Saucier, D. A. (2015). A systematic literature review of "rape victims" versus "rape survivors": Implications for theory, research, and practice. *Aggression and Violent Behavior, 25*, 1-14.

Jensen, T. K., Thoresen, S., & Dyb, G. (2015). Coping responses in the midst of terror: The july 22 terror attack at utøya island in norway. *Scandinavian Journal of Psychology, 56*(1), 45-52

Kashdan, T. B., & Kane, J. Q. (2011). Post-traumatic distress and the presence of post-traumatic growth and meaning in life: Experiential avoidance as a moderator. *Personality and Individual Differences, 50*(1), 84-89.

Kia-Keating, M., Sorsoli, L., & Grossman, F. K. (2010). Relational challenges and recovery processes in male survivors of childhood sexual abuse. *Journal of Interpersonal Violence, 25*(4), 666-683.

Kilpatrick, D. G., Saunders, B. E., & Smith, D. W. (n.d.). Youth victimization: prevalence and implications. *PsycEXTRA Dataset.*

Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of

extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Krosch, D. J., & Shakespeare-Finch, J. (2017). Grief, traumatic stress, and posttraumatic growth in women who have experienced pregnancy loss. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(4), 425-433.

Kurian, A. G., Currier, J. M., Rojas-Flores, L., Herrera, S., & Foster, J. D. (2016). Meaning, perceived growth, and posttraumatic stress among teachers in el salvador: Assessing the impact of daily spiritual experiences. *Psychology of Religion and Spirituality, 8*(4), 289-297.

Lather, P. (1986). Research as praxis. *Harvard Educational Review*, 56(3), 257–276.

Lacelle, C., Hébert, M., Lavoie, F., Vitaro, F., & Tremblay, R. E. (2012). Child Sexual Abuse and Women's Sexual Health: The Contribution of CSA Severity and Exposure to Multiple Forms of Childhood Victimization. *Journal of Child Sexual Abuse, 21*(5), 571-592.

Leeners, B., Richter-Appelt, H., Imthurn, B., & Rath, W. (2006). Influence of childhood sexual abuse on pregnancy, delivery, and the early postpartum period in adult women. *Journal of Psychosomatic Research, 61*(2), 139-151.

Legerski, J., & Bunnell, S. L. (2010). The Risks, benefits, and ethics of trauma-focused research participation. *Ethics & Behavior, 20*(6), 429-442.

Lemieux, S. R., & Byers, E. S. (2008). The Sexual Well-Being of Women Who Have Experienced Child Sexual Abuse. *Psychology of Women Quarterly, 32*(2), 126-144.

Lepore, S. J., Ragan, J. D., & Jones, S. (2000). Talking facilitates cognitive-emotional processes of adaptation to an acute stressor. *Journal of Personality and Social Psychology, 78*(3), 499-508.

Leserman, J. (2005). Sexual abuse history: Prevalence, health effects, mediators, and psychological treatment. *Psychosomatic Medicine, 67*(6), 906-915.

Levi, O., Liechtentritt, R., & Savaya, R. (2012). Posttraumatic stress disorder patients' experiences of hope. *Qualitative Health Research, 22*(12), 1672-1684

Levitan, R. D., Parikh, S. V., Lesage, A. D., Hegadoren, K. M., Adams, M., Kennedy, S. H., & Goering, P. N. (1998). Major Depression in Individuals With a History of Childhood Physical or Sexual Abuse: Relationship to Neurovegetative Features, Mania, and Gender. *American Journal of Psychiatry, 155*(12), 1746-1752.

Lev-Wiesel, R., Daphna-Tekoah, S., & Hallak, M. (2009). Childhood sexual abuse as a predictor of birth-related posttraumatic stress and postpartum posttraumatic stress. *Child Abuse & Neglect, 33*(12), 877-887.

Littleton, H. L., Grills-Taquechel, A. E., Axsom, D., Bye, K., & Buck, K. S. (2012). Prior Sexual trauma and adjustment following the Virginia Tech campus shootings: Examination of the mediating role of schemas and social support. Psychological Trauma: Theory, Research, Practice, and Policy, 4(6), 578–586.

