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Laboring to Mother in the Context of Past Trauma: The Transition to Motherhood

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Abstract

The occurrence of interpersonal trauma is a reality for many women, with effects that often persist long after the traumatic events end. The purpose of this feminist grounded theory study was to examine how past trauma shaped the lives of women as they became new mothers. We recruited a purposive sample of 32 women from two Canadian communities and conducted semistructured, dialogic interviews during the second trimester of pregnancy. We analyzed data using thematic content analytic methods, including open coding whereby we read transcripts line by line and applied codes to portions of text that illustrated concepts or themes. The substantive grounded theory, "laboring to mother in the context of past trauma," describes the exceedingly difficult emotional and cognitive work undertaken by pregnant women with histories of trauma as they anticipate becoming mothers. In this article, we present key components of the theory and offer recommendations for health and social service providers.

Keywords

grounded theory; mothers, mothering; pregnancy; trauma; women's health

Contemporary notions of mothering are abundant and seemingly omnipresent in both the lay and scholarly literature. Book stores are replete with sections advising women about what they need to do to achieve success as mothers, often in "ten easy steps"; magazines on mothering have proliferated exponentially over the past two decades; a Google search of mothering resulted in more than 1,600,000 hits, whereas Google Scholar produced 82,000 hits. Clearly, there is no shortage of advice for women who embark on this significant phase of life. Underpinning this literature is a set of fairly narrow and prescriptive assumptions about "the good mother," who she is, what she looks like, and how she must behave.

Missing from the prevailing discourses about mothering is an understanding of what becoming a mother means for women who have experienced interpersonal trauma. Given the prevalence of violence, abuse, and trauma in the lives of girls and women, this absence is, in some respects, surprising. Many researchers have examined the emotional and physical sequelae associated with intimate partner violence (IPV; Campbell, 2002; Coker et al., 2002; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008), and it is widely understood that women who are survivors of violence often experience lifelong challenges. Although the effects are particularly salient during the reproductive years, they are often invisible, only to emerge in subtle yet insidious ways, often long after the traumatic events occurred.

Because research in this area is so limited, there is relatively little to guide health professionals who work with women who have experienced past trauma as they make the transition into motherhood. In this article, we present findings from a feminist grounded theory study undertaken to address this knowledge gap. We examine how past interpersonal trauma affects women as they negotiate the transition to motherhood, while taking into account participants' multiple and intersecting social locations and identities.

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Conceptualizing Trauma

Although our understanding of trauma and the range of human responses to traumatic events is evolving, there is still confusion and dissent regarding definitions, diagnoses, and appropriate treatment modalities for trauma survivors. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013), the tool used by mental health professionals to determine a clinical diagnosis of trauma survivors, recognizes posttraumatic stress disorder (PTSD) in an individual who has been exposed to an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. Common symptoms include reexperiencing the event, avoidance or numbing, heightened arousal, and negative thoughts lasting more than a month in duration and with evidence of significant distress or functional impairment. The label of PTSD has been applied to individuals who have faced a variety of traumatic events, including combat, rape, accidental injury, kidnappings, natural disasters, and forms of abuse.

The PTSD diagnosis has been extremely useful in generating research that scientifically analyzes predictors and outcomes of traumatic events. The diagnostic criteria lend themselves well to measurement and assessment, strengthening the evidence that trauma is a pervasive problem with significant health effects. However, several limitations to the prevailing trauma paradigm merit consideration. Most notably, the PTSD framework emphasizes individual responses and pathology while neglecting consideration of the social and cultural context of trauma. For example, prevailing instruments do not recognize racially based psychological trauma (Gilfus, 1999), including the historical and ongoing injuries and colonial genocide faced by Aboriginal peoples. Similarly, social inequalities, such as poverty and racism, described by Root (1992) as insidious forms of trauma, typically fall outside the traditional PTSD paradigm, despite their saliency for many oppressed and/or marginalized women and the recognition that they might contribute to chronic stress.

In our research, we defined interpersonal trauma as experiences involving a disruption in trusted relationships as the result of violence, abuse, war or other forms of political oppression, or forced uprooting and dislocation from one's family, community, heritage, and/or culture. This definition is derived from a synthesis of ideas put forward by Herman (1992) and Wesley-Esquimaux and Smolewski (2004), and addresses the primary limitations of PTSD models described above. In particular, the work of Wesley-Esquimaux and Smolewski is centered on the social and cultural context of trauma, particularly for Aboriginal peoples. Our understanding of interpersonal trauma is thus based on a valuing of women's responses to trauma as potential tools for self-preservation and the recognition that stories of strength and resilience are also central components of women's trauma experiences (Sperlich & Seng, 2008).

