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Exploring Attachment and the Transition to Motherhood for Survivors of Childhood Sexual Abuse

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A thesis submitted in partial fulfillment of the requirements for the Master of Education degree in Education

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EXPLORING ATTACHMENT AND THE TRANSITION TO MOTHERHOOD FOR
SURVIVORS OF CHILDHOOD SEXUAL ABUSE

(Thesis Format: Monograph)

by

Laura E. Bellhouse

Faculty of Education

Submitted in partial fulfillment
of the requirements for the degree of
Master of Education

The School of Graduate and Postdoctoral Studies
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Abstract

This study explored the experiences of 8 new mothers who were survivors of childhood sexual abuse. The women completed interviews during their second trimester of pregnancy and 4-6 months following the birth of their child. Specifically, the study focused on attachment during the transition to motherhood. The women's experiences were examined using a qualitative research design. Two major themes relating to attachment emerged from the data: Trauma and the Impact on Self in Relationships and Moving Forward into Motherhood. Implications for counselling and research are discussed.

Keywords: Childhood Sexual Abuse, Motherhood, Attachment

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Literature Review

The public recognition and acknowledgement of childhood sexual abuse (CSA) is a recent development in our history. The impact of CSA on survivors emerged as a significant topic in the research literature following the women's liberation movement in the 1970s (Herman, 1992). Although major steps have been taken in advancing our understanding of the effects of CSA (Briere, 1996; Finkelhor, 1987; Freyd, 1996; Herman, 1992), there are areas that remain to be explored. The transition to motherhood for survivors of CSA is one area requiring further study, as this period appears to be a time of particular vulnerability. Their history of sexual violence may put survivors and their children at a greater risk for the development of both physical and mental health problems (Leeners et al., 2006). The current study will examine this transition and the overarching goal is to inform both research and practice regarding the necessary components of a healthy pregnancy and birth as well as a strong mother-child bond, for women who are survivors of CSA and who are from outside Canada. I will examine this transition period through the testimonies of survivors themselves using a qualitative approach to give voice to these women and to learn from their experiences. Specifically, this study seeks to examine attachment and the transition to motherhood for survivors of childhood sexual abuse. This paper will begin with an overview of relevant theoretical frameworks to explore the impact of CSA. A literature review will also be offered, including a focus on research regarding the impact of CSA, the transition to motherhood, motherhood and the transition to motherhood for survivors of CSA, as well as the impact of correlates of CSA on motherhood. The research questions and

methodology will be presented, and the results of the study will be presented and discussed.

The information presented in the following literature review was gathered from a number of sources. Based on the knowledge that I have gained throughout my educational training, I selected and presented information from the works of foundational figures that have contributed to theory and research on trauma, attachment, and the transition to motherhood. I also used the databases PsycINFO and Google Scholar to search for relevant articles. The searches were performed using several keywords including 'attachment', 'motherhood', 'childhood sexual assault', 'culture', 'collectivist', 'immigration', 'refugee', 'relationships', 'interpersonal', 'parenting', and 'pregnancy'.

Childhood sexual abuse is a pervasive problem within society and can have long lasting consequences for survivors (Briere & Runtz, 1993; Finkelhor, 1994). A review of reported prevalence rates of CSA in 21 countries, including Canada, found that estimates ranged from 7-36% for females and 3-29% for males; this variability in prevalence rates is likely due to inconsistencies between definitions of CSA as well as methods of assessment (Finkelhor, 1994). Childhood sexual abuse can have a significant impact on multiple domains of life (Herman, 1992). For instance, survivors of childhood sexual abuse report problems with interpersonal functioning (Davis & Petretic-Jackson, 2000). In a study by Aspelmeier, Elliot, and Smith (2007), college students with a history of childhood sexual abuse showed poorer attachment security in their relationships, when compared to their peers. Few studies have examined the impact of childhood sexual abuse on the experience of motherhood.

Several theorists have proposed frameworks to guide our understanding of the impact of CSA (Briere, 1996; Finkelhor, 1987; Herman, 1992). A common criticism raised by theorists pertains to our current diagnostic system. It has been argued that survivors of CSA are often mislabeled, as these individuals rarely fit into the criteria for diagnoses outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Herman, 1992). Finkelhor (1987) observed that even post-traumatic stress disorder (PTSD), a diagnosis that delineates common reactions to the experience of a traumatic event, does not capture the full spectrum of consequences experienced by survivors of CSA. In an effort to conceptualize the experience of CSA, Finkelhor proposed the Four Traumagenic Dynamics Model. The four traumagenic dynamics include traumatic sexualization, betrayal, stigmatization, and powerlessness. These dynamics have an adverse impact on child emotional and cognitive development. Traumatic sexualization refers to the act of providing a child with distorted information and teaching them unhealthy views regarding their sexuality. CSA also involves the dynamic of betrayal, as the child is often victimized by a person on whom he or she is dependent. In the dynamic of stigmatization the child internalizes negative messages about the self. These messages may be communicated to the child by the abuser (e.g. the child may be told that he or she is bad). Others may also contribute to the development of negative self-attributions upon the child's disclosure of the abuse. Finally, the fourth dynamic, powerlessness, involves the continuous denial of the child's will. Moreover, the child also experiences powerlessness through threats of serious injury or death.

Herman (1992) describes the impact of CSA from a feminist perspective. She writes of the impossible position of the child abuse victim: children are dependent on adults for protection and care, however, children who are sexually abused often experience this abuse at the hands of those on whom they rely to provide these basic needs (e.g. a parent). To survive in this environment, the child must work to maintain a sense of safety, control, and trust. Most importantly, the child must maintain their relationship with their abusive caregiver. Freyd (1996) further explains this process. Given their extreme vulnerability, the child needs the care (even poor care) provided by the abusive caregiver. Therefore, they must act in ways that encourage caregiving behaviours. To do so, the child must justify the abuse (e.g. believe that the abuse is due to his or her own badness) or use dissociation to block the abuse from conscious awareness (Herman, 1992). If the child were to recognize the reality of the abuse, this knowledge would interfere with their ability to act in ways that preserve the relationship. CSA that occurs within a relationship with a trusted caregiver has been termed betrayal trauma. Child sexual abuse survivors may also experience feelings of betrayal toward a non-offending caregiver who failed to protect them from the abuse (Freyd, 1996).

Herman (1992) argues for the acceptance of a new diagnostic category called complex post-traumatic stress disorder (CPTSD), thought to account for the range of reactions to chronic trauma. Symptoms of CPTSD include difficulties with affect regulation, interpersonal relationships, and meaning making. Moreover, individuals may also experience changes in consciousness, self-perception, and perception of the abuser.

Finally, Briere (1996) proposed the self-trauma model to account for the long-term impact of childhood abuse. Briere suggests that a primary adverse effect of childhood abuse is the interference of the abuse in the development of healthy coping skills. Due to inadequate coping skills, child abuse survivors are more likely to be overwhelmed and unable to cope with future stressors as well as with memories of the abuse. Furthermore, child abuse survivors are at an increased risk for the development of unhealthy coping strategies (e.g. dissociation, self-harm, substance use, etc.). These coping strategies develop in response to difficulties with affect regulation. Moreover, the self-trauma model provides an explanation for the chronic pattern of intrusive (e.g. flashbacks) and avoidant symptoms observed in survivors of childhood abuse. According to this model, intrusive symptoms are the mind's attempt to heal from the trauma. Intrusive symptoms re-expose the individual to a fragment of the traumatic memory. Through re-exposure the individual may become desensitized to the memory and the memory may be processed. The intrusive symptoms are followed by avoidant symptoms. Avoidant symptoms protect the individual from prolonged and overwhelming exposure to these memory fragments. However, if avoidant symptoms occur with too much regularity, they will disrupt desensitization and the processing of the trauma.

This study was guided by attachment theory. Attachment theory describes the association between child development and the nature of the relationship established between a child and their primary caregiver(s). The theory argues that healthy child development is dependent on the quality of this caregiver-child relationship. In the early years of life, children depend on their caregiver to satisfy

their basic needs (Bowlby, 1998). John Bowlby (1988) postulated that children are biologically driven to develop attachment behaviours that function to elicit protection and caregiving. Attachment behaviours are behaviours that either seek or maintain proximity to the caregiver. The ability to use the caregiver as a 'secure base' from which to explore the world and a 'safe haven' from which to draw comfort is fundamental to healthy development (Bowlby, 1982, 1988). Variations in patterns of attachment behaviour may be classified into 4 attachment patterns: secure, avoidant (insecure), ambivalent (insecure), and disorganized attachment. A securely attached child is able to use their caregiver as a secure base and safe haven. Children who display avoidant or ambivalent attachment patterns are less able to use their caregiver as a source of security. However, these children continue to use organized patterns of behaviour to get their needs met. Children with a disorganized attachment pattern do not have an organized pattern of behaviour to promote caregiving and protection (Bowlby, 1988; Main & Solomon, 1986).

The process of adapting to an abusive environment may also be described from the perspective of attachment theory. In optimal conditions, a caregiver acts as a secure base, providing the child with a sense of safety to explore new and sometimes adverse experiences. Children who are able to use their caregiver as a secure base are characterized as being securely attached. Having a secure attachment to a caregiver permits a child to fully experience their emotions. Conversely, children with an insecure attachment, including many abused children, have learned that their emotions are uncomfortable or unacceptable to their caregiver. This position is threatening to children, who rely on their caregiver for

their very survival. In order to maintain their relationship with their caregiver, the child must disown and hide emotions that dysregulate the caregiver, a process known as defensive exclusion (Bowlby, 1988). Attachment classifications have been found to be fairly stable across the lifespan, although changes in attachment classification do occur (Waters et al., 2000). Moreover, insecure attachment in adulthood is associated with interpersonal difficulties, including poorer interpersonal communication competence (Anders & Tucker, 2000).

The transition to motherhood poses many challenges for all expectant mothers, regardless of whether they have a history of abuse. Several studies have outlined the struggles that women face within this transition period. The transition to motherhood includes a shift in identity as a woman adjusts to her new role as 'mother'. In a meta-synthesis of studies examining the transition to motherhood, five areas of change were identified as occurring during this period. The first change is the commitment that women make to mothering. This commitment seems to be enhanced by the mother-child attachment bond. Furthermore, commitment involves accepting the responsibilities of motherhood. Feelings of anxiety regarding the daily responsibilities and long-term commitment of motherhood are commonly reported among new mother. Secondly, women must make changes in their daily lives. Many women have reported feeling ill prepared and overwhelmed by the daily tasks of motherhood. Additionally, new mothers who felt that they did not receive adequate mothering have reported worries about repeating the parenting habits practiced by their mothers. The third area of change involves changes in relationships. Changes have been observed in relationships with romantic partners,

family, and friends. Changes concerning employment make up the fourth area of change. Women must decide whether to return to work, when to return, and how to balance work and family life. Finally, the fifth area of change is change within the self. Women have reported both positive and negative changes in the self. For instance, women have observed changes in their capacity for patience and for understanding love. However, the transition to motherhood has also been associated with loss. Many women experience losses in self-esteem and in their sense of self (Nelson, 2003).