Locke, K. D., & Sadler, P. (2007). Self-efficacy, values, and complementarity in dyadic interactions: Integrating interpersonal and social-cognitive theory. *Personality and Social Psychology Bulletin, 33*(1), 94-109.

Macmillan, H. L., Tanaka, M., Duku, E., Vaillancourt, T., & Boyle, M. H. (2013). Child physical and sexual abuse in a community sample of young adults: Results from the Ontario Child Health Study. *Child Abuse & Neglect, 37*(1), 14-21.

Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual review of psychology*, *51*(1), 445-479.

Mason, R., Berman, H. (2014). Vulnerability, risk and harm: The business of institutional review boards. *Humanities and Social Sciences Review,* 517- 524.

Mccarthy, B. W. (1986). A cognitive-behavioral approach to understanding and treating sexual trauma. *Journal of Sex & Marital Therapy, 12*(4), 322-329.

Mcelheran, M., Briscoe-Smith, A., Khaylis, A., Westrup, D., Hayward, C., & Gore-Felton, C. (2012). A conceptual model of post-traumatic growth among children and adolescents in the aftermath of sexual abuse. *Counselling Psychology Quarterly, 25*(1), 73-82.

Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American journal of public health*, *91*(5), 753.

Moor, A. (2007). When recounting the traumatic memories is not enough: Treating persistent self-devaluation associated with rape and victim-blaming rape myths. *Women & Therapy*, *30*(1-2), 19-33.

Morse, J. M. (1994). Designing funded qualitative research. In Denizin, N. K. & Lincoln, Y. S., *Handbook of qualitative research* (2nd Ed). Thousand Oaks, CA: Sage.

Murthi, M., & Espelage, D. L. (2005). Childhood sexual abuse, social support, and psychological outcomes: A loss framework. *Child abuse & neglect*, *29*(11), 1215-1231.

Münzer, A., Fegert, J. M., & Goldbeck, L. (2016). Psychological Symptoms of Sexually

Victimized Children and Adolescents Compared With Other Maltreatment Subtypes. *Journal of Child Sexual Abuse, 25*(3), 326-346.

Newman, E., Risch, E., & Kassam-Adams, N. (2006). Ethical issues in trauma-related research: A review. *Journal of Empirical Research on Human Research Ethics, 1*(3), 29-46.

Pavani, J., Le Vigouroux, S., Kop, J., Congard, A., & Dauvier, B. (2016). Affect and affect regulation strategies reciprocally influence each other in daily life: The case of positive reappraisal, problem-focused coping, appreciation and rumination. *Journal of Happiness Studies, 17*(5), 2077-2095.

Polusny, M. A., Rosenthal, M. Z., Aban, I., & Follette, V. M. (2004). Experiential avoidance as a mediator of the effects of adolescent sexual victimization on negative adult outcomes. *Violence and Victims, 19*(1), 109-120.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 269-278.

Rodger, S., Leschied, A. (2012). The long term impact of victimization in cases of historical child sexual abuse and intimate partner violence. In Hutcherson, A. N. *Psychology of victimization* (181-191). Nova Science Publishers.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs, 80*(1), 1-28.

R. University. (2009). Developing Self Confidence, Self Esteem and Resilience. Retrieved from http://mams.rmit.edu.au/elh5d4nc7sfd.pdf

Schwerdtfeger, K. L. (2009). The appraisal of quantitative and qualitative trauma-focused research procedures among pregnant participants. *Journal of Empirical Research on Human Research Ethics, 4*(4), 39-51.

Seligman, M. E. P., & Csikszentmihalyi, M. (Eds.) (2000). Positive Psychology—An Introduction. *American Psychologist*, 55, 5-14.

