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Transitioning to Motherhood After Trauma: Interacting With the Healthcare System

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Nursing
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TRANSITIONING TO MOTHERHOOD AFTER TRAUMA: INTERACTING WITH THE HEALTHCARE SYSTEM

(Thesis format: Integrated Article)

by

Karen E. Haines

Graduate Program in Nursing

A thesis submitted in partial fulfillment
of the requirement for the degree of
Master of Science in Nursing

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London, Ontario, Canada

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Abstract

Little is known about the interactions with the healthcare system among women with past interpersonal trauma accessing maternal health care. The purpose of this study was to critically examine the experiences of women with past interpersonal trauma as they interacted with the healthcare system during the transition to motherhood. A critical feminist perspective informed by Relational-Cultural Theory was used to guide this secondary analysis of 29 interview transcripts from: (a) Aboriginal women, (b) refugees, and (c) survivors of childhood sexual abuse. Four themes emerged: 1. Birthing a healthy baby: the common relational thread; 2. Receiving physical care over the emotional needs of the mothers; 3. Moving beyond sharing information to meaningful relational interactions; and 4. Women's past trauma: little choice over their needs then and now. Findings support the need for both a relational-cultural and trauma-informed approach in education and practice when caring for women transitioning to motherhood after trauma.

Keywords: aboriginal, childhood sexual abuse, critical feminist, healthcare system, refugee, relational-cultural theory, trauma-informed care, transition to motherhood.

Co-authorship

This thesis has been completed by Karen Haines under the supervision of Dr. Susan L. Ray, and under the direction of advisory committee members, Dr. Helene Berman and Dr. Robin Mason. Drs. Ray, Berman and Mason will be co-authors of the publications based on this work.

Acknowledgements

I would like to thank Dr. Susan L. Ray for her help and feedback during the stages of this thesis. Her support and guidance have been appreciated. I would also like to thank the members of my advisory committee, Dr. Helene Berman and Dr. Robin Mason, for provision of the primary study data, and for feedback and valuable suggestions throughout the study process. A thank-you is also extended to Dr. Susan Rodger for providing me with inspiration and an introduction to Relational-Cultural Theory during my counseling theories coursework. To my parents, family and friends, who helped me to keep things in perspective and showed me their love and support on so many occasions, thank you.

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CHAPTER 1

Introduction

The transition to motherhood including the prenatal, delivery, and postnatal period, is a well-documented time of physical and psychological vulnerability for women (Berman et al., 2014; Brown, Varcoe, & Calam, 2011; Coles & Jones, 2009; Kornelesen, Kotaska, Waterfall, Willie, & Wilson, 2010; Lukasse, Schei, Vangen, & Olan, 2009; Palmer, 2004). In Canada, nearly 99% of women give birth in hospitals (Canadian Institute for Health Information, 2012: Statistics Canada, 2012), attended by healthcare providers previously unknown to the woman. The transition to motherhood may be particularly complicated for women who have experienced past interpersonal trauma (Berman et al., 2014; Palmer, 2004; Phillips-Beck, 2010; Richmond, 2005; Shah, 2007), such as, physical, sexual, spiritual, emotional and intimate partner abuse (Hegadoren, Lasiuk, Coupland, 2006; Herman, 1992). Researchers have concluded that women with past interpersonal trauma may be at high risk of further interpersonal trauma during the transition to motherhood (Berman et al., 2014; Palmer, 2004; Phillips-Beck, 2010; Richmond, 2005; Shah, 2007).

At the turn of the 20th century in North America, maternal health care began to shift from care provided at home by family and friends who were experienced, or not, in giving birth, to care provided by the formalized healthcare system (Mitchinson, 1986). Women who lacked the support of family and friends during the birthing process were forced to attend public hospitals. Public hospitals provided male-directed obstetrical medical care that left women with little choice about the prenatal, delivery and postnatal care they received (Goer, 2010; Mitchinson, 1986). While some women continued to choose home-based care, the continuing high rates of infant and maternal mortality, along with promises of less pain and fewer deaths, drew many women to choose hospital delivery over home-based care (Goer, 2010; Mitchinson, 1986). While feminist scholarship typically works against homogenous constructions of women and draws attention to how different groups' social status and experiences of gender, health, and sexuality, and power are unique, authors Jordan, Walker and Hartling (2004) and Sen and Ostlin (2007) suggest that the patriarchal values structuring health and social systems have perpetuated the subjugation of women within the social power structure. During the past two-hundred years, the emancipation of women has been increasing, however, women's position within the social power structure when associated with interpersonal trauma, may prevent many

women having their needs met and exercising choice during the transition to motherhood. Women transitioning to motherhood who have experienced past interpersonal trauma hold a precarious and vulnerable position as they access care in the present day healthcare system.

Health Canada characterizes the healthcare system as one that offers "universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay." (Health Canada, 2012, Paragraph 1). Within the healthcare system, frontline care is delivered to patients by healthcare professionals, including doctors, nurses, midwives, and other healthcare professionals and support staff, most often, within hospitals or clinics, although care may also be delivered in women's homes.

Specifically, there is a paucity of research literature about the interactions of women who have experienced interpersonal trauma with the healthcare system as they access maternal health care The data for this secondary analysis was accessed from a primary grounded theory study (Berman et al. 2014) that considered how women who have experienced past interpersonal trauma negotiate the transition to motherhood. The primary study results indicated that women with a history of past interpersonal trauma encountered varying relational experiences with the healthcare system. Therefore, the purpose of this secondary analysis was to critically examine the experiences of women with a history of past interpersonal trauma as they interacted with the healthcare system during the prenatal, delivery, and post-natal period of the transition to motherhood.

Past Trauma

Trauma is conceptualized as violence in the form of non-interpersonal psychological trauma or interpersonal psychological trauma (Hegadoren et al., 2006). Traumatic events are often perceived survivors with horror and terror, and threaten human health, psychological well-being or existence (Briere, 2004; Hegadoren et al., 2006; Herman, 1992). In 2002, the World Health Organization defined violence to be

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or depravation (Krug, Dahlberg, Mercy, Zwi, & Lozano, [Eds], 2002, p. 5).