A review of the literature on the transition to motherhood suggests that a mother's relationship with her own mother can have a significant impact on her experiences as a parent (Mercer, 2004). For instance, in a study by Priel and Besser (2001), the prenatal mother-child attachment relationship was influenced by the mothers' internal representations of their own mothers. Poorer relationships with their own mothers also appear to negatively affect the postpartum mother-child attachment relationship (Mercer & Ferketich, 1990). Moreover, mothers who had experienced parental rejection were more likely to report symptoms of postpartum depression. Symptoms of postpartum depression were related to less maternal sensitivity in women reporting parental rejection, but were not related in women reporting parental acceptance (Crockenberg & Leerkes, 2003).

Maternal perceptions of parental competence have also been examined during the transition to motherhood. In a study by Mercer and Ferketich (1990), greater perceived maternal competence was associated with stronger mother-child attachment. This relationship was found for both women who had experienced

high-risk and low-risk pregnancies. Furthermore, women with greater perceived maternal competence have been found to be more likely to be satisfied in their maternal role (Zabielski, 1994).

The postpartum period is also a period of risk for the development of mental health concerns. For instance, an estimate of 13% of mothers experience postpartum depression (O'Hara & Swain, 1996). Adequate social support has been shown to be an important protective factor for new mothers, decreasing the likelihood of experiencing mental health disturbances (Hung & Chung, 2001).

Finally, Caplan (2000) describes several myths of motherhood that compound the difficulties faced by mothers. The belief that mothers are unfailingly nurturing is one such myth. This myth sets an impossibly high standard for mothers. Mothers may judge themselves harshly and may be judged by others when they are inevitably unable to live up to this standard. Another damaging myth is the belief that mothering comes naturally to all women. In a study by Wilkins (2006), new mothers reported feeling pressured to be immediately adept at caring for their child. Moreover, they feared the criticism of others and were uncomfortable revealing their mothering skills to perceived experts.

The challenges faced by women in the transition to motherhood are likely amplified for women who have experienced CSA. Given that many survivors were raised by caregivers who were abusive and/or negligent, these women may not have positive role models to guide them in assuming their new role. This may lead survivors to question their competence as mothers. Moreover, survivors may worry about repeating the patterns of their abusive or negligent caregiver. The research

literature has found support for poorer perceived competence in CSA survivors. For instance, Fitzgerald et al. (2005) examined observed parenting behaviours and perceptions of self as a parent in incest survivors and non-abused mothers. Incest survivors reported significantly less self-efficacy as parents when compared to non-abused mothers. However, their observed parenting behaviours were comparable to those of non-abused mothers. These mothers were observed to provide comparable support and assistance. Moreover, the two groups were comparable in terms of observed maternal confidence. Nevertheless, further examination of observed parenting behaviours is warranted, as the aforementioned study was limited to the observation of mother-child interactions during a problem-solving task. Other studies have further supported the relationship between CSA and the negative appraisal of one's parenting capacity. Survivors have reported less confidence and satisfaction with their parenting in comparison to women without a history of CSA (Banyard et al., 1997; Roberts et al., 2004). Wright, Fopma-Loy, and Fischer (2005) found that partner support acted as a moderator between symptoms of depression and self-assessment of parental competence in survivors of CSA. Greater partner support was associated with more perceived competence for survivors reporting symptoms of depression. As previously discussed, poor perceived parental competence has been associated with poorer mother-child attachment and less satisfaction with the maternal role (Mercer & Ferketich, 1990; Zabielski, 1994).

Survivors may struggle to form a secure attachment relationship with their children. According to attachment theory, a history of abuse puts survivors at a

greater risk for developing attachment insecurity (Bowlby, 1988). An insecure attachment status appears to interfere with a mother's ability to form a secure attachment relationship with her child. Benoit and Parker (1994) provide evidence to support the transmission of attachment classifications across generations. For 65% of this sample, attachment classification was found to remain constant across three generations when a three-category attachment classification system was used (secure, avoidant, ambivalent). Caregiving behaviours and child attachment were examined in a sample including survivors of CSA and their infants. Survivors were observed to display less engagement with their child and to show restricted affect, when compared to other mothers in this low-income sample. The children in this sample were more likely to be insecurely attached if their mother had a history of abuse (Lyons-Ruth & Block, 1996). Another study suggests that problems may persist in the mother-child relationship. Survivors reported more negativity and less positivity in their relationship with their child (33 months old), when compared to other mothers (Roberts et al., 2004).

Research examining the relationship between CSA and parenting stress further supports difficulties in the mother-child relationship. In a study measuring overall levels of parenting stress, parenting stress was not found to differ significantly between mothers with a history of CSA and those without (Barrett, 2009). Moreover, an association between CSA and the frequency of survivors' worry over problems related to their children was not supported (Banyard, 1997). However, results differed in a study involving a clinical sample. In this study, a history of CSA was associated with increased parenting stress, especially stress

related to dysfunctional interactions between the parent and child and difficult child behaviours (Douglas, 2000).

Mothers with a history of CSA may also struggle with intimate aspects of the mother-child relationship. As previously discussed, as children, CSA survivors were given inappropriate messages regarding sexuality (Finkelhor, 1987). Therefore, survivors may have difficulty recognizing appropriate boundaries and expressing healthy intimacy. Research examining intimate parenting anxiety appears to support difficulties in this area. Intimate parenting anxiety includes anxiousness over parenting tasks that involve displaying affection or the provision of personal care. Such tasks include bathing the child, changing their diaper, as well as hugging and kissing the child. In a clinical sample, survivors of CSA reported more intimate parenting anxiety when compared to another group of mental health outpatients with no history of CSA (Douglas, 2000). However, this relationship was not supported in a community sample of adolescent mothers (Bowman, Ryberg, & Becker, 2009).

Several studies suggest that a history of CSA may have an adverse effect on parenting practices in adult survivors. These studies highlight the need to examine the experience of motherhood for survivors of CSA. Through this examination it is hoped that information can be gained to adequately support these women in coping with the challenges of motherhood. In a study by Barrett (2009), self-report measures indicated that CSA survivors were higher on levels of psychological aggression toward their children, lower on parental warmth, and used corporal punishment more frequently to discipline their children. However, these

relationships were nonsignificant when sociodemographic variables and other forms of childhood maltreatment and misfortune were considered. Banyard (1997) found that having a history of CSA was associated with a greater use of physical violence toward one's children. Research also suggests that children of CSA survivors are at greater risk for adjustment problems when compared to their peers whose mothers do not have a history of CSA (Roberts et al., 2004). Collishaw et al. (2007) suggest that this compromised adjustment in offspring may persist over time. However, this study examined the adjustment of children whose mothers had a history of sexual, physical, and/or emotional abuse. The study did not specifically examine the relationship between CSA and offspring adjustment.

Research also indicates that survivors of CSA can experience trauma symptoms triggered by aspects of prenatal care and delivery. A review of studies examining the pregnancy experiences of survivors of CSA identified various reported triggers. During pregnancy, survivors may be triggered by body changes, vaginal examinations, and the need for dependency on others. Survivors have also reported experiencing flashbacks during labour. Moreover, survivors may be triggered by breastfeeding (Leeners et al., 2006).

Furthermore, maternal and infant health, both during and following pregnancy, has been examined among survivors and their children. In a study by Mohler et al. (2008), women abused in childhood were more likely to develop prenatal complications than those without a history of childhood abuse. The abuse survivors in this sample included women who had been sexual abused and those who had been physically abused. The children of the women in this sample

experienced more postnatal complications when compared to the children of non-abused women. Survivors of CSA have been reported to have higher rates of hospitalization during pregnancy. They may be hospitalized due to complications such as premature contractions and delivery (Leeners et al., 2010). During labour, women who were sexually abused as children report more pain than non-abused women (Clarke, 1998). Moreover, survivors may experience delivery as a repetition of their past abuse (Christensen, 1992). Finally, Leeners et al. (2006) identified a trend in the research literature to report higher rates of postpartum depression among survivors of CSA.

Given the association between CSA and psychopathology, research concerning the impact of psychopathology on motherhood will be reviewed. CSA has been linked to an increased risk for the development of anxiety, depression, and borderline personality disorder (Kendler et al., 2000; Zanarini et al., 1997). Mothering among women with each of these diagnoses has received attention in the research literature.

Maternal anxiety has been associated with adverse effects for both mother and child. In a study by Sayil, Gure, and Ucanok (2006), maternal prenatal anxiety was significantly related to postnatal maternal depression. Women with prenatal anxiety also had a greater tendency to perceive their child as being difficult. Moreover, prenatal anxiety in women increases the likelihood for child emotional and behavioural problems (O'Connor, Heron, & Vivette, 2002).

Depression has been found to have various effects on mothering. In a study by Frankel and Harmon, (1996), mothers with depression evaluated themselves as

demonstrating poorer parenting competence than mothers without depression. These mothers also reported weaker attachment relationships with their children. In another study, infants of women with depression were more likely to be insecurely attached than infants of non-depressed women (Coyl, Roggman, & Newland, 2002). Women with depression have been observed as being less attuned to their infants when compared to non-depressed women (Murray et al., 1996). Chronic depression in mothers has also been associated with more mother-reported child behaviour problems. Moreover, maternal depression is related to higher ratings of parenting stress (Cornish et al., 2006). Finally, mothers with postpartum depression with high suicidality tend to have lower self-esteem and to perceive themselves as being less prepared for parenthood (Paris, Bolton, & Weinberg, 2009).

Borderline personality disorder (BPD) has also been associated with increased parenting difficulties. Women with BPD report greater dissatisfaction in their role as mothers. They tend to perceive themselves as being less competent and to report more distress related to motherhood. Parenting behaviours have also been observed in mothers with BPD. Mothers with BPD have been found to provide less structure in their interactions with their children (Newman, Stevenson, Bergman, & Boyce, 2007). When compared to other mothers, mothers with BPD appear to be more likely to show intrusive insensitivity in their interactions with their children. Furthermore, children of mothers with BPD are more likely to be insecurely attached than children of mothers without BPD (Hobson et al., 2005).