Current Knowledge and Understandings

There is a considerable body of literature examining the impact of current abuse and other traumas that occur during pregnancy, childbirth, and/or the postpartum period (Beck, 2004, 2006; Daoud et al., 2012; Gazmararian et al., 2000). Much of this work concerns IPV and the resulting emotional sequelae, including the risk for postpartum depression (Beydoun, Al-Sahab, Beydoun, & Tamin, 2010) and pregnancy loss (Stockl et al., 2012). The stress of parenting in the context of a current abusive relationship has been shown to impinge on the mother–child relationship, increasing the risk of attachment problems, harsh or abusive parenting, and overly permissive or neglectful parenting (Levendosky & Graham-Bermann, 2001).

Few researchers have explored the impact of past interpersonal trauma on women during the transition to motherhood. These women might experience pregnancy and childbirth as particularly threatening to their physical and emotional well-being. For example, obstetric procedures that are part of regular perinatal care might trigger memories of previous traumas, thereby increasing the risk of a traumatic stress reaction and compromising the attachment process (Beck, 2006; Lukasse et al., 2010; Mezey, Bacchus, Bewley, & White, 2004).

According to the Canadian Incidence Study of Reported Child Abuse and Neglect report, 1 in 10 investigations by child welfare agencies in 1998 involved sexual abuse as the primary reason for the investigation. Sexual abuse was confirmed in more than one third of these cases (Trocmé & Wolfe, 2001). This finding supports the notion that childhood sexual abuse (CSA) is a disturbingly frequent occurrence in Canada. Several researchers have documented strong associations between CSA and a host of chronic and acute physical, psychological, and substance use problems for women during adulthood (Felitti et al., 1998; McCauley et al., 1997); however, research on how CSA affects women during the transition to motherhood is sparse.

Several researchers have examined pregnancy outcomes among women who have experienced CSA. Positive relationships have been described between CSA and unintended pregnancies (Gazmararian et al., 1995), adolescent pregnancies (Silverman, Raj, Mucci, & Hathaway, 2001; Young, Deardorff, Ozer, & Lahiff, 2010), prenatal depression (Rich-Edwards et al., 2011), poor health during pregnancy (Yampolsky, Lev-Wiesel,

& Ben-Zion, 2010), and significantly more hospital admissions during pregnancy (Leeners, Stiller, Block, Gorres, & Rath, 2010). The emotional effects of CSA on labor and delivery include extreme fear of childbirth (Heimstad, Dahloe, Laache, Skogvoll, & Schei, 2006), unintentional triggering of repressed memories and flashbacks (Hobbins, 2005; Leeners, Richter-Appelt, Imthurn, & Rath, 2006), and intense fear (Prescott, 2002). Women with histories of CSA have reported posttraumatic stress symptoms before and after childbirth (Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009).

Researchers have identified the following during the postpartum period: difficulties with lactation (Kendall-Tackett, 1998; Monahan & Forgash, 2000), postpartum depression (Buist & Janson, 2001), and problems with attachment and adaptation to mothering (Kendall-Tackett, 2001; Leeners et al., 2006). Additionally, some survivors of CSA are reluctant to seek help (Hobbins, 2005). According to Skinner (2010), uninformed health care providers often label these women as difficult patients when they seek maternity care.

The impact of premigration trauma on refugee women's experiences during childbirth and the transition to motherhood has garnered some attention. Women refugees are likely to have experienced multiple losses and traumatic experiences, including war, rape, sexual violence, sexual slavery, harassment, and abduction before or during the process of migration (Amnesty International, 2004a; Berman, Irias-Giron, & Marroquin, 2006; Oxman-Martinez, Abdool, & Loiselle-Leonard, 2000). Rape and sexual violence are often perpetrated systematically and deliberately to dominate, humiliate, and disrupt social ties among civilian populations (Coles, 2004), and are used as a weapon of war (Bourke, 2006; Hynes, 2004). Sexual assault and other forms of abuse are common occurrences in refugee camps (Cardozo, Talley, & Crawford, 2004). Martin, Mackie, Kupper, Buescher, and Naracco (2001) suggested that between 4% and 26% of displaced and refugee women experience some form of abuse during the year preceding pregnancy.