Non-interpersonal trauma results from “natural disasters", as described by Herman (1992, p. 7) and may include: fires, floods, earthquakes or landslides. Interpersonal trauma

includes: childhood sexual abuse, historical trauma, war trauma, domestic violence, sexual, physical, emotional, and spiritual abuse, or assault (Briere & Scott, 2006; Hegadoren et al., 2006; Herman, 1992). Interpersonal trauma is categorized further into trauma experienced in the family and through intimate partner violence, as well as, community violence (Hegadoren et al., 2006). Hegadoren et al. (2006) suggest that family violence or intimate partner violence occurs most often within the home, and includes physical, sexual, and psychological deprivation and / or neglect. Community violence most often occurs outside of the home but also involves other individuals who may or may not know each other, for example, during war or historical trauma.

In this research, interpersonal trauma will be defined as "experiences involving disruption in . . . relationships as the result of violence, abuse, war or other forms of political oppression, or forced uprooting and dislocation of one's family, community, heritage and /or culture" (Berman et al., 2014, p. 3). The effects of past interpersonal trauma in women's lives positions them at risk of further interpersonal trauma later in life (Arata, 2002; Classen, Palesh, & Aggarwal, 2005; DePrince, 2005; Noll, Horowitz, Bonnanno, Trickett, & Putnam, 2003). Models have been created to help explain the human response to trauma and these include the diagnostic category of Post-Traumatic Stress Disorder (PTSD) and the trauma response model. These models are helpful, but take little consideration of the relational aspects of interpersonal trauma and cultural aspects of women's lives (Berman et al., 2014).

The Transition to Motherhood: Women's historical experience with healthcare

The healthcare of women transitioning to motherhood has dramatically changed over the centuries. Historically, most women performed birth with the support of other women; midwives were known to attend births with only the technical support of a birthing stool on which women would deliver their infants (Ephesians 1:16 New International Version). In early Roman times, women enlisted female family and friends who had successfully delivered their own infants to garner comfort and social support. It was believed that men were better left out of the delivery room (Leavitt, 1983). However, in A.D. 98 the Roman physician, Soranus, documented his observations of childbirth, and thus, created a medical guide and teaching tool for physicians that continued to be followed over the next 15 centuries (Dunn, 1995).

Although the majority of births in North America and the U.K. in the 18th and19th centuries occurred at home and involved women only as caregivers, more privileged women began inviting physicians into their birthing rooms (Leavitt, 1983). These women hoped that physicians, who carried education, gender status, and obstetrical tools to the birthing room, would somehow ease the pain of childbirth and prevent death, which was the most feared outcome of all (Leavitt, 1983).

Over the centuries, stories of maternal and infant mortality were passed by word of mouth. The risks of death and infection that resulted from hospital based maternal care encouraged women to continue trusting their social supports and home remedies instead of giving birth in hospitals unless there was no other choice. During this time, physicians often went straight from performing autopsies to delivering infants (Raju, 1999). The value of cleanliness when providing maternal care was eventually recognized, resulting in physicians washing their hands before attending births. With this new practice in place, maternal and infant mortality rates still did not improve because technical practices in the delivery room often resulted in harm to infants and mothers (Leavitt, 1983).

In her study of nineteenth century medical literature, Mitchinson (1986) found that a significant body of published work from this era focused on obstetric and maternal care. Mitchinson noted that prior to the women's movement of the 20th century; women were understood by most physicians to have an inherent purpose in life dictated by their sex. Differences between men and women were reinforced in the medical literature resulting in women being considered almost "another species", an existence that de Beauvoir described as 'the other' (as cited in Mitchinson, 1986, p. 207). Physicians made it clear, that in their opinion, women were less intelligent than men, however, they were more intuitive and nurturing and carried men's children in their bodies, birthing them in a complex physiological way that often resulted in death. At the beginning of the 20th century in Canada, infant mortality rates were recorded to be as high as 200-333 deaths per 1000 infants delivered, while more recently, maternal deaths have lessened to 6-7 per 1000 deliveries (Statistics Canada, 2009).

Statement of the Problem

Little is known about the experiences of women with a history of past interpersonal trauma as they transition to motherhood, particularly regarding their interactions with the healthcare system. In the past, patriarchal values have subjugated women within the social

power structure, and this, in combination with past experience of interpersonal trauma, situate women with few interpersonal, physical, financial and educational resources to enable them to meet their needs and exercise choice during the transition to motherhood. Thus, women with past interpersonal trauma hold a precarious and vulnerable position as they access the present healthcare system during this transition.

Methodology

Critical Feminist Inquiry

Critical feminist inquiry forms the philosophical base for this study. It is the logical choice because the core concepts of egalitarianism and empowerment (Lather, 1987) can be applied to women with past interpersonal trauma as they transition to motherhood as a disempowered group. Critical feminist inquiry also focuses on gaining increased understanding while maintaining that social justice and change are important moral aspects of the work (Lather & Ellsworth, 1996).

Historically, research has added to the oppression of women by excluding women's perspectives and contributions (Lather & Ellsworth, 1996). However, in the past century critically-informed feminist research pertaining to motherhood and marginalized women's health has begun to evolve (Hankinson- Nelson, 1990; Hubbard, 1990). Within the critical paradigm, reality is understood to be socially and historically constructed through social and political structures, and constantly changing (Berman, Ford-Gilboe, & Campbell, 1998). Developing knowledge for the purpose of social criticism is a basic assumption of critical research (Kincheloe & McLaren, 1994). Social criticism allows for delineation of social power stratifications (Marx, Engles & Smelser, 1973), injustices, and the subjugation that affects women’s lives and influences their understandings of the world (Patton, 2002). The goal of the primary study was to promote change in maternity healthcare practices for women as an oppressed and vulnerable population.