Finally, the issue of intersectionality should be considered when exploring the experiences of individuals from any marginalized group. Intersectionality refers to the co-occurrence of multiple forms of oppression (Ontario Human Rights Commission, 1999). An intersection is a structure based on a power over dynamic. Within an intersection an individual will have more or less power based on a characteristic such as gender, race, sexual orientation or class. Multiple intersections interact and influence the lived experience of each individual. An individual may be oppressed due to their position within one intersection, but may experience privilege due to their position within another. Additionally, an individual's membership in multiple oppressed groups can have a compounding effect (Centre for Research, 2005). The life of each woman impacted by CSA will be differentially influenced by her interacting experiences of privilege and oppression.

The current study explored the experiences of women who have immigrated to Canada. The sample of participants was composed of women from a variety of cultures and nationalities who came to Canada as either immigrants or refugees. The process of immigration can involve significant losses. These losses include a loss of identity, sense of belonging, customs, language, family, and friendships (Garza-Guerrero, 1974; Sawicki, 2011; Ward & Styles, 2003). Moreover, the challenge of coping with these many losses may be amplified by a lack of social support in the new country of residency. In a study examining the experiences of immigrants and refugees in Canada, the newcomers' limited social networks were identified as a common obstacle to coping with the stresses of immigration (Stewart, 2008). Finally, newcomers may come to Canada with an extensive history of

trauma. In a study exploring the experiences of refugees from Sudan, every participant reported experiencing at least one of the categories of trauma on the Harvard Trauma Questionnaire. Social support from the participants' ethnic community was associated with greater mental health outcomes (Schweitzer et al., 2006). A study by Robertson et al. (2006) also reported a high level of exposure to trauma among Somali and Oromo refugee women.

Parenting may present unique challenges for newcomers to Canada due to different levels of acculturation across generations. The term 'acculturation gap' has been used to describe this disparity in acculturation (Smokowski, Rose, & Bacallao, 2008). In a study exploring the experiences of mothers who had immigrated from China, a larger perceived acculturation gap was associated with poorer communication between mother and child, greater uncertainty concerning how to deal with certain parenting situations, and less satisfaction in the mothering role (Buki et al., 2003). However, in a study by Schofield et al. (2008), disparity between mother and child acculturation was not related to mother-child conflict or child adjustment in a sample of Mexican American families. Acculturation conflicts are incidents in which the values and teachings of the country of origin and the country of residence conflict. Acculturation conflicts have been associated with poorer family dynamics and greater parent-adolescent conflict (Smokowski, Rose, & Bacallao, 2008).

As the women in our study come from diverse cultural backgrounds, it is important to examine the research literature on attachment across cultures.

Research suggests that western perspectives on attachment behaviour may not

provide an entirely accurate understanding of attachment behaviour across cultures. Attachment theory's foundational concept of the secure base appears to be supported across cultures. In a study by Posada et al. (1995), children from seven different countries were observed to use their caregiver as a secure base from which to explore their environment. This study examined attachment behaviour in samples from China, Colombia, Germany, Israel, Japan, Norway, and the United States. Furthermore, caregiver sensitivity and attachment security have been associated in samples from Colombia, Chile, and Japan (Posada et al., 1999; Valenzuela, 1997; Vereijken, Riksen-Walraven, & Kondo-Ikemura, 1997). However, the definition of maternal sensitivity appears to vary across cultures. In a study comparing attachment behaviour in Puerto Rican and Anglo mother-child pairs, greater maternal physical control was related to attachment security in Puerto Rican dyads. However, greater maternal physical control was related to attachment insecurity in Anglo mother-child pairs. The researchers suggest that sensitive caregiving behaviours may be specific to the culture in question. They explain that in a collectivist culture, greater structuring of child behaviours may constitute sensitive caregiving, as the caregiver is helping the child to gain valued relational skills. Conversely, in an individualistic culture, greater physical control is perceived as insensitive caregiving as it interferes with the development of the child's autonomy (Carlson & Harwood, 2003).

The number of caregivers who share in the responsibilities of childrearing varies across cultures. In many cultures, caregiving tasks are shared among the parents, extended family, and community. These multiple-caregiver contexts

contrast with western societies, where it is typical for children to be raised predominantly by their parents. Upon reviewing a number of cross-cultural attachment studies, it was observed that children in multiple-caregiving contexts form multiple attachment relationships. These children develop a preference for one caregiver and are more likely to direct their attachment behaviours toward this caregiver (Van Ijzendoorn & Sagi-Schwartz, 2008).

Studies using a quantitative research approach have provided valuable findings on the associations of CSA with variables of interest. However, such studies cannot convey the rich depth of information afforded by qualitative research methods. Qualitative methods may be particularly valuable in exploring the complex relationship between childhood sexual abuse and motherhood.

The current study used a qualitative research design. A few studies have examined motherhood in survivors of abuse using a qualitative approach. Pitre, Kuchner, and Hegadoren (2011) explored the experiences of mothers of children above the age of 3, who had been physically, emotionally, or sexually abused as children. Several themes emerged throughout the interviews with these women. Women shared their desire to provide their children with a different environment than had been provided to them as children. They hoped to give their children safety, love and support, and to allow their children to feel heard and believed. However, these mothers reported persistent doubt in their ability to parent. They looked to others in search of a model for 'good' parenting and were harshly critical when they fell short of these standards. Furthermore, the mothers reported a lack of trust in others and a desire to protect their children from harm. Another study

specifically examined the experiences of expectant mothers who had a history of sexual abuse, either in childhood or adulthood (Schwerdtfeger & Wampler, 2009). These mothers also reported a desire to protect their children from harm, particularly their female children. They also expressed worries about helping their daughters through puberty. Finally, these mothers were hopeful that their daughters would never experience the trauma that they had endured.

Previous research suggests that a history of childhood sexual abuse can have a significant impact on women in their role as mothers. The quantitative literature provides support for the influence of CSA on parenting practices and level of anxiety (Banyard, 1997; Barrett, 2009; Douglas, 2000; Roberts et al. 2004). Moreover, CSA has been associated with poorer adjustment in the children of survivors (Collishaw et al., 2007; Roberts et al., 2004). Several studies have supported the relationship between CSA and negative perceptions of self as a mother (Banyard et al., 1997; Fitzgerald et al., 2005; Roberts et al., 2004; Wright, Fopma-Loy, & Fischer, 2005). Helping survivors to challenge these negative perceptions may be particularly important in promoting the wellbeing of the mother-child dyad and in helping survivors to function more effectively in their role as parents.

Few studies have taken an in-depth look at factors associated with attachment security between mother and child, with mothers who have a history of childhood sexual abuse. Research suggests that survivors of CSA may struggle to form secure attachment bonds with their children (Lyons-Ruth & Block, 1996). Moreover, survivors of CSA have reported more negativity in their relationships with their children and greater parenting stress, especially stress related to difficult

interactions with their children and difficult child behaviours, when compared to other mothers (Douglas, 2000; Roberts et al., 2004). The current study aimed to build on this research by exploring attachment during the transition to motherhood. To date, there have been no qualitative studies that specifically examine the experiences of survivors of CSA as they transition to motherhood. Qualitative studies examining the experiences of mothers with a history of abuse suggest that these women struggle with several insecurities and fears as parents. They also hope for the wellbeing and safety of their children (Pitre, Kuchner, & Hegadoren, 2011; Schwerdtfeger & Wampler, 2009).

The purpose of the current study was to explore factors associated with attachment and the experiences of survivors of childhood sexual abuse as they transition to motherhood. It is important for helping professionals to understand the experiences of these women in order to best support them through this transition period. Moreover, it is important to understand the full range of experiences during this transition period, including experiences of joy and the strengths that these women bring to mothering. Attachment is an important process that occurs between mother and child during the early years of life. The ability to form secure attachment bonds can be interrupted when individuals have been impacted by childhood abuse (Bowlby, 1988). Examining the experiences of survivors during the transition to motherhood can help us understand how we can support these women to form secure attachment bonds with their children. As attachment is a central task in the mother-child relationship and fundamental to healthy child development, attachment security between mother and child may be

expected to impact both the future lives of these women and the lives of their children. This study used a phenomenological approach to examine the unique and shared experiences of survivors as they anticipate the birth of their first child and later reflect on their first months as mothers.

Method

Participants

The current study used secondary data collected for the project *Embodied Trauma: The influence of past trauma on women during the transition to motherhood*. Participants for this project were recruited from two major cities in Ontario. Purposive sampling was used to recruit women into three groups: child sexual abuse survivors, refugee women, and Aboriginal women. All participants self-identified as trauma survivors. However, after the sample had been selected, it became evident that the majority of participants were survivors of sexual abuse. The current study will utilize data from all participants with a history of childhood sexual abuse who were born outside of Canada.

To be eligible to participate, women were required to be at least 18 years of age and in the second trimester of their first pregnancy during the study's enrolment phase. Women currently undergoing counselling involving more intensive forms of un-packing were excluded from the study. Participants were recruited through advertisements in newspapers, flyers, and posters that were displayed in public areas and organizations catering to the populations of interest. Women were also referred by nurses, family physicians, obstetricians, doulas,

midwives, counsellors, and social workers. These professionals were sent letters detailing the study in question.

Biographies of the participants are presented below. Pseudonyms have been used to maintain confidentiality.

Nicole. Nicole was born in the Caribbean and moved to Canada as a teenage. At the time of her interview, she was in her mid-twenties. Nicole was sexually abused by her father in mid childhood.

Alexis. Alexis is a woman of Asian and Latin American decent in her mid-twenties. She was born in the United States of America. The date of her immigration to Canada was not disclosed. Alexis was sexually abused by her mother's boyfriend during early childhood.

Emma. Emma was born in the Caribbean and immigrated to Canada as a young child. At the time of the initial interview, Emma was in her mid-twenties. Emma was sexually assaulted by her brother during childhood. She was gang raped by a group of older boys as a preadolescent.

Alyssa. At the time of her interview, Alyssa was in her late teens. Alyssa is originally from a county in East Africa, and came to Canada to attend university. Alyssa reported multiple sexual assaults. In her preteen years, she was raped by an older male acquaintance. She was also assaulted by an older male relative.

Ashley. Ashley is a woman in her early thirties. She immigrated to Canada from Russia as an adult. Ashley reported multiple sexual assaults that occurred during her childhood and adolescence. These assaults were perpetrated by her mother's boyfriend and other male guests that came into her home.

Sarah. Sarah was in her mid thirties at the time of the initial interviews. She was born in Latin America and immigrated to Canada as a child. A father figure sexually abused Sarah throughout her childhood and adolescence.

Emily. Emily immigrated to Canada with her family in late childhood. She is original from Central America. Emily identified herself as a survivor of childhood sexual assault. She did not disclose any information about her experiences of childhood sexual assault.

Donna. Donna was born in a country in East Africa. She moved to Canada during childhood. An older male relative sexually abused Donna when she was a toddler and young child.