The general health of refugee women is not well understood; however, in a systematic review, Gagnon, Merry, and Robinson (2007) reported health concerns that included a lack of sexual control, perinatal health problems, female genital mutilation, impaired mental health, lack of appropriate health services, and discrimination among this group. Although we found no research concerning the experiences of women refugees who give birth in Canada, in other countries the physical injuries associated with sexual assault have been shown to lead to complications before, during, and after birth, and to varied psychological problems, including difficulty meeting the physical and emotional needs of the infant (Amnesty International, 2004b).

It is now widely acknowledged that Aboriginal women in Canada have experienced multiple and cumulative forms of trauma. Collectively, these have stressed communities, disrupted relations, challenged traditional cultures, and undermined the role of women. This historical trauma, in essence a "collective non-remembering," is "passed to next generations through different channels, including biological (in hereditary predispositions to PTSD), cultural (through story-telling, culturally sanctioned behaviours), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory processes) channels" (Wesley-Esquimaux & Smolewski, 2004, p. 76). Over time, trauma becomes normalized in communities and individuals, destroying the social systems of care, protection, and meaning (Kleber, Figley, & Gersons, 1995), fostering relational disconnections as opposed to the connections that allow individuals to thrive in relationships.

Research with other traumatized communities—for example, holocaust survivors—has demonstrated that the impact of past trauma is often transmitted to and experienced by successive generations with profound effects on parenting (Danieli, 1998). How the legacies of historical trauma influence the transition to motherhood among Aboriginal women has received little scholarly attention. One exception is an edited collection by Lavell-Harvard and Corbiere Lavell (2006), who wrote about the impact of colonization on Aboriginal mothering practices and the strengths of Aboriginal women to overcome adversity.

In sum, the published literature related to past trauma in the lives of women demonstrates that they experience a multitude of physical and emotional health problems. Moreover, the research suggests that these problems might be intensified during pregnancy and childbirth. Notably absent is research examining how past trauma influences women as they contemplate the transition to motherhood; how the dominant discourses on mothering shape women's hopes, dreams, and expectations; and how, in the context of past trauma, these discourses might contribute to a sense of dissonance. Furthermore, little is known about the sources of resilience and strength, or the resources, services, and social contexts that support, promote, or act as barriers to their health. Similarly, few researchers have examined how individual and systemic experiences of trauma intersect and impact women during this critical period. We designed this research to address these knowledge gaps.

Research Methodology

We employed grounded theory methodology informed by feminist principles to explore the ways in which past interpersonal trauma shapes the transition to motherhood. Grounded theory is a highly systematic qualitative

research approach used to examine and describe the social processes that occur in human interactions. When used in conjunction with feminist perspectives, the aim is to capture the diversity and strength of women's experiences through a participatory process that invites dialogue and reflection (Kushner & Morrow, 2003; Wuest, 1995). Consistent with principles underlying feminist methodologies (Jaggar, 2008), the women's subjective experiences and insights are the primary sources of data and the research "space" is one that allows the researchers and participants the opportunity to critically reflect on the content and process of the study.

Data collection, analysis, and theory development occur concurrently rather than sequentially, with movement back and forth between these interrelated processes. The emerging theory is continuously modified and refined through constant comparative analysis until a basic social process that explains the salient issues is discovered (Glaser, 1978, 2002, 2005; Glaser & Strauss, 1967). This process results in the formulation of a substantive theory "grounded" in the data.

Research Methods

Prior to the start of data collection, we obtained ethics approval from the institutional review boards where the investigators were located. Because of the sensitive nature of this research, we paid particular attention to the preparation of research assistants who would be conducting the interviews. We developed a training program for all team members, focusing on strategies for building rapport, active listening, probing for clarification, responding to disclosures and/or distress during the interviews, and optimizing the women's emotional well-being and safety. We put strategies in place to support the research team members who would be conducting the interviews.

We recruited most study participants through advertisements posted on an online forum or a list server. Women who were interested either emailed or used a toll-free number to contact the research coordinator for more information about the study. We asked women who agreed to participate for a telephone number where they could be safely contacted. Following a preliminary phone call to determine their eligibility, we scheduled an interview at a location chosen by the woman.