The basic core methodological characteristics which are common to all critical approaches (Berman, et al., 1998) are addressed in this study, including: (a) the care of vulnerable women who are transitioning to motherhood with the influence of past interpersonal trauma in their lives, as they interact with the healthcare system; (b) the findings of this secondary analysis hold the potential to benefit women with past interpersonal trauma by potentially influencing care provided for other women; (c) my assumptions, motivations, biases, and values are made explicit and are examined; (d) I

examined and critiqued the literature in attempt to identify distortions of knowledge; and (e) respect for the expertise of the participants was shown in the interactions of the primary study researchers with participants.

Theoretical Perspective

Relational cultural theory. The feminist construct, Relational Cultural Theory (RCT) (Jordan, 2010; Miller, 1976, 2008; Miller & Stiver, 1993; Walker & Miller, 2004), was created by physician, psychotherapist, and researcher, Jean Baker Miller, and a working group of psychotherapist researchers at the Wellesley Centers for Women in Massachusetts, U.S. RCT, is particularly well suited to guide this study because it is provides a sensitive approach to engagement with marginalized populations, including women who have experienced past trauma. Contrary to traditional theories of psychological development that emphasize separation from relationship, individual competition, hyper-independence and self-sufficient autonomy (Jordan, 1999), "RCT offers a new view of development, proposing that people grow through participation in relational interactions that include mutually empathic, mutually empowering relationships" (Hartling & Sparks, 2002, p. 1). RCT is supported by a body of research revealing that supportive relationships in life enhance and develop resilience (Spencer, 2000; Hartling & Ly, 2000).

Judith Jordan (2010), author and member of the working group, described RCT as a theory of psychological development based on the assumption that "throughout the lifespan, human beings grow through and toward connection . . . it furthermore, calls attention to the need to alter sociopolitical forces of disconnection that create significant pain for people" (p. 1). As reflected in RCT, the effects of “privilege, marginalization, and cultural forces are central to psychological development” (Jordan, 2010, p. 23). Jordan states that the goals of RCT are “to lessen the suffering caused by chronic disconnection and isolation, either at the individual or societal level, and to increase the capacity of clients for relational resilience and to foster social justice” (p. 23). Culture and connection are at the center of this relational theory (Jordan et al., 2004). RCT is therefore, particularly useful with populations who are disadvantaged and marginalized because it addresses the interpersonal experiences of devalued groups (Comstock et al., 2008).

RCT can be applied to the experience of women as they transition to motherhood in the healthcare system and can help to inform and guide healthcare providers in relating to

pregnant, delivering, and postpartum women. The authors of RCT suggest that the personal and relational experiences of the aftereffects of trauma: isolation, shame, humiliation, oppression, marginalization and micro-aggression, are at the core of human suffering (Birrell & Freyd, 2006; Comstock et al., 2008; Hartling, Rosen, Walker, & Jordan, 2000; Miller & Stiver, 1993).

Within the construct of care of individuals who have experienced past trauma, RCT acknowledges that in order to offer power to clients, relational interactions must include mutual empowerment, mutual empathy, mutual impact, fluid expertise and radical respect, must be present (Miller 2008; Miller & Stiver, 1993). Connection is a central concept of RCT and includes mutuality of impact, empathy and empowerment. This mutuality is defined as a manner of relating involving cognitive awareness and emotional recognition (Jordan, 2010). Jordan (2010) continues to explain that mutuality involves "openness to influence, emotional availability, and a constantly changing pattern of responding to and affecting the other's state" (p. 68).

Seven core concepts of RCT are based on the feminist premise that male-female relationships are predicated on inequality and male privilege, while power dynamics are formulated around the dominant groups' needs and wishes. The concepts include:

1. People grow through and toward relationship throughout the lifespan.
2. Movement toward mutuality rather than separation characterizes mature functioning.
3. Relationship differentiation and elaboration characterize growth.
4. Mutual empathy and mutual empowerment are at the core of growth-fostering relationships.
5. Authenticity is necessary for real engagement and full participation in growth-fostering relationships.
6. In growth-fostering relationships, all people contribute and grow or benefit. Development is not a one-way street.
7. One of the goals of development from a relational perspective is the development of increased relational competence and capacities over the life span. (Jordan, 2010, p. 24)

Jordan (2010) argues, "to be disconnected causes pain, and that social pain, is *real* pain"(p. 74). The social pain of being excluded, and even the anticipation of exclusion has been noted to follow the same neural pathways and is registered in the same area of the brain as physical injury and pain (Eisenberger & Lieberman, 2004) which supports RCT's claim that marginalization, rejection, and isolation cause significant pain.

RCT may provide benefit for both the client and the caregiver. From their clinical experience, the builders of RCT describe sensing a metaphorical "living current" of growth enhancing aspects of healthy relating, represented by the "five good things": zest, action, knowledge, sense of worth, and the desire for more connection (West, 2005). Aspects of relational connection, including equality, choice, respect, and empowerment, are values of RCT that are reflected in the values and practice of professional nursing. In the Practice Standards for Nurses related to ethics, the College of Nurses' of Ontario (CNO) has identified the following values as being most important in providing nursing care: "client well-being, client choice, privacy and confidentiality, respect for life, maintaining commitments, truthfulness, and fairness" (2009, p. 4). In the Practice Standards for Nurses related to the therapeutic relationship, the CNO has identified: therapeutic communication, client- centered care, maintaining boundaries, and protecting clients from abuse, as areas of focus that promote healthy ways of relating (CNO, 2006). The values inherent in RCT also link to trauma-informed care, a theoretical approach that emphasizes the importance of relationship, patient choice, equality, respect, empowerment, acknowledgement of, and acceptance of, cultural differences and patient's strengths (Covington, 2008; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

Research Design

A secondary analysis was conducted with data from the primary grounded theory study that considered how three groups of women negotiate the transition to motherhood after interpersonal trauma (Berman et al., 2014). This study has a strong fit with a critical feminist approach as it highlights the experience of vulnerable women who have historically been oppressed within a patriarchically dominated healthcare system as they transition to motherhood (Goer, 2010; Mitchinson, 1986).