Procedure

Individuals interested in participating in the study were provided with a 1-800 number where they could reach the research coordinator. The research coordinator provided callers with further information about the study, including the purpose and breadth of the study. All inquiring women were assessed for eligibility. Those who were eligible and wished to participate were asked to provide a phone number where they could be safely reached. A research assistant then contacted the women to set up their first interview.

Participants completed semi-structured interviews on two separate occasions. Each participant chose the time and location for their interviews. All interviews were completed in safe and private settings. Participants could elect to complete the interviews over the phone. The first interview occurred when participants were in their second trimester of pregnancy. Interviews were

conducted at this time, as the second trimester is generally a low risk period during pregnancy. Furthermore, this allowed those who experienced distress, due to the interview, time to seek support before the arrival of their child. The second interview took place four to six months following the birth of their child. Informed consent was discussed prior to each interview. Participants completed both interviews with the same interviewer. Each interview was conducted in the preferred language of the participant. Throughout the research process, participants were invited to keep a journal. Any material from these journals that was shared with the research team was included as further data.

The current study used data from both interview times. These interviews included a series of open-ended questions as well as prompts when appropriate. The questions in the first interview explored the women's thoughts and feelings as they approached motherhood, their past experiences with trauma, the potential impact of this trauma on their pregnancy, experiences with the health care system, sources of support, and their hopes for their children. Some of the questions that are particularly relevant to the interests of the current study include: "Can you tell me a little about how the traumas you have experienced may be affecting your thoughts, feelings and actions as you are becoming a new mother?" "In what ways, if any, do you think these past traumatic experiences may influence your ability to care for your baby?" and "What are your hopes and dreams for your baby?" The second interview explored the women's experiences during labour and delivery as well as their experiences throughout their first months as mothers. Consistent with the first interview, this interview asked about the women's past traumas, how the

trauma has impacted on the transition to motherhood, and the interactions that the women had with the health care system. Some of the questions from this interview include the following: “Can you describe your strengths as a mother?” and “Based on your experiences, what have you learned that you think might be helpful to other women who are becoming new mothers and who have had past trauma in their lives?”

Analysis

All analyses were performed using a systematic classification system. The interview transcripts were coded and organized into meaning units. That is, participate interview data was examined for references to themes related to attachment. Phrases and answers associated with themes relating to attachment were given labels specifying subthemes. When all transcripts were coded, these labels were examined for patterns and themes that emerge across the sample.

The current study used a phenomenological approach and the six steps outlined by Creswell (2003) for general qualitative inquiry. The six steps are data organization, reflection, coding, categorization, representation, and interpretation. The first step, data organization, was completed as part of the *Embodied Trauma* project. In this step, the researchers from the *Embodied Trauma* project transcribed all interviews and field notes. This project began with the second step, reflection. This step involves gaining an overall sense of the data. I read through each of the interviews and considered the general quality and underlying meaning spanning across participant interviews. The third step, coding, involved segmenting the interviews into smaller units. These units could be sentences, paragraphs, or entire

answers. The interviews were segmented into categories according to underlying themes in the data. These segments were assigned labels based on their meaning. In the categorization phase, the categories from the previous step were examined. These categories were altered, combined or discarded to obtain a smaller number of key themes. The final themes were each supported by multiple statements from multiple participants. These themes were presented in the fifth step, representation. This step involved a description and discussion of each theme. Subthemes were also discussed. Furthermore, quotations from the interviews were used to clarify and highlight each theme. Finally, the relationships between themes were explored. In the last step, interpretation, I examined the overall meaning that can be gained from the data. I compared what was learned to existing theories concerning the impact of CSA. That is, I examined whether our findings support or contradict these theories (Creswell, 2003). Finally, based on the results of this study, I made recommendations for future directions in both clinical and research work with survivors of CSA.

Trustworthiness

Several steps were taken to increase the methodological rigor of this investigation. Throughout the data collection phase, researchers kept records of field notes and theoretical notes. As well, all interviews were audio recorded. These interviews were then transcribed. Research team members checked each transcription for accuracy. Inter-rater reliability checks were also used. That is, a second independent reader re-coded the participants' statements to ensure a high

level of consistency in coding between raters. The current study includes the use of direct quotes to increase the credibility of the research findings.

Personal Perspective

It is important for the reader to understand the perspective from which I have approached this study. My personal background, educational training, and experience working with survivors of sexual assault have all influenced my conceptualization of the data. I was born in Canada into a middle class family and have lived predominantly in urban areas in Ontario and Quebec. I briefly moved to Germany, with a limited knowledge of the culture and language. This experience gave me some exposure to the challenges faced by newcomers.

I have worked with women who have been impacted by sexual abuse both as a volunteer on a crisis line and as a counselling intern. In my work with these women, I have had the honor of bearing witness to their stories and have seen how women are impacted by sexual violence. Moreover, my experiences as a counselling intern have strengthened my view of attachment security as being foundational to mental health and wellbeing.

The process of completing this study has helped me in my own growth as a counsellor. I have come to develop a greater appreciation for the complexity of the issues faced by women with a history of childhood sexual abuse. Reading the interview transcripts was challenging, as the women described multiple contributing stressors including a sense of isolation and chaotic life situations (i.e. unstable housing, recent victimizations, poor support from their partners, etc.). I

was struck by the strength that these women displayed by sharing their stories and admire their determination to change the story for their children.

Results

Verbatim interview transcripts from eight women, identifying as survivors of childhood sexual assault, were analyzed for themes relating to attachment. The women ranged in age from 19 to 34 years ($M = 26.5, SD = 4.3$). Each of these women were born outside of Canada and immigrated to Canada at varying ages. Their date of arrival in Canada was not reported by all of the participants. Of the women who reported their arrival date, length of time in Canada ranged from 4 to 21 years. The women represented diverse ethnic backgrounds. Their origins ranged from countries in North America, Central America, Africa, and Europe. Three of the women identified themselves as refugees to Canada. Marital status was listed as “other” by 7 participants and as “married” by 1 participant. Five of the women reported that they were employed at the time of data collection. Finally, 2 women identified that their pregnancy was planned, 1 stated “yes and no” when asked whether the pregnancy was planned, and 5 stated that the pregnancy was not planned.

The women were asked to complete two interviews, one during their second trimester and then a second interview occurring four to six months following the birth of their child. Table 1 indicates which women completed an interview at time 1, which completed an interview at time 2, and which women completed both interviews. Three of the participants completed both the time one and time two interviews. The remaining women completed a single interview: four completed

only the time one interview and one participant completed only the time two interview. The participant who completed only the second interview was asked some of the questions from the first missed interview, in addition to the time two interview questions.

Table 1

Interviews Completed by each Participant

Participant	Interview 1	Interview 2
Alexis	Complete	Complete
Nicole	Complete	Incomplete
Emma	Complete	Incomplete
Ashley	Complete	Complete
Sarah	Complete	Incomplete
Alyssa	Complete	Incomplete
Donna	Incomplete	Complete
Emily	Complete	Complete

The questions posed during the two interviews targeted three areas of experience:

1. The history of traumas experienced by the participants
2. How the trauma has impacted on the transition to motherhood
3. The interactions that the women have had with the health care system and health care providers throughout the transition to motherhood

In total, 11 interview transcripts were coded, 7 from interview 1 and 4 from interview 2. From these interviews, 404 statements were coded into two major themes. These themes are entitled Trauma and the Impact on Self in Relationships and Moving Forward into Motherhood. Trauma and the Impact on Self in Relationships is divided into 6 subthemes: *betrayal*, *emotion regulation*, *view of self*, *view of other*, *relationships*, and *recent abuse*. The theme Moving Forward into Motherhood contains only 3 subthemes: *role model*, *mothering*, and *changes in mom*. These subthemes can be further subdivided into smaller meaning units. For instance, betrayal is subdivided into betrayal by the perpetrator of sexual abuse and betrayal by others. The two major themes and their subthemes are listed in Table 2 along with their associated meanings.

The meaning units were classified by the number of participants whose statements fell into each category. Hill et al. (1997) recommends a method for classifying the frequency of categories. They suggest that a category be classified as *general* if each participant endorses it. A category is classified as *typical* if at least half, but not all, participants endorse it. If a category is endorsed by fewer than half of the participants, that category is classified as *variant*. Using this classification system, 4 meaning units were classified as *general*: distress (under the subtheme *emotion regulation*), coping (under the subtheme *emotion regulation*), protection (under the subtheme *mothering*), and emotional transition (under the subtheme *changes in mom*). Furthermore, 13 meaning units were classified as *typical* and 5 were classified as *variant*. Coping, under the subtheme *emotion regulation*, was the

category containing the most statements. Table 3 shows the number of women who endorsed each category and the number of statements in each of these categories.

An inter-rater reliability check was performed. To obtain a measure of inter-rater reliability, an independent reader re-coded the data and reliability was determined based on the consistency between the primary researcher's classification of the data into meaning units and the classification of the data by the independent reader. Inter-rater reliability was .93.

Theme 1: Trauma and the Impact on Self in Relationships

In this theme, the women reflected on their past and present traumas and on how they have been impacted by these experiences. They described how these experiences have affected their emotional life, their view of themselves, their view of others, as well as their interactions with others. Moreover, they talked about how they have coped with these past experiences and have grown through their ability to survive challenging life events.

Subtheme 1: Betrayal. The women talked about betrayal as part of the trauma of their history of childhood sexual assault. Many women reported being harmed within close relationships, by caregivers and trusted elders:

“I didn't know if it was right or wrong, but I did it. Just because ... I liked him and he was my friend.” (Alexis)

Some spoke of the trust that was broken by a caregiver, a figure who is in a position of power and is expected to provide care and protection:

“The one person that's supposed to protect me from this is the person that actually like, you know, exposed me to it.” (Nicole)

The women spoke about betrayal that went beyond that of the perpetrator of the abuse. They shared that they also felt betrayed by significant others who, either through conscious non-action or a lack of awareness of the abuse, failed to provide protection. For instance, one participant talked about being the only child who was abused in a family with multiple children:

“So ... nothing happened to them. It was just me. And I kind of felt singled out, like why my mother wasn’t? You know? How could something like that happen to me repeatedly? For YEARS.” (Donna)

Furthermore, the women spoke of feeling silenced and a lack of support following disclosures of abuse:

“I felt like when my family and, you know, some family friends were like ... had told me “You can not talk about this. You can not discuss this.” I felt like I couldn’t feel how I could feel. I had to feel how they had to feel. You know?” (Alexis)

Finally, a few of the women talked about feeling betrayed by helping professionals who did not provide protection and/or support. Some of the women in this study experienced sexual traumas both in childhood and as adults. Women talked about feeling betrayed by professionals in connection to assaults that occurred both in childhood and adulthood:

“And they always point the finger at women. And ... yeah, you’re seen as a whore. You’re seen as ... a piece of garbage in the eyes of the law. And in the eyes of the health system. I got herpes because I was raped. They don’t believe it.” (Sarah)

Subtheme 2: Emotion Regulation. Many of the women in this study reported feeling significant emotional distress, both in the past and present, in relation to their past traumatic experiences:

“Day-to-day functions are interrupted by what I’ve been through” (Alexis)

“There are days I wake up, and to be honest, I will want to jump off a bridge.”