Initially we used purposive sampling to recruit women from two urban areas in Ontario, Canada, and subsequently moved to theoretical sampling to develop and refine emerging theoretical categories (Charmaz, 2006). We continually modified interview questions based on our initial data collection and analysis. Eligibility criteria for inclusion were first pregnancy and in the second trimester at the time of enrolment; self-identified as having experienced past interpersonal trauma; and 18 years of

age or older. Even though we were interested in recruiting women with diverse experiences of interpersonal trauma—for example, survivors of CSA, refugee women, and Aboriginal women—the vast majority of the sample was composed of survivors of CSA. The rationale for conducting the interview during the second trimester was that this is usually a relatively stable time during pregnancy. We conducted all interviews in the language preferred by the women, using culturally appropriate interpretation and translation procedures. We obtained written informed consent from each woman prior to the interviews.

We conducted all interviews in a dialogic, open manner, using semistructured interview guides developed for this research. We began each interview inviting the women to share their reasons for participating in the study. Most used this opening as an opportunity to share their trauma-related stories. Questions and discussions focused on the women's perceptions about how their trauma stories influenced their current physical and emotional states, thoughts about becoming a mother, sources of strength and resilience, hopes and dreams for their baby and future family, and their experiences with the health care system. Data collection continued until the point of saturation, when no new information was elicited from additional interviews. We provided an honorarium of $25 for each interview in appreciation of the women's time and to defray any costs of traveling or child care. Each interview lasted approximately 2 hours.

Throughout the data collection and analytic processes, we used field notes and theoretical notes to record the analytical thinking and decisions of the research team, composed of an interdisciplinary group of academics with backgrounds in nursing, psychology, and psychiatry, as well as community researchers with frontline expertise in working with women who have experienced trauma. We maintained a detailed audit trail to document all the processes by which core categories and related concepts occurred and all decisions about the study design, sampling technique, and data collection. We digitally recorded and transcribed all interviews verbatim. We entered the transcripts into NVivo 8 qualitative software (QSR International, 2008) to assist with organizing and retrieving coded data.

The processes for data analysis included substantive and theoretical coding (Glaser, 2005). Initially, all members of the research team engaged in open coding by analyzing the initial interview transcripts line by line, creating the preliminary coding chart of broadly based concepts. After we identified initial codes, two members of the team independently conducted selective coding to analyze subsequent transcripts, compare data, and focus on recurring phrases and ideas within each participant interview, and to refine the initial coding chart. We

discussed, reviewed, and revised the evolving coding chart during meetings with all members of the research team. When a discrepancy existed between researchers, we achieved a consensus through collective reflection and dialogue. We then reread each transcript to encourage deeper analysis. We focused subsequent analyses on comparative categories that were consistently emerging across participant transcripts to identify core categories.

We conducted theoretical coding to conceptualize how the substantive codes related to each other and the core category. We selected relevant quotations based on their frequency, richness, and ability to reflect the main ideas within each category. We ensured trustworthiness of the data through the reflective memoing we engaged in throughout data collection and analysis, data confirmability by multiple researchers, and researcher consensus of similarities and differences in data coding through open dialogue (Graneheim & Lundman, 2004).

Sample

Thirty-three women participated in the study. More than half of the sample (*n* = 18) identified themselves as survivors of CSA. Eight participants identified as refugees, but during the course of the interviews 3 of them revealed that they had also experienced CSA. Three participants identified as Aboriginal women. One participant had experienced interpersonal trauma as a young adult. The participants ranged in age from 19 to 48 years. Eleven participants were engaged/married and/or in a common-law relationship. The participants came from diverse ethnic and religious groups. The refugee women were from countries in Asia, Africa, and Central America. Where employment status was indicated, almost half of the participants were not employed outside the home (*n* = 14).

Findings

Our substantive grounded theory indicated that pregnant women with histories of trauma undertook exceedingly difficult emotional and cognitive work as they anticipated becoming a mother, a process we have called laboring to mother in the context of past trauma. The women described their efforts to make sense of the trauma in their life and to integrate these experiences into their sense of self in a way that would enable them to become the mother they wanted to be. They viewed this making-sense process as a necessary and time-sensitive endeavor, which they believed required resolution prior to the birth of their child. For some women, this process entailed efforts directed toward forgiving and forgetting. Fundamental to this process was a perceived need to forgive those who were responsible for the trauma.