In considering the gap in the literature, along with the rich interview data from the primary study and the appropriate fit of a critical feminist approach, the following research questions were developed: (a) What were women’s relational interactions with the

healthcare system as they transitioned to motherhood?, and (b) How does past trauma (childhood, historical and / or pre-immigration / war) influence women's interactions with the healthcare system?

Relevance for Nursing

This study is relevant to nursing because virtually all women who access the healthcare system for maternal care come into contact with nurses, and nurses are the most common healthcare providers with whom the women interact. However, few nurses have received education in the care of women transitioning to motherhood after interpersonal trauma. This study is also relevant to nursing as it seeks to inform nurses of more effective ways to interact with women after trauma as a disadvantaged and oppressed group during the transition to motherhood in the healthcare system. Critically examining women's relational interactions with the healthcare system as they transition to motherhood after trauma will inform best nursing practice, education, and health care policy.

Declaration of Self in Front of the Text

In stating my position related to this research, I acknowledge my ontological and epistemological beliefs (Guba & Lincoln, 1994) as experiences shared with other individuals that affect how I sense and understand the world. I tend to align myself in the critical feminist paradigm and focus on gaining increased understanding while maintaining that social justice and change are important moral aspects of my life and work goals. Therefore, a critical feminist approach was a logical choice for my research as it includes an effort to increase understanding and promotes investigation of social justice issues and change.

Researching from the perspective of a Caucasian female living in Ontario, Canada, I chose to learn more about the healthcare system experiences of women with past trauma who are transitioning to motherhood. It is crucial to understand the experience of traumatized women in order to develop ways to assist women to build the power and capacity to meet their needs and to flourish within societies that readily subjugate them through the maintenance of overt power differentials. A critical feminist approach informed by relational cultural theory placed me, as the researcher, as an advocate for women who historically have been disempowered within the healthcare system. My past experience influenced my interpretation of the data, and because it is impossible to separate self from the research, this allowed for enhanced understanding and development

of new knowledge. Furthermore, to ensure authenticity, I reflexively examined my research ideas and approach while being mindful of the influence of subjectivity.

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CHAPTER 2

Manuscript

Introduction

The transition to motherhood, including, pregnancy, childbirth and the post-partum period, has historically been a time of some degree of physical pain and fear (Goer, 2010; Mitchinson, 1986). However, these stages of transitioning to motherhood are normal physiological processes and highlight significant emotional and social events for women and their families (Dahlen, Barclay, & Homer, 2010). While traumatic labour and delivery experiences are well-described in the literature (Ayers & Ford, 2009; Elmir, Schmied, Wilkes, & Jackson, 2010; Soderquist, Wijma, & Wijma, 2002; Soet, Brack & Dilorio, 2003; Thomson & Downe, 2008), for a woman who has experienced past interpersonal trauma, the prenatal, birth, and postnatal accessing of healthcare may be especially difficult (Palmer, 2004).

Although the effects of past interpersonal trauma are usually not visibly apparent, women who have experienced interpersonal trauma often experience increased levels of autonomic nervous system arousal in general, including higher levels of fear, avoidance, emotional numbing, emotion dysregulation, and dissociative coping mechanisms (Palmer, 2004). Kendall-Tackett (2005) notes that these women are at risk of developing post-traumatic stress disorders, peritraumatic responses including guilt and shame, and difficulty developing trust in relationships. Van der Kolk (2010) informs us that repeated trauma exposure in individuals is an additional risk. The compound effects of past trauma and the physical and psychological vulnerability associated with pregnancy place women at increased risk of additional trauma and negative experiences with the healthcare system during their transition to motherhood.

Statement of Purpose

The purpose of this study is to conduct a secondary analysis to critically examine the experience of women who have experienced childhood sexual abuse (sexual trauma), aboriginal women (historical trauma), and women who are refugees (premigration / war trauma) as they access the healthcare system during the transition to motherhood.

Literature Review

The purpose of this selective literature review is to critically analyze women’s' experiences in the healthcare system while transitioning to motherhood. In this review, I focus on

building increased understanding of the poorly understood topic of the relational interactions of women with past trauma that are accessing maternal care.

The primary grounded theory, upon which this study is based, was conducted to explore the influence of past interpersonal trauma on women during the transition to motherhood. Consistent with the primary study, three groups of women are considered: (a) women who were sexually abused in childhood (CSA); (b) Aboriginal women, for whom historical trauma affects their lived experience; and (c) women who have experienced premigration trauma, either prior to, or during, the immigration process. Women's experiences with maternal health care throughout history are also considered to gain insight into how gender roles and socialization of both women and healthcare providers affect women's transition to motherhood.

Electronic databases searched to identify conceptual and empirical studies for this literature review include: CINAHL, ERIC, Medline, ProQuest, PsycInfo, and SCOPUS. Combinations of key terms used to access the literature, included: "childbirth", "pregnancy", "interpersonal trauma", "abuse", "childhood sexual abuse", "Aboriginal", "refugee", "post-partum", "mothering" and, "healthcare". The types of research articles found in the literature that focus on women who have a history of trauma and their healthcare experiences during the transition to motherhood include: qualitative studies, quantitative studies, clinical practice findings, literature reviews, and theoretical articles. The majority of studies in this review were published within the past five years, however, the inclusion of some historically focused literature allows for understanding of the socialization and oppression of women.

Review of Current Knowledge

More specific knowledge is needed regarding past interpersonal trauma in the forms of sexual abuse, historical trauma, and premigration trauma as it affects women who are transitioning to motherhood. Moreover, little is known regarding women's' experiences with the healthcare system as they access maternal care. There is some evidence, however, that women who have experienced past interpersonal trauma perceive healthcare services and professionals as threatening or intrusive (DOliveira, Diniz, Schraiber, 2002; Elmir et al., 2010; Goer, 2010; Yee & Simon, 2011). Moreover, encounters with the healthcare system may trigger past traumatic memories and lead to avoidance of health care services, resulting in increased risk of physical and mental health difficulties (Bacchus, Mezey, &

Bewley, 2004; Schore & Schore, 2008). There is a considerable body of knowledge that shows traumatic labour and delivery experiences negatively impact the mother-child bond (Palmer, 2004; Soet et al., 2003).