Seng, J. (1998). Relationship strategies and interdisciplinary collaboration improving maternity care with survivors of childhood sexual abuse. *Journal of Nurse-Midwifery, 43*(4), 287-295

Seng, J. S., Low, L. K., Sparbel, K. J. H., & Killion, C. (2004). Abuse-related post-traumatic stress during the childbearing year. Issues and Innovations in Nursing Practice, 46, 604–613

Shakespeare-Finch, J., & Dassel, T. D. (2009). Exploring posttraumatic outcomes as a function of childhood sexual abuse. *Journal of Child Sexual Abuse, 18*(6), 623-640.

Smith, M. V., Rosenheck, R. A., Cavaleri, M. A., Howell, H. B., Poschman, K., & Yonkers, K. A. (2004). Screening for and detection of depression, panic disorder, and PTSD in public-sector obstetric clinics. *Psychiatric Services, 55*(4), 407-414

Snyder, C. R., & Pulvers, K. M. (2001). Dr. Seuss, the coping machine, and "Oh, the Places You'll Go.". *Coping with stress: Effective people and processes*, 3-29.

Southwick, S. M., Gilmartin, R., Mcdonough, P., & Morrissey, P. (2006). Logotherapy as an adjunctive treatment for chronic combat-related PTSD: A meaning-based intervention.

Spinelli, M. G. (1997). Interpersonal psychotherapy for depressed antepartum women: A pilot study. *The American Journal of Psychiatry, 154*(7), 1028-1030.

Stoltenborgh, M., Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79-101.

Su, Y., & Chen, S. (2015). Emerging posttraumatic growth: A prospective study with pre- and posttrauma psychological predictors. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(2), 103-111.

Sutherland, K., & Bryant, R. A. (2005). Self-defining memories in post-traumatic stress disorder. *British Journal of Clinical Psychology, 44*(4), 591-598.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-471.

Tedeschi, R. G., & Calhoun, L. G. (1999). *Facilitating Posttraumatic Growth A Clinicians Guide*. Routledge.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1-18.

Tedeschi. R. G., Calhoun, L. G.. & Cooper. L. (2000. August). Rumil! Uti(1/I ulld pO.frtraullratic !.'mwth ill older udulr.f. Paper presented at the ~eting of the American Psychological Association, Washington. DC.

Trocmé, N., Fallon, B., MacLaurin, B., Sinha, V., Black, T., Fast, E., . . . Holroyd, J. (2008). *Canadian incidence study of reported child abuse and neglect: final report*. Ottawa: Health Canada.

Undurraga, R. (2010). How quantitative are feminist research methods textbooks? *International Journal of Social Research Methodology, 13*(3), 277-281.

Yampolsky, L., Lev-Wiesel, R., & Ben-Zion, I. Z. (2010). Child sexual abuse: Is it a risk factor for pregnancy? *Journal of Advanced Nursing*, *66(*9), 2025-2037.

Zinzow, H. M., Amstadter, A. B., Mccauley, J. L., Ruggiero, K. J., Resnick, H. S., & Kilpatrick, D. G. (2011). Self-rated Health in Relation to Rape and Mental Health Disorders in a National Sample of College Women. *Journal of American College Health, 59*(7), 588-594.

.
.

Appendix A

Ethical Approval

May 11, 2017

Dear Dr. Beynon.

This is to verify that Alexandra Canzonieri, a student in the Master of Arts (Counselling Psychology), has permission to do a secondary analysis using data collected for the project entitled, "Embodied Trauma", NMREB approval # 15662S. I was the PI on this project.

Yours sincerely,

Dr. Helene Berman
Professor & Associate Dean (Research)

The University of Western Ontario
Faculty of Education, Althouse Faculty of Education Building
London, Ontario • N6G 1G7 • Canada
Telephone: (519) 661-3182 • Fax: (519) 661-3833 • www.edu.uwo.ca

Office of Research Ethics

The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. H. Berman
Review Number: 15662S **Review Level:** Full Board
Review Date: December 12, 2008
Protocol Title: Embodied Trauma: The Influence of Past Trauma on Women During the Transition to Motherhood
Department and Institution: Nursing, University of Western Ontario
Sponsor: CIHR-CANADIAN INSTITUTE OF HEALTH RESEARCH
Ethics Approval Date: February 06, 2009 **Expiry Date:** December 31, 2011
Documents Reviewed and Approved: UWO Protocol, Letter of Information and consent, Advertisement
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