Permeating the women's stories about the transition to mothering in the context of past interpersonal trauma were not only a number of prevailing discourses that prescribed what constituted a good mother, but also discourses that dictated what the process of healing from trauma entailed. For some women, this process involved efforts directed at deliberately containing their experiences of trauma; literally isolating painful pasts so these would not dominate their life or the life of their child. As with the process of forgiving and forgetting, deliberately containing was also shaped by pervasive notions and discourses about motherhood and about women more generally. Laden with underlying social, moral, and political assumptions and imperatives, these dominant discourses of mothering and trauma offered the women a fairly narrow and highly prescriptive set of behaviors and ways of being that were often difficult, if not impossible, to achieve.

The women in this study faced many challenges because of the difficult circumstances of their lives, which commonly included poverty, housing insecurity, social isolation, difficult interpersonal relationships, and a multitude of adverse health sequelae associated with a history of past trauma and abuse. Their efforts aimed at navigating the chaos of everyday life revealed the resilience and resourcefulness of women in the face of seemingly enormous hardship. Finally, despite the challenges, the women also shared their hopes and dreams for the perfect family, often drawing on a concept of the idealized family as constructed through normative discourses. We have called this social process pregnant with possibilities. Together, these processes comprise the grounded theory, laboring to mother in the context of past trauma, examined in more depth throughout this section.

Forgiving and Forgetting

During the interviews, we asked the women how they thought their past experiences of trauma might affect the transition to motherhood, or alternatively, if they thought it had little impact. Consistently, the women stated that their past traumas did indeed have an impact, and that to be good a mother, they needed to do the work of healing prior to the birth of their child. This perception was a powerful motivator for women to engage in the dual processes of forgiving and forgetting. They spoke about the importance of growing from their pain, the need to let go of their anger, and to learn from their past while focusing on their future. Conversely, they believed that the inability to forgive and forget was tantamount to the inability to be whole, good, well, competent, or healthy, as one survivor of CSA so clearly stated:

For a while I still hated those people. Then as I grew older and more mature, you learn to forgive. You feel even better about yourself. Someone that forgives is a better person than the person that does harm to people. You feel better about yourself. It felt good.

Without forgiving and forgetting, participants feared that they would not be able to become the mother they wanted to be. There was a clear sense of urgency to this process, a belief that to be emotionally available to their infant, the women first needed to become emotionally whole themselves—and the way to achieve this was through forgiving and forgetting. One woman told about her desire to see a counselor so she could do the work of healing before her baby was born:

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. You can't move on. You don't move on, you're stuck and you'll always be unhappy. And then you won't be able to love yourself.

Inherent in these remarks is the idea that forgiving and forgetting are requisite conditions for emotional well-being and for motherhood. The person who does not forgive and forget is the person who is stuck in the past and lacks resilience. In essence, the discourse of forgiving and forgetting is rooted in a fundamentally Christian worldview (Levy & Sznaider, 2006) that places the burden on the women who have been victimized to do the work of healing. It is an individualistic neoliberal discourse that disallows the expression of hurt or anger, extols personal suffering as the vehicle for personal transformation, and fails to take into account the larger contexts of women's lives. The capacity to heal, to forgive and forget, is viewed as an individual responsibility, with the onus lying entirely with the women. According to Levy and Sznaider, "the political significance of forgiveness is contingent on a set of historical and institutional circumstances that condition the respective meanings forgiveness can (or cannot) assume" (p. 84). This idea is obscured within the prevailing social expectations about forgiving.

Deliberately Containing the Trauma

Many women described an array of strategies they used to deliberately contain the trauma that continued to shape, and at times dominate, their lives. This process was evident in their voices as they shared their stories, and we were struck by the very deliberate, determined, and difficult work the process of containment entailed. The women exercised enormous creativity as they sought

ways to live with their past, while carrying on with their lives in the present and imagined future. Strategies that reflected this process included blocking it out, deliberately blurring, reframing, and confronting the memories. As one participant who was a survivor of CSA said,

You're always thinking about it. "Oh, I have this trauma, blah, blah, blah," so, you're just stressing yourself, and not just you. There's a little, like a little life, a little life inside you, so you don't have to think about it. You have to block that feeling.