One qualitative study (Aston, Saulnier, & Robb, 2010) considered women's relational experiences with healthcare providers while giving birth and two years postpartum. Of the 11 women interviewed, most described the importance of the healthcare provider-client relationship, and most stated that nurses were more supportive and empowering to them than were their physicians. The women emphasized the importance of relational connection with healthcare providers, continuity of care, respect for and support of the women's autonomy, and of healthcare providers' time spent with them. The quality of their relationships with healthcare providers was noted to be important to women, while the least satisfying, unresponsive care was described as occurring within disrespectful, rushed, and disempowering relationships where little choice or control was offered.

Encounters with the healthcare system among women who have experienced child sexual abuse (CSA). Much discussion exists about the definition of CSA (Felliti & Anda, 2010; Finklehor, Hotaling, Lewis, & Smith, 1990; Haugaard, 2000). Horan, Hill, and Schulkin (2000, p. 28) suggest that CSA is "any activity that engages a child in sexual activities that are developmentally inappropriate, with or without threatened or actual violence or injury". Horan et al. also note that CSA may not include sexual intercourse or physical force, but often involves coercion and deception. An adolescent health survey conducted in British Columbia revealed that 16% of teenage girls reported past CSA (Public Health Agency of Canada, 2008), however, a paucity of research exists related to CSA and its effects on women during the transition to motherhood.

In Ontario, Canada, Barker-Collo (1999) conducted a survey to examine the differences between 60 Aboriginal and 78 Caucasian women in reported symptomology after CSA. There were no significant differences between the two groups with 30% of participants reporting more than 50 separate incidents of CSA beginning at a mean age of 9.2 years. In Norway, Lukasse, Schei, Vangen, and Olan, (2009) completed a survey of 2,635 pregnant women and found that women who had experienced childhood abuse, including physical, emotional or CSA, reported intense fear of childbirth significantly more than other women. In a grounded theory study, Palmer (2004) found that women

with a past history of CSA can be retraumatized if healthcare professionals do not support women's strategies to achieve internal balance during childbirth.

In their qualitative study of 18 postpartum women in Australia, Coles and Jones (2009) explored women CSA survivors' response to perinatal touch and examination of themselves and their babies. Two themes were identified from the interview data: safety issues for survivors and their babies in the clinical encounter, and, ways of making service provision safer. The women identified that they experienced pain, dissociation, fear, blame, helplessness, and guilt during encounters with health care providers. Recommendations from this inquiry include the use of "universal precautions" in order to respect and protect women who have experienced CSA and who may not have identified their abuse to their caregivers. The recommendations for universal precautions include: (a) never assume consent; (b) explain any professional touch, including examination or procedures, what is to be done and how, and why it is necessary; (c) explain baby examinations as carefully as an adult examination; (d) no procedure or examination should be routine, since professionals may be unaware of women's past CSA; (e) obtain informed consent for maternal and baby touch, including examinations and procedures; and (f) stop or slow examinations at the woman's request or in response to distress and check in with the woman during examinations and ask "Are you comfortable with this?" or "Is this OK with you?" (p. 235).

Canadian researchers, Schachter, Stalker, Teram, Lasiuk, and Danilkewich (2009), conducted two multidisciplinary, multi-site grounded theory studies with the intent of facilitating a process in which CSA survivors and healthcare providers could develop and influence ways in which improved healthcare services could be provided to survivors of CSA. An outcome of this work, the *Handbook on Sensitive Practices for Health* Care *Practitioners,* delineates principles of sensitive practice. The principles include: "respect, rapport, taking time, sharing information, sharing control, respecting boundaries, mutual learning, understanding non-linear healing, and demonstrating an understanding of CSA" (p. 18).

Encounters with the healthcare system among Aboriginal women transitioning to motherhood. Aboriginal women have experienced multiple cumulative forms of trauma throughout history including, colonization, relegation into the residential school system, warfare, conquest, slavery, cultural assimilation, and racism (Aboriginal Healing

Foundation, 1999). Aboriginal communities have suffered under these traumas resulting in eradication of culture and severely disrupted communities (Aboriginal Healing Foundation, 1999; Assembly of First Nations, 2012). Palacios and Portillo (2009) suggest that both historical trauma theory and weathering theory apply to Aboriginal women's health.

Historical trauma theory was developed from concepts related to psychology, psychiatry and from research conducted after the Jewish Holocaust (Palacios & Portillo, 2009). Historical trauma theory assumes that survivors of traumatic events transmit their response onto others and that the trauma affects the survivors well-being, results in unresolved grief, and the psychological pain is passed on to future generations. Aboriginal trauma began in 1492 in North America and continues to affect Aboriginals in the present time (Palacios & Portillo, 2009).

While historical trauma theory emphasizes the transmission of pain and social problems onto future generations, weathering theory, described by Geronimous (2000), emphasizes that health disparities of racial groups are the physical manifestations of social inequalities between the groups. Weathering theory focuses on the effects of cumulative stress, health outcomes, and on the effects of cumulative trauma on the timing of reproduction. Palacios and Portillo (2009) argue that weathering exerts a progressively negative effect on women’s health over time and may accelerate poor health in Aboriginal women due to the stresses of poor living conditions, discrimination, racism, and malnutrition. The authors suggest that both historical trauma theory and weathering theory can be applied to Aboriginal women to provide a clearer understanding of the effects of historical events and Aboriginal women's health outcomes related to childbearing.