(Nicole)

Some of the participants in this study described difficult and sometimes chaotic daily living conditions. For instance, they spoke of stressors such as living in poverty as well as safety concerns. Many of the women described multiple concurrent stressors in their lives:

“I really feel like I’m losing control of everything in my life.” (Nicole)

Women also reported distress due to feeling alone and lacking needed support. These women tended to have few supportive relationships or identified that the members of their support system live primarily in their country of origin:

“It’s just like when the day comes when you have to give the life to your baby there’s a lot of worry, cause it’s your first time. You don’t know what’s gonna happen. And you don’t have support from anyone.” (Emily)

The women reported a number of strategies that they use to cope emotionally on a day-to-day basis. These include drawing on the support offered by family and friends, talking to others, helping others, journaling, writing poems, and going for walks. Women also talked about having coped through the use of alcohol, drugs, self-harm, restricting food, and suicidality, either in the past or present. Some of the women identified their spirituality as a major source of strength and healing.

Women also reported using formal resources to cope, including individual counselling, group counselling, and support groups.

Active avoidance was a strategy that many of the women reported using to cope with distress. They spoke of avoiding others, “pushing things aside”, and trying to “ignore” problems. Some of the participants shared that they had learned to “block all the negative feelings” and have “blurred” their memories. When explaining how she has coped with her past traumatic experiences, one of the women stated:

“Just think about it as ... Try to erase it from my memory. And not to think about it as part of my life. Just to think about it as fiction. Something ... Like ‘Did it happen to me? It was just in a book somewhere.’” (Ashley)

One participant shared that she has learned to cope by trying to focus only on the positive. She described her past as negative and her present and future as positive.

Finally, when making suggestions regarding what might be helpful for other women who have experienced past trauma and are becoming new mothers, a few women agreed that it would be helpful for them to be able to meet others who have the shared experiences of both historical trauma and the transition to motherhood:

“Because even though like all mothers are different, mothers who have been through a lot of trauma, like emotional and physical – especially if it was like sexual abuse – it’s really hard to ... to speak about it with people who don’t understand. Because you feel like you’re being judged.” (Alexis)

They explained that the opportunity to meet others with similar experiences would allow these women to gain support and to learn from one another:

“Like you’ll open books and ... you’ll be like ‘Oh, how to be a mother. You’ll go through this and this and this.’ NO ONE ever tells you ... if you’ve been through something traumatic, how will you cope and how will it affect you later?” (Alexis)

Subtheme 3: View of Self. During the interviews, each woman disclosed beliefs that she holds about herself or beliefs that she has held in the past. A prominent belief held by these women was that they are somehow to blame for their past traumatic experiences, due to some internal flaw:

“I must be crazy. I must be ... sick. I must be ... something wrong with me.

There must be something wrong with me that allows them to hurt me, cause I must be bad – a bad person, or ... maybe I did something wrong and this is a way of them punishing me.” (Sarah)

The women revealed several other beliefs that they have held about themselves that suggest that they perceive themselves to be flawed. Some of these beliefs include the following, “I just think about myself as a loser”, “I wish I was stronger”, “I feel insecure and filthy about myself”, “I’m fat”, “I’m a really closed person”, “I went and became a delinquent”, and “I was a pathological liar”.

Conversely, some of the women shared that their ability to survive and persist following hardship has led them to value and to believe in their own inner strength:

“I feel like I’m a warrior.” (Sarah)

“I associate being a survivor with, you know, like the strength that I think that I’ve had over the years, to actually lead a productive lifestyle like, you know. To finish university. Come back.” (Nicole)

Moreover, a few of the women reported that they have grown as individuals after surviving and coping with past experiences:

“Empathy ... will definitely be a strength. Because I’ve been through a lot. I’ve experienced a lot. So I think I can understand a lot more of what my child goes through.” (Emma)

“There are people I can relate to on a different level because of what I’ve gone through. And it’s made me grow as a person. And it taught me a lot.” (Alyssa)

Subtheme 4: View of Other. The women also shared general beliefs that they carry about the behaviour and intentions of others in the world. One of the beliefs that was identified was the expectation that others cannot be trusted:

“It’s a very, very hard lesson I learnt actually in life. Which is the only one I can count on to always be there for me, is me.” (Alyssa)

Another reported belief that emerged throughout the interviews was that others are callous. They fail to provide needed help, either due to a blatant disregard for the welfare of others or due to discrimination, ignorance, and incompetence. Moreover, they show indifference to the harm that they cause:

“He sent me a text message the next day, and he’s like ‘I’m sorry about what happened last night. I was DRUNK. Can we still be friends?’ And I was s-h-o-c-k-e-d and appalled. And that’s what made me cry – not what he had done. But that’s what made me cry. Because I’m like “You DIDN’T steal my dog.

You didn't run over my toe with your bike. You assaulted me... it reminds me about how STUPID and arrogant and ignorant people can be." (Alyssa)

A final belief that appeared was the belief that all men are dangerous and have the potential to be perpetrators of abuse:

"Because ... I don't think I would have been so promiscuous, and so out there. Kind of had this mindset that if I don't give it to them they're going to take it anyway. So you might as well just give it to them." (Emma)

Subtheme 5: Relationships. The women also talked about their relationship patterns as well as their fears and beliefs within relationships. Many of the women disclosed that they have difficulty being vulnerable in romantic partnerships. This includes a discomfort with emotional intimacy and sexual intimacy:

"Once it becomes intimate – and I'm not talking about sex. I'm just talking about them being in my space – knowing me and wanting to get to know me more. And me wanting to know them. It gets scary and I usually push them away." (Emma)

"I won't go near him. I ... don't think I've had sex in like the last three months. I ... will not let him touch me. We used to have a shower together every morning. I ... will not let him see me change. It's ... And he's confused." (Alyssa)

Furthermore, the women shared that they struggled to feel trust in their relationships:

"Even at family parties I couldn't face people. Because I felt like they knew. Well they did know, and they still didn't protect me, so I felt if I were to

become friends with anyone at school they wouldn't protect me either. Who-why would THEY? My family didn't do it for me." (Alexis)

Finally, the participants shared general beliefs that they hold concerning the concept of a healthy relationship:

"So far it seemed healthy cause he hasn't like abused me in any way. So to me I associate health with ... I mean, yeah, health; a healthy relationship with not being abused." (Nicole)

Subtheme 6: Recent Abuse. During the interviews, there were women who reported that they have been abused by the father of their child, either in the past or present. At the time of the interviews, some of these women had left their abusive partner and others had remained in the relationship.

"You know, every time he did something to me it brought back scars of what my father ... – and he was very much like my father. He was ... disturbing. He was dirty. He was unclean. He was violent. He was sick. He was perverted. He was very controlling. He was dangerous. He was evil. He was completely deluded. Like ... I mean ... I feel like ... I was ... dating my father." (Sarah)

Theme 2: Moving Forward into Motherhood

In this theme, the women talked about their experiences during the transition to motherhood. They shared their hopes and fears for their child and for themselves in their new role. Moreover, they reflected on the mothering that they had received in childhood, and shared their hopes and fears in relation to these early relational images. The women also reported changes in themselves and their behaviour that occurred during the transition to motherhood.

Subtheme 1: Role Model. When thinking about themselves in their new role as mothers, the women reflected on the mothering that they had received and on how they wanted to compare to the model provided by their own mothers. Many of the women stated that they wanted to provide their child with the protection from harm that they did not receive as children. They worried about inheriting what they perceived as “weakness” in their own mothers:

“It’s almost as if like I’m ... like trying to be ... the alter ego mom that my mom wasn’t for me.” (Alexis)

Moreover, should her child experience harm, one of the participants stated that she wanted her child to be able to confide in her so that she could provide them with the help that would be needed:

“Like I can say easily like I’ll do anything for my son. But I hope that if he approaches me and he tells me, you know, something has happened. Even if it’s only as small as “Some kid at school is making fun of me.” That I will actually take care of the situation. Unlike what had happened to me.” (Alexis)

Some of the women also spoke of their wish to be attuned to their child’s emotional needs. They hoped to provide the emotional support and attention that was not provided to them in childhood:

“My strengths will be how attentive and focused I am ... on my child. Cause ... one, I’ve lived without attentive parents before. So ... I know that.” (Alyssa)

One of the women, shared that she admired her mother’s willingness to sacrifice her own safety to protect her when she was young, and hoped to be able to do the same for her own child:

“She sacrificed herself for me. So we’ve never been ... closer. I don’t think ... I love anyone as much as I love my mom. Because I can’t imagine anyone doing that; which was amazing. And ... I was like if I ever have a child that’s who I want to be like” (Alyssa)

Subtheme 2: Mothering. The women shared their hopes and fears concerning motherhood. A major worry shared by each of the women in this study was that their child would go through the same trauma that they had experienced. They talked about their desire to protect their child. Some of the women stated that they hoped that their child would be male, as they believed that a boy would be easier to protect:

“Please let it be a boy. Because, like you know, I don’t want her to ... like, you know, cause a part of me was even saying, you know, what if my fiancé, like you know, tries to do the same thing that my dad did to me?” (Nicole)

Some of the women feared leaving their child in the care of others, including close friends and family members:

“I would not leave him with a male figure. My boyfriend, his father.
(laughing) Even him. Even him, he’s mostly here, you know, with me. I don’t even think he’s been by himself.” (Donna)

The women worried about being “overprotective” and how this might impact their relationship with their child.

“I don’t know how it’ll affect my relationship with my child too. That I’m so overprotective. And I know too much protection is just ... your children could

rebel. Maybe I'm thinking too far ahead, but I'm just ... that's something that I worry about." (Alexis)

One of the participants explained that she would protect her child from either being victimized or from perpetrating offenses by educating her child about the "dangers of the world":

"I want my child to know as much danger so that ... so that my child is able to prepare him or herself." (Sarah)

The women also shared that they hope to foster healthy emotional development and a strong sense of self in their children. They talked about allowing their children to be heard and teaching them to respect and value themselves.