Through the process of deliberately containing the trauma, the women felt able to protect themselves, their developing fetus, and others from whatever expression or outburst, fears, and anxieties that might emerge should they fail to contain them. Underlying this process were dominant discourses of what it meant to be a good (pregnant) woman, which made a display of anger or rage unacceptable. If they did not contain the trauma, they would be viewed as mad, bad, hysterical, and overly emotional. Through the processes of containing, the women worked to protect themselves, their fetus, and their relationships.

A survivor of CSA who had come to Canada as a refugee described a different strategy to contain the trauma:

You know what, I think I did a very good thing. I, I just blurred my memories. Because I really, I really wanted to get rid of them because I, I really felt that they were affecting my life. I had this diary with me, the one that I kept for several years. I just, I just threw it [emotional voice]. I just, I just stepped on it. I just, you know, I let it all out. Because I started completely new right here in Canada.

Whereas some women tried to expunge their memories, others used a process of cognitive reframing to contain what had occurred:

I try to find an opposite thought; a positive thought. And just tell myself, "This is wrong. Your thoughts are wrong. You're a very strong woman. Look what you've achieved [excited voice]. Now you're pregnant. This is quite an achievement, and you go to university now, and you have work, you have job, you have husband who loves you, and you love him. It is a lot."

These interrelated processes of blocking, blurring, containing, and reframing appeared to serve as ways for the women to disembody the trauma, to extricate the experience from their self, to dismember the memory. Biomedical discourses about healing are predicated on a division between mind and body (Foucault, 1973; Grosz, 1994) whereby the physiological self is accorded priority status. The women's processes of ridding themselves of

the trauma in their life reflect and underscore powerful notions about what it means to be healthy, and about the "filth" of the traumatized body. The profound need and desire to literally purge the trauma from their body and soul by destroying the journal, or by other acts of containing, blurring, and reframing are, in essence, efforts to purify and transform themselves so that they could become good mothers.

Navigating the Chaos of Everyday Life

Consistent with much of the literature on trauma, the women in our study faced a constellation of challenges that stretched their capacity to cope on a daily basis. Embedded in their stories were lives shaped by poverty, racism, legacies of colonialism, marginal or substandard housing, employment difficulties, limited access to education, as well as tenuous and unstable relationships with partners and other family members. The women described a range of coping behaviors, including substance abuse, self-harm and disordered eating patterns:

> I guess like for coping mechanisms my eating disorder was the biggest one I had for a long time. Because that was the only thing in my life that I could control. And . . . it was so hard to like even let that go. But I'm glad that I'm doing a lot better now, but when I was younger, like preteen and like early, early teenager, I would like self-harm. And also be attracted to, like I had a really abusive boyfriend when I was fifteen. I actually lived with him. It was very abusive and he tried to strangle me as well.

For some women, the ability to engage in mutually satisfying and emotionally supportive relationships appeared to be compromised by the legacy of past trauma:

> I had this family friend when I was twelve. He was about ten years older than me but he befriended me. He got married when I was sixteen; his wife wasn't very fond of us, so she kept him away from us for ten years. But last year I found him on Facebook, and so he was in our lives again. Then things happened between us. Crossing that boundary was weird, but I kept pushing at it. Finally, we broke that barrier, but the following weeks were just hell. I guess he either felt guilty, or he got what he wanted and just left. It was just really, really hard for me to deal with. And then he hurt me again after I tell [him] that "[the baby] is yours." But I explained in the email that I sent him, that "I'm completely fine if you don't want it. Completely okay with that. Just, you know, don't stop being my friend. I can't bear it." You know, he's the only friend I have in my life right now.

Similarly, another woman spoke about her loss of interest in sexual relations, the discomfort she had with her body, and the ensuing negative effect these had on her relationship with her fiancé:

> Like he knows what I've been through, but it's just confusing for him because, "Why are you acting like this now?" And like I said, he's already skeptical about this baby. And now I'm pushing him away more. So our relationship is going through hell in a hand basket. I wake up and I'm petrified. And it's . . . there are days I wake up and I'm like, "I'm not having this baby." I'm like, "I'm going to jump off the balcony. I don't want to have this baby." There are days I'll wake up and I'll break my shavers open so I can cut myself and then, the only reason I don't is because I promised my fiancé I wouldn't.