The Nechi Institute in Canada and the Ontario Federation of Indian Friendship Centres (OFIFC) in partnership with the Metis Nation of Ontario and the Ontario Native Women's Association reported that 80% of Aboriginal women had experienced childhood sexual abuse (CSA) (The Nechi Institute, 1988). A survey by Barker-Collo (1999) reported that Aboriginal women who had experienced CSA were at greater risk of somatic complaints, sleeps disorders, sexual difficulties, and uncontrollable crying, and were less likely to disclose their abuse than the Caucasian population who had experienced CSA. Kornelsen, Kotaska, Waterfall, Willie and Wilson (2010) revealed the cultural importance of Aboriginal women giving birth within their community and suggested that a community

birth ensures ongoing social inclusion of the child, provides social support to the woman, and honours cultural values related to the social importance of geography in relation to the birthplace. In their quantitative case control study of preterm birth between Aboriginal and non-Aboriginal women in Manitoba, Heaman, Blanchard, Gupton, Moffat, and Currie (2005) noted that Aboriginal women encountered greater stress and barriers to care compared to non-Aboriginal women.

In her grounded theory dissertation of a sample of 9 Aboriginal women who experienced postpartum depression in Saskatchewan, Clarke (2008) discovered that high rates of post-partum depression occurred within the context of three socio-cultural constructs: cultural disconnectedness, socio-demographic barriers, and a history of childhood physical and sexual abuse. Clarke (2008) also noted that poverty, isolation, limited economic opportunities, and diminishing funding for local maternity services also force many native women to leave their communities to give birth in city hospitals.

Losing the option for medical care within Aboriginal communities, and thus having to travel to hospital, often without family supports, has resulted in negative implications related to women's and infants' long-term mental and physical health (Brown, Varcoe, & Calam, 2011; Kornelsen et al., 2010). In her thesis, employing a multi-method institutional ethnography, Phillips-Beck (2010) created a framework to support improved childbirth care for First Nations women in Manitoba. Findings from this study suggest that birth is an important cultural construct and includes the need for the birthing of infants to return back to the First Nations community, to reduce ongoing individual and community suffering.

Encounters with the healthcare system among women transitioning to motherhood who have experienced premigration trauma. Canada admits approximately 250,000 immigrants every year and resettles approximately 11,000 refugees (Statistics Canada, 2011). Refugees are likely to experience premigration trauma that arises from multiple losses and traumatic experiences occurring prior to, or during, the process of immigration. These traumas can include rape, sexual violence, war, sexual slavery, harassment, and abduction (Amnesty International, 2004a; Oxman-Martinez, Abdool, & Loiselle-Leonard, 2000).

Of the refugees entering Canada each year, approximately 40% are women in the childbearing years of 15-45 (Statistics Canada, 2011). Although little research exists related to the healthcare experiences of women refugees who are transitioning to

motherhood, a qualitative study by McKeary and Newbold (2010) has considered the impact of systemic barriers and the specific needs of refugees in Ontario. Refugees tend to have greater health needs than other immigrants to Canada because of their premigration experiences and the stressful resettlement process (McKeary & Newbold).

Refugees experience difficulty accessing healthcare services for reasons such as language barriers, being unfamiliar with how to navigate the Canadian healthcare system, and being uncomfortable with different methods (Lawrence & Kearns, 2005) and values (Vissandjee, Weinfeld, Dupere, & Abdool, 2011) within healthcare. McKeary and Newbold (2010) suggest that healthcare providers must take extra time to get to know the story or history of the refugees they serve in order to understand their healthcare needs. Developing trust in the nurse, as an aspect of the therapeutic relationship, may be particularly challenging because it requires time, consistency, and ability to overcome language barriers. It may be influenced in refugee women by a belief that their current residence is tenuous, and may be further challenged in situations where patriarchal power is exerted and little choice is offered to the client (Hynes, 2003).

McKeary and Newbold (2010) note that refugees are more likely than other immigrants to be illiterate or have limited ability to communicate their symptoms to healthcare providers. The authors explain that this is complicated by an institutionalized form of power-over discrimination against refugees committed by healthcare providers who sometimes accept clients only if they can speak and understand English. Along with social and cultural differences and legal frameworks that focus on citizenship status, economic barriers to healthcare also influence refugee health in Canada. They may have gained safety, but are often dealing with unemployment and loss of social and job status. They usually depend on governmental financial support while adjusting to a new country and its social norms and values (McKeary & Newbold, 2010). McKeary and Newbold also found that access to healthcare facilities is frequently complicated by social isolation and challenges to transportation. Many refugees depend on public transportation and lack their own vehicles. They may need to rely on friends or neighbours and experience difficulties in travelling to scheduled appointments.

In his retrospective quantitative study considering the adverse birth outcomes among foreign-born women in Canada, Shah (2007) assessed a cohort of women living in Toronto that included 1435 Canadian-born women, and 3672 foreign-born women, of

whom 241 women were refugees. The study results indicated that refugee women had a higher risk of delivering lower birth weight infants (mean weight 3284.8 grams) than Canadian women (mean weight 3424.1 grams): 5.0% of refugees compared to 3.7% of Canadian-born women delivered infants <2500 grams, and 25.8% of refugees compared to 14.9% of Canadian-born women delivered infants weighing 2501-2999 grams. Refugee women (7.5%) delivered earlier at 32-36 weeks, compared to Canadian-born women (5.4%). The high rates of cesarean section births for refugee women (primiparous 45.0% and multiparous 54.9%) although similar to Canadian born women (primiparous 43.3% and multiparous 56.7%) demonstrates that refugee women seeking maternal care have higher health-related risks than Canadian-born women.