"And I want him to be also ... emotionally healthy. This is for me actually it's the most important part." (Ashley)

Furthermore, the women talked about aspects of parenting that they identified as areas of insecurity. These areas of parenting included discipline and socialization. Moreover, the women worried about the possibility of their emotional wellbeing and past experiences having impact on their parenting abilities:

"I think there's still so many things that I need to work through. And in order to be ... It's kind of like ... 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." (Emma)

Subtheme 3: Changes in Mom. The women described various changes that they noticed in themselves that occurred in connection to the transition to

motherhood. These included emotional changes and changes in their sense of meaning, sense of self, and their perceptions of the past, present, and future.

For many of these women, the transition to motherhood represented a “new chapter in [their] life”. They explained that the baby had brought about great internal transformations. For instance, they shared statements such as “I’m a new person. The baby has brought me closer to God”, “I’m complete”, “Self-actualization is here”, and “I can love again.”

“It’s I feel that way when you go to that little girl and doesn’t have no shoes and she’s really, really poor. And you’re gonna give a toy, a simple toy, but you’re gonna bring the little light in their eyes. So that kind of feeling I felt.”
(Emily)

For some, the transition to motherhood represented loss and uncertainty. For example, one of the women explained that becoming a mother meant losing her childhood and needing to “grow up”. For another, it meant letting go of her plans for the future. One of the women disclosed that the father of her child may be her fiancé or may be the perpetrator of her assault. She shared the following statement:

“In 17 weeks I find out what changes in my life. Do I ... lose my fiancé? Find a new place to live? Go back to Kenya? Raise this child on my own? Or do I have a happy family and get married like I wanted to and live with a person I love?” (Alyssa)

The women also described how their methods of coping have changed during the transition to motherhood. This change was sometimes a conscious choice:

“I stopped drinking. I stopped cutting myself; because as much as I go it’s only hurting me, it’s not hurting my baby, it actually will hurt my baby.”

(Alyssa)

At other times, the change felt out of her control:

“I always put up my fort. Cause like I feel so safe behind that wall. And now that like, you know, I’m pregnant, it’s like ... no matter how much I try to put up this wall, it’s like my emotions are just b-u-r-s-t-i-n-g through and it’s like I feel like it’s just EVERY where.” (Nicole)

The women also reported other changes in their self-care behaviours that were motivated by the transition to motherhood. These changes included quitting smoking, no longer drinking alcohol, developing healthier eating habits, and seeking out appropriate medical and mental health care.

“And it’s so funny how ... It’s so hard to think of yourself. But when it comes to another life that you’re responsible for, it doesn’t start when you give birth and they’re in your arms. You know it starts when you find out that they’re inside of YOU. And then you’re like ‘Oh, that means I’m going to have to take care of myself.’ (Emma)

Table 2

Themes and Associated Meanings

Major Themes	Subthemes	Associated Meaning		Associated Meaning
Trauma and the Impact on Self in Relationships	Betrayal	Harm, either intentional or unintentional, inflicted by those who	By Perpetrator	Betrayal by the perpetrator of the sexual abuse

		would be expected to provide protection	By Others	The failure of significant others to provide protection from harm and/or support following discloses of abuse
Emotion Regulation	Indicators of emotional well-being		Distress	A high level of emotional suffering, difficulty regulating emotions, a lack of coping, and other signs of decreased emotional well-being
			Coping	Active attempts to help manage distressing emotions and/or situations
View of Self	Beliefs that the women hold about themselves		Flawed	The belief that there is something inherently wrong with oneself, either internally or externally
			Survivor	The view of oneself as strong and resilient, as evidenced by one's ability to persist

				despite adverse experiences
			Growth	The view that one has grown and developed as a person due to facing and coping with traumatic experiences
	View of Other	Beliefs that the women hold about others in society	Dangerous	The belief that all men are potential perpetrators of abuse
			Callous	The belief that others are uncaring and indifferent to their pain
			Untrustworthy	The belief that others cannot be trusted or relied upon
	Relationships	Patterns that the women observed in their relationships as well as their fears and beliefs in relationships	Vulnerability	Difficulty with emotional intimacy, touch, and sexual contact in romantic relationships
			Trust	Difficulty trusting others
			View of Relationships	Expectations that the women hold for relationships

	Recent abuse	Abuse that is present in a current or recent relationship		
Moving Forward into Motherhood	Role Model	The women's reflections on how their experiences with their own mothers have influenced their hopes for themselves as mothers	Protective	A woman's desire to shield her child from experiencing the pain that she experienced in childhood
			Attunement	A woman's intention to be present, attentive, and responsive to her child's emotional needs (actions that would be in contrast to the mothering she experienced)
			Mom as a Positive Role Model	A woman's hope to emulate the example provided by her own mother
	Mothering	The hopes and fears that the women have for themselves as they take on their new role	Protection	A woman's desire to protect her child from harm, particularly from experiencing the trauma that she

				experienced
			Emotional Development	The desire to foster healthy emotional development and a healthy sense of self in one's child
			Areas of Insecurity	Aspects of parenting that are identified as potential areas of weakness
	Changes in Mom	Changes that the women report in themselves that are attributed to the transition to motherhood	Emotional Transition	Changes in a woman's sense of meaning, her sense of self, and/or her perceptions of the past, present, or future, that occur in connection to the transition to motherhood
			Caring for Self	Changes in self-care behaviours that are motivated by the transition to motherhood

Table 3
Classification of Themes by Frequency

Major Themes	Sub-Themes		Number of Quotes	Number of Women	Classification
Trauma and	Betrayal	By Perpetrator	14	5	Typical

the Impact on Self in Relationships					
		By Others	34	5	Typical
	Emotion Regulation	Distress	44	8	General
		Coping	76	8	General
	View of Self	Flawed	25	7	Typical
		Survivor	6	3	Variant
		Growth	2	2	Variant
	View of Other	Dangerous	6	4	Typical
		Callous	16	2	Variant
		Untrustworthy	8	5	Typical
	Relationships	Vulnerability	7	4	Typical
		Trust	9	4	Typical
		View of Relationships	6	4	Typical
	Recent Abuse		14	4	Typical
Moving Forward into Motherhood	Role Model	Protective	24	6	Typical
		Attunement	2	2	Variant
		Mom as a Positive Role Model	2	1	Variant
	Mothering	Protection	31	8	General
		Emotional Development	12	5	Typical
		Areas of Insecurity	10	6	Typical
	Changes in Mom	Emotional Transition	40	8	General
		Caring for Self	16	5	Typical

Discussion

The present study focused on exploring attachment and the transition to motherhood for immigrant or refugee women who are survivors of childhood sexual abuse. Eleven transcripts from eight participants were coded using trauma theories and attachment theory to guide the interpretation of the data. Analyses revealed two major themes: Trauma and the Impact on Self in Relationships and Moving

Forward into Motherhood. The following section will provide an interpretation of these results.

Trauma and the Impact on Self in Relationships

The women in this study shared their stories and reflected on how they have been influenced by their past traumas. In their reflections, many of the women talked about betrayal as a significant and damaging factor in their experiences of childhood sexual abuse. They related devastating experiences of being harmed within close and trusting relationships with caregivers and older male relatives. They also spoke of being harmed by the non-action of significant others who failed to protect them or to provide needed support. This finding is consistent with the work of several trauma theorists who argue that betrayal is a major factor leading to the difficulties faced by childhood sexual abuse survivors (Finkelhor, 1987; Freyd, 1996; Herman, 1992).

Due to this significant breach of trust inherent in childhood sexual abuse, it is not surprising that many of the participants reported having difficulty with trust, both in their past and current relationships. The women talked about having a general difficulty trusting in others as well as feeling uncomfortable with emotional intimacy in their romantic relationships, due to this disturbance in their ability to trust. These women have learned to protect themselves from further abuse by adopting greater caution in relationships. One of the women explained:

“Cause for a long time I put that away... I would put away how I felt, and that’s why it was so hard for me to be very close to people. So I had ... almost this wall up... And every time... people had come ... tried to become close to me, I

pushed them away. And then now I understand why. It's because I didn't ... I didn't learn how to deal with what I'd been through. It's just because I had wanted to avoid it... It ... affected me tremendously. Like socially I was just ... I didn't trust anyone." (Alexis)

However, Haskell (2003) notes that women do not always come to have greater mistrust following abuse. Conversely, survivors may come to trust too easily, as a self-protective strategy. When a caregiver victimizes a child, the child is faced with the unimaginable challenge of maintaining trust in the very person who is causing them harm. This is essential to their survival, as the child must depend on the caregiver to provide their basic needs, including their need to feel loved and protected. Therefore, the child learns to disregard signs of danger in order to maintain their trust in the caregiver. This tendency to trust too easily can last into adulthood. Unfortunately, their lower threshold for trust can put women at a greater risk for revictimization (Haskell, 2003; Herman, 1992). Half of the women in this study reported that their current partner or the father of their child had physically, sexually, or emotionally abused them. This is congruent with the findings of Classen, Palesh, and Aggarwal (2005), showing that 2 out of 3 survivors of sexual assault will be revictimized.

Herman (1992) and Freyd (1996) have elaborated on how children cope when they are betrayed by trusted others. As mentioned, children are dependent on their caregivers and must maintain a sense of trust in the caregiver-child relationship in order to feel safe. Therefore, children learn to block their awareness of the abuse through dissociation. This includes numbing the feelings associated

with the abuse, feeling that the abuse was not real, or forgetting all or part of the abuse. Many of the women in our study talked about blocking aspects of their trauma experience through dissociation.

The women also shared that they struggled to regulate their emotions. Some of the women reported frequently feeling intense emotions and that these emotions interfered with their everyday lives. This finding can be explained using attachment theory. An individual's capacity for emotion regulation develops in childhood and is closely related to their attachment history. Secure attachment is established through the successful regulation of affect within a caregiver-child relationship, in which the caregiver is acting as a secure base for the child. That is, the child learns that their caregiver is available to provide both physical and emotional safety. In a securely attached caregiver-child relationship, the caregiver is emotionally attuned to the child and responsive to the child's needs. The caregiver regulates the child's emotions by providing appropriate emotional support and stimulation. Overtime the child internalizes the parent's soothing and learns to self-soothe (Fosha, 2003). Conversely, when a child is sexually abused by a trusted adult, their needs and emotions are blatantly disregarded. Without an attuned caregiver, these children cannot learn to self-soothe and are left alone to manage the intense emotions related to the abuse.