Although the women described the multiple impacts of trauma on their current life, they also showed a great deal of resilience and resourcefulness as they labored to reconcile their past with the present, and future realities and expectations:

> I've been in counseling forever. And just going through that [school] program, like that's all you do is deal with that stuff. And I have no problem. I do have like posttraumatic stress disorder. I have flashbacks and memories of him all the time. But they don't, you know, they don't really inhibit like anything. I can still like live normally and stuff like that. I have panic and anxiety issues which are something that is challenging for me in my life, but other than that I'm good.

For many women, pregnancy and the transition to motherhood provided the impetus for positive change. As one participant stated, "I could be doing a lot worse. I'm blessed in that way, and that's a huge reason I think about everything all the time. I'm trying to better myself based on all I've been through." A similar idea was shared by another woman who recounted her struggle to deal with her past, allowing herself to revisit past traumatic events but trying hard not to dwell in them:

> Certain things don't need to be stable, but others do, like where you live; the fact that you have somewhere to live, that you have food, and a relationship with God. Those are my pillars. Some days are better than others. Today is a good day. I've had to learn to pull myself out of the past and into the present, and visit the past without staying there. Pick something out, deal with it, then go back. That's something you learn. Sometimes you go back there to pick something out and it really holds you back there.

Pregnant With Possibilities

Despite the difficult circumstances of their lives, many women were determined to create a sense of stability for themselves and their new family. As is common among pregnant women, hopes and dreams for their baby and for themselves as a mother were frequently shared:

My child is my dream. So when I make things happen it's not just for me. I just don't want nothing bad happening. Just give me the opportunity. Don't take it away before I even get there. And this time, this time I'm going to follow through a hundred percent.

As the women shared their vision for the future, we heard about highly idealized notions of family and the possibilities that lay ahead, which were distinctly different from the past they left behind. In this idealized family, there was perfect understanding between mother and child; a family with finely balanced relationships, highly attuned to the needs and desires of one another; a family in which there were no violations of space, self, or innocence. One woman stated,

I have a good boyfriend who is going to be home with the baby 'cause he just got out of surgery, so I think it's gonna work out fine. I want him to take care of the baby for the first two months and then I want to put the baby in day care so he can go back to work and I can go to school. That way, he's not like, "Oh, I've been home all day with the baby. I need a break." Which is totally understandable. So, I want him back working so when we come home together it's, "Let's make dinner together. How was your day?" The little white picket fence and, you know, the little happy-go-glory family.

Implicit in this notion of the wished-for perfect family was a belief in the possibilities for change, and that through the creation of this family, a new and different future would evolve, one that was free of violence. In this sense, the birth of the child was a catalyst for making life changes, for hope, and for possibilities. This idea was captured in one woman's comments:

If you want to change your life you, you have to think about your child, about your happy family. And what a good mother you're going to be. Concentrate on [the] positive. 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. I feel much stronger. There is no way; there is no way that I'm going to experience something like that [sniff]. No.

Even though pregnancy evoked hopes and dreams for the future, it also served as the impetus for the women to reflect on their own experiences of being mothered. On several occasions, women expressed a fierce determination to not be like their mother. This idea was particularly evident among the women who felt that their mother was aware of the sexual abuse they had experienced in childhood; from their perspective, their mother was unable to or chose not to protect them. Thus, the women presented a construction of themselves as a mother who would be quite unlike their own mother. One woman explained:

The main question I ask myself, "Am I going to be as weak as my mother?" Because what happened to her was weakness. And it affected our life, her daughters' life, right? And this is what I ask myself. And I don't want to be like her. Sometimes I'm scared that I might. If some unexpected events, like very terrible events happen to me, I might just, you know, not be able to cope with it. This is what I'm scared of. Yeah.

The women's past experiences of trauma also gave them an almost exaggerated notion about their capacity to protect their child from similar harm, especially should their child be a daughter:

I realize that she is going to hurt. But God forbid that she should go through what I went through. I'm hoping that if I keep an eye on her, and watch the people that are around her, that that will be enough. I'm hoping that if I do what I'm supposed to do, that God will protect her from that. She can have other horrors, but just not, not that.

This determination to protect was intense, uncompromising, and unrelenting. The women were going to have the perfect, happy family, and their perfect, happy baby would be safe from harm.

Finally, we heard the women poignantly and eloquently describe their intent to create a different reality from their own. The idea that the pregnancy and impending motherhood served as the catalyst for change was clear:

From the point when I started trying to conceive I was thinking about the baby. I was thinking how good is going to be his or her life. Not like mine. And I will definitely . . . when my child grows up and understands something, you know, some things about life, I will definitely tell him or her how difficult it was for me.