The treatment of women transitioning to motherhood in the global healthcare system. A growing body of literature exists regarding the mistreatment of women transitioning to motherhood within the healthcare system globally. From this body of literature, we can conclude that women refugees entering Canada who have received obstetrical care in developing countries may have encountered obstetrical mistreatment and trauma. Brazilian authors, DOliveira et al. (2002) reviewed health care literature from 1991-2001 and note that an increased understanding of violence against women in healthcare institutions in developing countries reflects dynamics that are broadly present in society. These authors suggest that in Brazil, Peru and South Africa, physical violence toward patients by healthcare providers is common and can include deliberate refusal to give anesthetics or analgesics when clinically appropriate. The authors note that in Brazil, complaints of obstetrical neglect are often heard and even though care is sometimes provided, women are not given the information, support or compassion needed for them to feel properly cared for.

In a 1958 article published by the *Ladies Home Journal*, Shultz brought the issue of abuse by healthcare providers in North American maternity wards into public discussion. Fifty-one years later, the *Journal of Perinatal Education* printed a guest editorial (Hodges, 2009) in which the author indicates that many women transitioning to motherhood continue to be treated inhumanely in hospital maternity ward settings.

The U.S. Agency of International Development *Translating Research into Action Project* (Bowser & Hill, 2010) provided a review of evidence found in the published and gray literature related to: definition, scope, contributors to, and the impact of disrespect

and maltreatment in childbirth. The review considers both promising new approaches and gaps in the literature. These authors found that a "lack of respectful and non-abusive care at birth may encompass many points along a continuum that spans dignified, patient centered care, non-dignified care, and overtly abusive maternal care" (p. 3). The report identified that disrespect and abuse may be multi-factorial, perceived differently and sometimes normalized depending on the setting. However, they also noted that many health experts report that disrespect and abuse in facility-based childbirth represents an important cause of suffering for women, is an important barrier to care and quality of care, and is often a violation of women's human rights. Data in the Bowser and Hill report was drawn from both qualitative and quantitative studies and includes growing evidence of the negative impact of disrespect and abuse in healthcare facilities across a range of countries worldwide. The report supports the findings of others who have concluded that disrespect and abuse during maternal care is a more serious threat to accessing skilled care than geographical location or financial obstacles (Amnesty International, 2009; Centre for Reproductive Rights & Federation of Women Lawyers-Kenya, 2007; DOliveira et al., 2002; Jewkes, Abrahams, & Mvo, 1998; Khayat & Campbell, 2000).

Bowser and Hill (2010) revealed the need for additional study surrounding a prevalence estimate of abuse and disrespect in facility-based childbirth. The authors suggest an urgent need for advocacy, active programming and implementation research, and evaluation of interventions to accelerate the evidence base for effective policy changes and interventions to reduce abuse and disrespect in maternal care.

Physicians' sexual abuse of patients. In Canada, the College of Physicians and Surgeons of Ontario (CPSO) recognized a need to assess physician sexual abuse of patients after the criminal justice system over-ruled decisions made by the college's disciplinary committee in four cases, in favour of physicians (Gray, 1991). The CPSO commissioned a Task Force on Sexual Abuse of Patients that held numerous hearings in 1991 throughout Ontario (Gray, 1991). The non-physician chaired Task Force identified more instances of sexual abuse of patients than anticipated, with over 400 phone calls received within the first 10 weeks from members of the public who registered complaints, concerns or suggestions (Gray, 1991). The public hearings included testimonies of sexual molestation and rape by physicians toward both male and female patients, including rapes of women that took place soon after childbirth (Gray, 1991). The attention attracted by the Task

Force's final report submitted to the CPSO and to the public in December 1991, resulted in the Ontario government passing Bill 100 to amend the Regulated Health Professions Act (Cohen, Woodward, Ferrier, & Williams, 1995). The amended act includes clear rules for disciplining healthcare providers found guilty of sexual abuse of a patient and defines the sexual abuse of a patient by a regulated healthcare provider, as:

1. Sexual intercourse or other forms of physical sexual relations between the member and the patient.
2. Touching, of a sexual nature, of the patient by the member.
3. Behaviours or remarks of a sexual nature by the member towards the patient. (Legislative Assembly of Ontario, 1993).

A Task Force physician committee member, Harvey Armstrong, noted that the Task Force inquiry took place in a time when physicians in Canada were not informed during their medical training about sexual abuse and its aftereffects (Armstrong, 1995). After the Task Force report was made public, a survey was conducted of the members of the Society of Obstetricians and Gynecologists of Canada. The survey focused on sexual contact between physicians and patients according to the definition in the Regulated Health Professions Act (1991) and labeled by the CPSO as: sexual violation, sexual transgression and sexual impropriety (Lamont & Woodward, 1994). Of the 618 physician responses, “3% of male and 1% of female physicians reported sexual involvement with a patient, and 37% of female and 19% of male obstetrician-gynecologists reported being aware of a colleague's sexual involvement with a patient that would meet one of the three categories labeled by the CPSO” (Lamont & Woodward, 1994, p. 1433). Twenty-four percent of physicians surveyed believed that loss of license should be permanent for proven sexual transgressions by physicians.

A zero tolerance policy against sexual abuse is now in place for health professionals in Ontario and has become a standard approach for others in positions in authority, however, the chair of the Task Force, lawyer Marilou McPhedran, notes that zero tolerance of physician sexual abuse is not being achieved (Koksal, Singh & Nixon, 2012). Since 2007, 125 doctors have been disciplined by the CPSO. One in four of these cases involved physician sexual comments or acts against patients and 22 cases remain under investigation, suggesting that sexual abuse of patients by physicians in Ontario continues to be a significant problem (Koksal et al., 2012).

In Canada, a Maternity Experiences Survey was completed with the sample drawn from the 2006 Canadian Census of Population (Public Health Agency of Canada, 2009). A total of 6,421 women (with the exception of First Nations women living on reserves and institutionalized women) who were 5-14 months postpartum, were interviewed by telephone and asked over 300 questions related to their pregnancy, labour and delivery, and postpartum period. Up to 5% of respondents reported to be dissatisfied or very dissatisfied with aspects of interactions with healthcare providers (Public Health Agency of Canada, 2009, p.165). When questioned about the compassion and understanding shown to them, which are similar to the concepts of relational connection and empathy that are considered in the current study, only 65% of women reported to be very satisfied and 20-25% of women reported to be somewhat satisfied. These findings confirm the need to further explore the interactions with healthcare providers among women with past trauma accessing maternal health care.