Our finding that the women experienced both overwhelming emotions and a numbing of emotion may be viewed from another perspective. The presence of intense and intrusive trauma responses, alternating with an avoidance of these trauma responses, is consistent with Briere's self-trauma model. Briere argues that

re-experiencing aspects of the trauma, through thoughts, emotions, images, and/or sensations, is the brain's attempt to heal from the traumatic experience. However, prolonged exposure to the traumatic memories would be overwhelming. Therefore, the brain alternates re-experiencing with an avoidance of trauma memories (ex. through dissociation) (Briere, 1996). The following quote provides an example of re-experiencing trauma:

“I get these flashbacks of when I was a kid. And it's weird cause I can still remember the smell of him. And ... the way his hands felt.” (Alexis)

Another participant described her experience of feeling emotionally numb:

“And when you're in that place you can't feel love. You can't feel nothing, and you're like a fricking zombie walking. And you have to go to the club to get your next fix to feel alive. You have to cut yourself. I have scars all over my hands, cause that was the only way I knew I was alive.” (Alyssa)

Briere (1996) also suggested that childhood abuse survivors are more likely to develop destructive strategies to cope with their experiences. He explained that these children often do not have the opportunity to learn healthy coping strategies in their abusive environment. Without healthy alternatives, they develop destructive strategies to cope with their trauma experiences. In this study, some of the women reported that they had used destructive strategies to cope, either in the past or present, including self-harm, suicidality, self-starvation, and substance use.

Our findings also revealed themes in the way that the women viewed themselves and others. The women tended to view themselves as flawed and others as dangerous, untrustworthy or callous. These themes may be understood through

the lens of attachment theory. Attachment theory posits that children develop internal working models of the self and others, through their interactions with their primary caregivers; that is, children develop expectations and beliefs about themselves and others that help them to understand and navigate social interactions, and these expectations and beliefs are directly related to their experiences with their primary caregivers (Bowlby, 1988). Therefore, it follows that a child who is abused by a caregiver would understandably come to believe that he or she is flawed. The caregiver's actions communicate to the child that they are somehow undeserving of appropriate care. This belief will then guide the child to act in ways that reduce the risk of further abuse. For example, the child may work to be deserving of care by becoming the "perfect child" or the child may withdraw, accepting the belief that they are not deserving. The belief that they are flawed also makes the abuse understandable in the eyes of the child. The child's internal working model of others also guides their future interactions. For instance, a child who is abused may come to view others as dangerous, untrustworthy or callous. These beliefs would lead the child to be more cautious in their interactions with others, providing them with some protection from further abuse. Some of the women also talked about their beliefs regarding relationships, which could be explained using the concept of internal working models. They shared the belief that a relationship is healthy if it does not involve abuse. According to attachment theory, this internal working model of relationships developed through interactions with attachment figures.

Herman (1992) offers an alternative theory regarding the development of negative self-beliefs in children who have been sexually abused. She argues that children come to blame themselves for the abuse as a form of self-protection. Acknowledging that their caregiver has been abusive is threatening to the child's need to depend on the caregiver to meet their needs. In order to regain a sense of security and control, children tell themselves that the abuse is their fault. In doing so, the child can continue to trust in the caregiver and can feel that they have some control over their caregiver's behavior (i.e. I deserve to get hurt because I'm bad, if I can be good I won't get hurt anymore).

Two themes emerged that are inconsistent with attachment theory's concept of internal working models. The women talked about feeling a greater sense of strength due to their ability to survive and persist following traumatic experiences. They also discussed how they have grown as a result of having coped with extremely challenging life events (i.e. developed a greater capacity for empathy). These themes were coded as Survivor and Growth. On review of the research literature, it became apparent that both of these themes are consistent with the concept of posttraumatic growth. Posttraumatic growth entails positive psychological changes that develop as a result of having struggled to deal with trauma. These changes may be divided into five areas of posttraumatic growth: an overall greater appreciation for life, enriched interpersonal relationships, a greater sense of personal strength, priority changes, and spiritual growth (Tedeschi & Calhoun, 2004). Although the participants in our study discussed other areas of posttraumatic growth, under these codes, I only included statements concerning

personal growth that involved changes in a woman's self-perception. Tedeschi and Calhoun (2004) suggest that posttraumatic growth emerges out of the process of rebuilding our assumptive world following a traumatic event. An assumptive world, a term closely related to attachment theory's internal working model, is a set of assumptions that a person holds about the world (i.e. the world is good and meaningful, and the self is worthy and has value) (Janoff-Bulman, 1992; Parkes, 1971). Traumatic events can greatly challenge these assumptions. The difficult process of developing new expectations and beliefs about the world may lead to posttraumatic growth.

Our findings also revealed themes that may be explained through the concept of traumatic sexualization. Traumatic sexualization is the damaging influence of sexual abuse on the development of the child's sexuality. Children who are sexually abused are often given special attention, affection, and/or privileges from their abuser. They are taught that they are valued as sexual objects (Finkelhor, 1987). Haskell (2003) discusses how this dynamic may effect a women's sexuality in adulthood. She explains that a woman may learn that her body is not her own and that attention is gained through sexual behaviour. Women may also respond to this exploitation by avoiding sexual intimacy. Some of the women in our study reported great discomfort with sexual intimacy and touch. They talked about having avoided sexual intimacy either in the past or present. Some of the women also shared their thoughts and beliefs about sex. One of the women talked about viewing sex as meaningless. She shared that, prior to committing to a relationship with God, she would have consented to exchanging sex for shelter. She also described herself as

having been promiscuous in the past. She explained that she had had the expectation that if she had not provided men with sex they would have forced it upon her. Another woman shared that she was confused by her own behaviour. She had cheated on a husband who she loves. She reflected that due to her past experiences, she could not conceptualize a healthy marital relationship.

Moving Forward into Motherhood

In this theme, the women talked about their experiences of becoming mothers. A common topic that emerged in conversations about their new role was the women's concern regarding the safety of their children. The women reported that they feared that their children would also experience trauma. A principal hope held by these women was that they would be able to protect their children from sexual abuse:

"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 ... not that." (Emma)

The women's desire to provide their children with the protection that they did not receive in childhood echoes the results of previous research investigating the mothering experiences of abuse survivors. In a study by Pitre, Kuchner, and Hegadoren (2011), survivors of physical, emotional, or sexual abuse shared their hope that their children will grow up safe from abuse. The theme of survivors wanting to protect their children from abuse was also reported in a study exploring the experiences of expectant mothers who had been sexually abused in childhood or

adulthood. The women in this study emphasized that they particularly worried about the safety of female children (Schwerdtfeger & Wampler, 2009). The view that daughters are in need of more protection than sons was shared by many of the women in the present study. Some of the women in our study explained that they would protect their child by closely monitoring the people who are involved in the child's life. Moreover, they expressed their hesitation to leave their child in the care of others. In some cases, the women were even hesitant to allow their child to be alone with the child's father. The desire to shelter their children is understandable and well intentioned. Unfortunately, the women's efforts to provide protection could have a negative impact on the well being of their children. Dearing (2004) examined associations between parenting styles and child outcome variables. One of the parenting styles examined was restrictive parenting, which was defined as parenting that values parental authority, control, and monitoring. This study found restrictive parenting to be positively related to child depression.

In discussing their desire to protect their children from abuse, many of the participants shared how their hopes for themselves as mothers compares to the mothering that they received in childhood. For many, their hope was to become the "alter ego" of their own mother, by shielding their child from abuse. However, some of the women worried that somehow they will inevitably end up repeating the cycle of abuse:

"We are like our parents in some way. Even if ... I know deep down inside she wanted to protect me, she DIDN'T. And I'm afraid that I'll end up like that too."

(Alexis)

Nelson (2003) reported a similar finding among women who felt that they had received inadequate mothering. These women feared that they would repeat the harmful parenting patterns practiced by their own mothers.

Another hope for themselves as mothers was that they would be able to foster healthy emotional development in their children. The women talked about wanting to be focused and attentive with their children. They wanted to help their children to develop their own opinions and to respect and value themselves. This was another area in which some of the women wanted to differ from their own mothers. In contrast to the mothering that they received, these women strove to be attuned to their child's emotional needs.

The women's emphasis on protecting their children and attending to their emotional needs clearly communicates the wish to provide their children with a safe and healthy environment, unlike the environments in which they were raised. Previous research suggests that these women may need some support in attaining this goal. Priel and Besser (2001) found a mother's internal representation of her own mother to be associated with the prenatal mother-child attachment relationship between the mother and her child. Postnatal mother-child attachment insecurity was found to be related to poorer relationship quality between the mother and grandmother (Mercer & Ferketich, 1990). Finally, research suggests that attachment classifications (i.e. secure, avoidant, ambivalent) are often transmitted across generations. In a study by Benoit and Parker (1994), 65% of the sample maintained the same attachment classification across three generations.

The topic of parenting also brought up feelings of self-doubt for some women. This finding is consistent with past studies reporting less confidence and poorer perceived self-efficacy concerning mothering in women who are survivors of childhood sexual abuse, when compared to women without a history of abuse (Banyard et al., 1997; Fitzgerald et al., 2005). One of the fears expressed by the women in our study was that their trauma would somehow impact on their parenting abilities. Their specific areas of self-doubt involved aspects of parenting that could be challenging given their responses to trauma. For instance, some of the women worried that their emotions would interfere with their parenting. This is an area in which survivors may need additional support. Difficulty with emotion regulation is a common response to trauma (Herman, 1992). This difficulty may pose additional challenges to women in their role as mothers, as emotion regulation plays an important part in forming a secure mother-child attachment bond. A child's emotional competence and capacity for secure attachment form through interactions with their caregiver. Specifically, the caregiver's ability to regulate both their own emotions and the child's emotions is crucial to the child's development in these areas of functioning. In a securely attached mother-child relationship, the caregiver assists the child in coping with intense emotions that would be too overwhelming for the child to handle alone. Over time, the child learns to self-soothe and regulate their emotions with less assistance from their caregiver (Fosha, 2003). New mothers with a history of childhood sexual abuse may need assistance in developing emotion regulation skills, in order to enhance both their own well-being and the well-being of their children. Finally, other areas in which the women

expressed self-doubt included helping their child to develop socially and providing discipline. These areas of self-doubt may reflect difficulties with trust, a common response to trauma (Haskell, 2003), and the absence of a positive role model to guide their parenting practices.

Another theme that emerged in the interviews reflected the changes in the women's self-care that were prompted by the transition to motherhood. Women shared that they were taking steps to live healthier lifestyles in order to provide their children with the best care possible. They talked about caring for themselves by eating healthier food and seeking out appropriate medical care. Some of the women also shared that they had stopped or made efforts to stop engaging in destructive forms of coping. This includes quitting smoking, abstaining from drinking alcohol, stopping unhealthy diet restrictions, no longer inflicting self-harm through cutting, and no longer attempting suicide. These changes in behaviour speak to the women's love for their children and desire to provide healthy caring. This finding suggests that the transition to motherhood may lead survivors to take active steps to heal from trauma. However, the transition to motherhood may also pose barriers to help seeking (i.e. childcare needs, limited time, etc.). Therefore, additional supports may need to be put in place to make health care services accessible to these women.