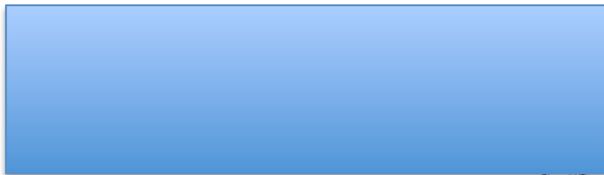
During the course of the research, no deviations from, or changes to, the study or consent form may be initiated without prior written approval from the NMREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the NMREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the NMREB.



Chair of NMREB: Dr. Jerry Paquette

Ethics Officer to Contact for Further Information			
☑ Grace Kelly	☐ Janice Sutherland	☐ Elizabeth Wambolt	☐ Denise Grafton

This is an official document. Please retain the original in your files. cc: ORE File

Appendix B

Four Major Themes Including Subthemes and Significance of Each One.

Main Theme	Sub-Theme	Associated Meaning
Change in Perception	Relief and acceptance	Mother accepting past experiences related to the trauma and focusing on present goals.
	Finding new meaning through tasks and hobbies	Mother taking up new activity or starting a tradition.
	Not sweating the small stuff (change in priorities)	No longer emotionally reacting to events/ situations that may have taken primary importance in the past
	Change in attitude towards past relationships	Mother's attitude towards relationship with family changes to either feeling closer to them or feeling anger towards their primary caregiver
Personal Growth	Newfound resilience	Mother's ability to recover from traumatic experiences and build greater strength.
	Self-confidence	Mother's are self-assured and trust their judgment.
	Thinking of self (self-improvement)	Taking care of one's self emotionally and physically as mother's to be.
	Confronting/Coping with Trauma	Mother's share their experience with coping With their past trauma.
Hope for Child	Thinking long-term/ future goals (hopes)	Hopes for their babies including future career, health status and personality.
	Newfound strength (protection) towards others	Protecting their children to prevent the same trauma

		each mother experienced from happening to them.
	Thinking and loving beyond self	Deep connection between mother and baby. Mother making sacrifices for her baby's well-being.
Spirituality	Deeper connection to faith	Finding comfort through religion and a higher being.
	Divine intervention	Belief that God is the creator of and reason for certain events occurring.

Appendix C

Categorization of Theme Frequencies Conceived from 18 Transcribed Interviews

Theme	Number of Quotes	Number of Women	Categorization
Change in Perception	31	15	Typical
Personal Growth	34	16	Typical
Hope for Child	44	16	Typical
Spirituality	5	5	Variant

*Typical: mentioned by 9-15 participants, Variant: mentioned by less than 8 participants

Curriculum Vitae

NAME Alexandra Canzonieri

EDUCATION

2016-2018 Master's of Arts in Counselling Psychology, Western University, London, ON

2010-2015 Bachelor of Science: Honors Psychology Specialist, Minor in Buddhism, Psychology and Mental Health, Toronto, ON

RESEARCH EXPERIENCE

2012-2016 Research Assistant, S.T.A.R.T. Clinic for Mood and Anxiety Disorders
Toronto, ON

2014-2015 Research Assistant, Emotion Focused Psychotherapy Research Laboratory
OISE, University of Toronto
Toronto, ON

2014-2015 Research Assistant, Computational Affective Neuroscience Laboratory
University of Toronto
Toronto, ON

COUNSELLING-RELATED EXPERIENCE

2017-2018 Intern, Daya Counselling Centre
London, ON

2017-2018 Intern, Psychoeducation and Social Groups
Anova
London, ON

2015-2016 Crisis Line Counsellor, Toronto Rape Crisis Centre
Toronto, ON

2015-2016 Crisis Line Responder, Toronto Distress Centre
Toronto, ON