A similar idea was shared by another woman, who commented,

It's just like my hopes and my dream is be the mother my baby wants me to be, and not make the mistakes that life is going to make you make. Just try not to make many mistakes during your being a mother.

Discussion

For the women who took part in this research, the effects of past trauma appeared to persist long after the traumatic events occurred. Our substantive grounded theory indicated that pregnant women with histories of trauma undertook exceedingly difficult emotional and cognitive work as they anticipated becoming a mother, a process we have called laboring to mother in the context of past

trauma. Based on our findings, we offer several recommendations for health care providers working with pregnant women with histories of trauma who are making the transition to motherhood.

As we discovered, pregnant women with histories of trauma were pregnant with possibilities. The hopes they had for their family-to-be grew as they progressed in their pregnancy. However, the narrowly prescriptive, ideologically driven, and socially mandated repertoire of strategies that constitute good mothering is embedded in a discourse that fails to take into account the experience of this history, and the sequelae that can extend as a consequence. Despite their challenges, the women in our study worked hard to assume the mantle of the good mother in a socially acceptable manner. This meant actively deploying strategies to contain their trauma memories, or otherwise ridding themselves of trauma's effects to "restory" their future to achieve the happiness expected of new mothers. The result was a disconnect between the social imperatives; a highly idealized, unattainable set of expectations for themselves and for others; and what was possible given their current lived reality.

Consequently, there is a powerful need to widen the range of possibilities for women to "story their experiences" of mothering differently, to create a space whereby women who dare to break their silence, to tell other stories, are empowered to do so, and where the range of possibilities becomes normalized. To achieve these aims, we need to create spaces and opportunities where dominant views of motherhood can be critiqued and challenged, where new discourses of mothering can emerge that recognize women with histories of trauma as capable and resilient, and where histories of trauma are not inherently incompatible with good mothering. In practice, this might mean engaging in discussions about the often unrealistic expectations that society holds regarding anyone's ability to be a perfect or perfectly attuned mother. Reminding pregnant and postpartum women that everyone makes mistakes and that motherhood often involves forgiving oneself and carrying on to the best of one's ability can serve as an important touchstone for both their parenting practices as well as their personal healing.

With regard to navigating the chaos of everyday life within the context of historical trauma, many of the coping strategies used by the women who participated in our study are traditionally viewed as maladaptive and incompatible with good mothering. Within some health settings, the women's strategies to survive would not be considered legitimate mechanisms for coping, and would be used as additional evidence of their inadequacies. Nonetheless, the women exhibited enormous strength and fortitude in the face of adversity in endeavoring to negotiate the transition to mothering in ways that would make possible their imagined futures for themselves and

their families. Nevertheless, health care providers and others who are supporting women whose lives are seemingly chaotic might want to offer real and concrete linkages to those resources that can be most helpful during pregnancy and the postpartum period. These might include, for example, information about emergency shelters or other safe and accessible housing options, and trauma-informed counseling.

Above all, we need to promote understanding and education regarding trauma. Because experiences of trauma are often rendered invisible and women tend not to bear physical scars, there is a critical need to enhance knowledge of trauma-informed practice among health care providers and counselors. Such practice should include the recognition that trauma can be a powerful construct in the lives of many women, with effects that are often subtle and insidious, eluding easy recognition if one is not attuned to the potential impacts. Interdisciplinary models of care could facilitate the exchange of practice-specific knowledge and enhance the care provided.

Rather than providing care focused exclusively on medical diagnoses, pathology, weaknesses, and deficiencies, emphasis on empowerment and strengths-based approaches are appropriate and warranted, likely to yield much more meaningful interactions between caregivers and their pregnant clients. The principles of trauma-informed care emphasize the provision of care and services that do no harm, thereby minimizing the likelihood of retraumatizing the individual, increasing feelings of safety for the survivor, and promoting healing and growth. Because the challenges faced by women who have experienced past trauma extend well beyond the physical realm, health care providers need to recognize the larger context of daily life. As we have learned, and as has been reported by other researchers, marginal housing, poverty, racism, tenuous family relationships, few educational opportunities, and substance abuse are all a part of the everyday reality for many of these women. Efforts must be directed toward the eradication of social inequalities that compound the impacts of trauma.

Declaration of Conflicting Interests

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