Finally, the women spoke about the emotional experience of becoming new mothers. For many women, the transition to motherhood represented a new beginning. The baby brought "purity and happiness", leading to a positive shift in their life course. Some of the women explained that the arrival of their child had

given them a greater sense of meaning and hope as well as a sense of spiritual growth. This finding suggests that the transition to motherhood can itself be healing. One of the symptoms of complex posttraumatic stress disorder is an alteration in systems of meaning. That is, a common response to complex trauma is a loss of faith or sense of hopelessness (Herman, 1992). The transition to motherhood appears to contribute to healthy changes in systems of meaning for some survivors of abuse.

Unfortunately, the transition to motherhood was associated with greater distress for some women. Specifically, these women discussed losses that accompanied the transition to motherhood and a few described a sense of losing control. These losses included the loss of relationships, future plans, freedom from responsibility, childhood, and a sense of certainty regarding the future. A study by Nelson (2003) also found an association between loss and the transition to motherhood. This sense of loss, particularly loss of control, may be reminiscent of the loss of control inherent in childhood sexual abuse. Finkelhor (1987) described the dynamic of powerlessness as a harmful element in childhood sexual abuse. In this form of trauma there is always an abuse of power, as the child's will is denied through physical and/or emotional control. Therefore, feelings of losing control may be particularly triggering for these women. They may need support to regain a sense of control.

Our findings do not appear to provide added information on the unique experiences of newcomers to Canada. The interviews did not ask the women to reflect on their experiences as newcomers or on how these experiences may have

influenced the transition to motherhood. A few of the women briefly talked about their experiences as newcomers. For instance, one of the women shared that her support network was primarily in her country of origin. These comments suggest that further research into the experiences of immigrant and refugee survivors during the transition to motherhood is warranted.

Limitations

When considering the results of the present study, there are limitations that must be considered. First, the present researcher did not have any influence over the information gathered during either of the two interviews, as this study used secondary data from the project *Embodied Trauma: The influence of past trauma on women during the transition to motherhood*. The *Embodied Trauma* project aimed to gather information about: (1) the women's history of trauma, (2) how the trauma has impacted on the transition to motherhood, and (3) the interactions that the women have had with the health care system throughout the transition to motherhood. The interviews did not ask specific questions targeting the women's attachment histories, their attachment with their children, or factors that have been associated with attachment. Therefore, information relevant to the current study may not have emerged during the *Embodied Trauma* interviews. It is possible that our results are missing important themes related to attachment and the transition to motherhood.

Another limitation concerns the recruitment of participants. The women in this study were mainly recruited through health care services and newspaper advertisements. These modes of recruitment are less likely to reach women who

are living with high levels of chaos and isolation in their daily lives. Women in these circumstances may be less likely to access health care services or to seek out information about events in their larger community. Therefore, the voices of these women were not heard in the present study.

Strengths

One of the major strength of this study is the rich data on which it is based. Few studies have examined the transition to motherhood for women with a history of childhood sexual abuse, and none were detected that examined this transition for survivors who were immigrants to, or refugees in, Canada. Fewer still have done so using a qualitative research design. Through the interviews, the women were able to tell their stories in their own words and to communicate their thoughts concerning motherhood. The depth of the information gathered was far greater than what would be gathered using a quantitative research design. As the interviews used open-ended questions, the women's responses were less limited than responses gained through more structured approaches (i.e. questionnaires).

Implications for Counselling

The current study lends further support to past research indicating that the impact of childhood sexual abuse goes beyond the re-experiencing, avoiding/numbing, and hyper-arousal responses of simple PTSD. Childhood sexual abuse often occurs within a relationship with a trusted adult. Coping with this significant relational trauma can influence the child's social, emotional, mental, and physical development. The diagnosis of complex posttraumatic stress disorder

provides a better framework for understanding the impact of childhood sexual abuse (Herman, 1992).

As childhood sexual abuse is a form of relational trauma, healing must occur in connection to others. Therefore, the therapeutic relationship is a primary factor in the treatment of women who are survivors of childhood sexual abuse. Within the therapeutic relationship women can slowly develop the capacity to build healthy trust in relationships. The therapeutic relationship can also provide women with a safe place to challenge distorted beliefs about themselves and others. Given the significant breach of trust inherent in childhood sexual abuse, the development of healthy trust within the therapeutic relationship will be a long-term process. This type of healing is not possible in the typical 8-12 counselling sessions offered by community agencies. For relational healing to occur, longer-term treatment must be made available to survivors. Unfortunately, treatment length is often out of the control of practitioners, as the number of sessions available to clients is typically limited by funding. Therefore change is needed within the broader social context. Greater public awareness of the prevalence and impact of sexual violence is needed, in order to gain greater support of mental health services for survivors.

The findings in this study also suggest that mothers who are survivors of childhood sexual abuse may benefit from support in developing healthy attachment relationships with their children. Helping women to strengthen their ability to regulate their emotions appears to be an important step toward this goal. Therefore, the development of emotion regulation skills should be a primary treatment focus. To develop secure attachment bonds with their children, the

women must be able to regulate their own emotions and their child's emotions. If a woman is frequently dysregulated, she will be unable to be attuned to her child and available to meet their emotional needs. A study by Lyons-Ruth and Block (1996) appears to support the relationship between emotion regulation, mother-child interactions, and attachment. This study found that survivors of childhood sexual abuse showed restricted affect and less engagement with their children. In this study, the children whose mothers had a history of abuse were more likely to be insecurely attached.

Survivors may also benefit from having a healthy role model to guide them in how to form secure attachment bonds with their children. Many of the women in this study shared that they did not have a healthy role model for mothering. Counsellors could offer programs for survivors that specifically focus on assisting these women in forming healthy attachment bonds with their children. For instance, in a group setting, a counsellor could facilitate discussions about attunement and appropriate affection. The counsellor could also actively teach these mothers how to interpret and reflect their baby's feelings. This counsellor could act as a model for the women and provide them with feedback and support. The Circle of Security is an example of a group intervention that supports caregivers in forming secure attachments with their children. This intervention provides practical assistance in navigating this difficult process (Marvin et al, 2002). Perhaps a similar intervention may be helpful in supporting survivors as they transition to their new role as mothers. Research suggests that survivors tend to show more anxiety about parenting tasks that involve displaying affection or providing personal

care, when compared to mothers without a history of childhood sexual abuse (Douglas, 2000). A therapeutic parenting group for survivors could help these women to manage aspects of parenting that may be more challenging given their history of childhood sexual abuse.

Finally, the availability of support groups for mothers who are survivors of sexual abuse may help to reduce the sense of isolation among this population. Support groups would offer survivors the opportunity to meet others with similar experiences. Moreover, survivors could learn from one another and support each other throughout the transition to motherhood.

Implications for Research

Further research should be conducted on the transition to motherhood for survivors of childhood sexual abuse. In particular, there are few qualitative studies that examine this transition period for survivors of abuse (Schwerdtfeger & Wampler, 2009). Moreover, the studies examining the experience of motherhood for survivors of sexual abuse have used samples of women with histories of various forms of abuse (i.e. physical, emotional, and sexual) that occurred in either childhood or adulthood. They have not been restricted to exploring the experiences of women who were sexually abused in childhood (Pitre, Kuchner, & Hegadoren, 2011; Schwerdtfeger & Wampler, 2009)

Future research should also focus specifically on attachment and the transition to motherhood for survivors of sexual abuse. This research can build on the current study by conducting interviews with survivors that elicit information

concerning the women's attachment histories, their attachment with their children, and factors that have been associated with attachment.

Finally, the experiences of survivors who have immigrated to Canada warrants further study. Future research should directly explore how trauma and the experience of immigration may interact to influence attachment patterns between mother and child.

Conclusion

The current study examined the experiences of survivors of childhood sexual abuse during the transition to motherhood. A qualitative research design was used to explore the women's experiences, using secondary data from the project *Embodied Trauma: The influence of past trauma on women during the transition to motherhood*. Two major themes emerged from our analysis: Trauma and the Impact on Self in Relationships and Moving Forward into Motherhood. Our findings suggest that the transition to motherhood represents a new beginning for some survivors of childhood sexual abuse. During this period, these women may need support to develop healthy attachment relationships with their children. Helping professionals can facilitate a healthy mother-child relationship by providing appropriate care to these mothers, so that they can care for their children.

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Appendix A

Letter of Permission



Arthur Labatt Family
SCHOOL OF NURSING

May 2, 2012

Goli:

Dear Dr. ~~Bezal-Rashti~~

This is to verify that Laura Bellhouse and Laura Waters, students in the Master's of Education in Counselling Psychology, have permission to use data collected by me for their theses. I am attaching a copy of the original ethical approval for the study, entitled "Embodied Trauma: The Influence of Past Trauma on Women during the Transition to Motherhood", NMREB #15662S.

If I can provide any further information or rationale for the decisions outlined above, I would be most happy to do so, at your convenience.

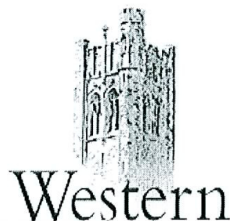
Regards,

Helene Berman, RN, PhD
Professor and Associate Director of Academic Programs

cc Susan Rodger

Appendix B

Ethics Approval



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:

- changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- all adverse and unexpected experiences or events that are both serious and unexpected;
- 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			
<input checked="" type="checkbox"/> Grace Kelly (grace.kelly@uwo.ca)	<input type="checkbox"/> Janice Sutherland (jsutherl@uwo.ca)	<input type="checkbox"/> Elizabeth Wambolt (ewambolt@uwo.ca)	<input type="checkbox"/> Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File

VITA

<u>Name</u>	Laura Bellhouse	
<u>Post-Secondary Education and Degrees</u>	University of Western Ontario, London, Ontario Master of Education: Counselling Psychology	2011-2013
	McGill University, Montreal, Quebec Bachelor of Arts: Honours Psychology	2009-2011
	University of Western Ontario, London, Ontario Bachelor of Music: Honours Violin Performance	2003-2007
<u>Related Work Experience</u>	Counselling Intern Daya Counselling Centre London, Ontario	2012-2013
	Volunteer Group Counsellor Sexual Assault Centre London London, Ontario	2012-2013
	Group Counselling Intern Search Community Mental Health Services Strathroy, Ontario	2012-2013
	Volunteer Co-facilitator Oxford-Elgin Child & Youth Centre St. Thomas, Ontario	2012
	Direct Service Volunteer Canadian Mental Health Association Wait-list Clinic London, Ontario	2012
	Volunteer in the Crisis Intervention Branch Sexual Assault Centre of McGill Students Society Montreal, Quebec	2010-2011
<u>Research Experience</u>	In-School Data Collection Volunteer The Child and Adolescent Social Competence Laboratory McGill University	2011