Trauma-informed healthcare. The current body of literature contains very few studies related to trauma-informed maternity care. This paucity of literature suggests that healthcare professionals may not be trauma-informed and may be relating to women in ways that unintentionally exacerbate trauma symptoms or retraumatization. Seng, Low, Sperlich, Lonis and Liberzon (2009) reported that of the 1581 nulliparous women receiving maternity care that they interviewed in Michigan, 7.9% met criteria for current PTSD, while 20.2% had experienced PTSD in the past. Women in the study with PTSD were most at risk for adverse perinatal behaviours, and depression appeared to be associated with underlying PTSD. These authors suggest that, "trauma-informed interventions may be more effective than separately applied substance use, primary depression or domestic violence interventions applied without consideration of the underlying cause" (Seng et al., 2009, p. 846).

Elliott, Bjelajac, Fallot, Markoff and Reed (2005) built on the early work of Harris and Fallot (2001) related to trauma-informed care of women with past trauma and substance use. Elliott et al. (2005) have identified 10 principles of trauma-informed care that create a bridge between service delivery and trauma theory, empowerment of women and relational theory. These principles may be applied to the healthcare of all women as trauma-informed services:

- recognize the impact of violence and victimization on development and coping strategies
- identify recovery from trauma as a primary goal
- employ an empowerment model
- strive to maximize a woman's choices and control over her recovery
- are based in relational collaboration
- create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance
- emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology
- aim to minimize the possibilities of retraumatization
- strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background
- solicit consumer input and involve consumers in designing and evaluating services (Elliott et al., 2005, pp. 465-469).

The authors suggest that although it has traditionally been difficult to integrate a trauma-informed approach into medical service delivery, healthcare providers can increase women's sense of safety and control over what is happening to them by explaining what is going to be done before a procedure and by continuing to explain each step of a procedure as it occurs. Having a support person present during procedures can help to reduce fear and anxiety. The authors also emphasize the importance of monitoring the procedure for triggering traumatic reactions and ensuring the woman has time to ground herself in the safety of the present.

These principles relate to the roles and responsibilities of registered nurses and maternal care. They include: informing patients of the best practices related to breast feeding (Registered Nurses' Association of Ontario, 2003), being knowledgeable of current practices in maternal and newborn care (Evans, Evans, Brown, & Orshan, 2009), client centered care (Registered Nurses' Association of Ontario, 2006a) and family centered care (Health Canada, 2000). Building a strong therapeutic relationship by incorporating the qualities of active listening, trust, respect, genuineness, empathy, and responding to client concerns, is central to all nursing practice (Registered Nurses' Association of Ontario,

2006b).

Summary of the Literature

While studies of traumatic births dominate the literature (Ayers & Ford, 2009; Elmir et al., 2010; Soderquist, Wijma, & Wijma, 2002; Soet et al., 2003; Thomson & Downe, 2008), more refined studies focused on women's experiences of trauma-informed care during the transition to motherhood are needed (Clifton, Cadzow, & Rowe, 2009). In addition, little is known about the experiences of women who have experienced past interpersonal trauma (including CSA, historical and pre-immigration / war trauma) as they transition to motherhood, particularly regarding their interactions with the healthcare system. The studies of Aboriginal women transitioning to motherhood noted the increased need for care in the Aboriginal communities to preserve culture and inclusion (Barker-Collo, 2009; Brown et al., 2011; Clarke, 2008; Heaman et al., 2005; Kornelsen et al., 2010). The studies related to refugees indicate need for increased understanding by healthcare providers of the unique cultural beliefs and needs of each refugee group (Lawrence & Kearns, 2005; McKeary & Newbold, 2010; Shah, 2007; Vissandjee et al., 2011).

A gap exists in the literature related to the healthcare system experiences of these three groups of women; child sexual abuse survivors, aboriginal women and refugees as they transitioned to motherhood. Further exploration is needed in order to understand their unique needs during their birthing experiences in the healthcare system.

Statement of Research Questions

The research questions that guided this study were: (a) what were women's relational interactions with the healthcare system as they transitioned to motherhood? and (b) how does past trauma (childhood, historical and / or pre-immigration / war) influence women's interactions with the healthcare system?

Methodology

This secondary analysis was conducted using data from a primary grounded theory study that considered embodied trauma as it relates to women who are transitioning to motherhood (Berman et al., 2014). The purpose of the primary feminist grounded theory study was to examine how past trauma shaped the lives of women as they became new mothers. The substantive grounded theory, "laboring to mother in the context of past trauma," described the exceedingly difficult emotional and cognitive work undertaken by

pregnant women with histories of trauma as they anticipated becoming mothers. Berman et al. (2014) recommended that instead of providing care focused exclusively on medical diagnoses, pathology, weaknesses, and deficiencies, emphasis on empowerment and strengths based approaches are appropriate and warranted; likely to yield much more meaningful interactions between caregivers and their pregnant clients. The primary study included rich unused data that provided the opportunity for a secondary analysis. A critical feminist methodology informed by relational-cultural theory was used to guide this secondary study.

Philosophical Perspective

Critical feminist philosophy. Critical feminist philosophy was a logical methodological approach for this study because of its core concepts of egalitarianism and empowerment, social justice, and change (Lather & Ellsworth, 1996) that can be applied to women with past trauma as they transition to motherhood as a disempowered group. Critical feminism asserts that knowledge is not produced from objectivity and that researchers cannot remain neutral or separate from the production of knowledge or from the world, thus, the subjective influence of the researchers' decisions and bias related to the research augment its usefulness (Lather, 1986).

Theoretical Perspective

Relational-cultural theory. Relational-cultural theory (RCT) is the theoretical perspective that informed this study. As a feminist theory, RCT recognizes that power-over in relationship results in lack of choice and disempowerment for those who are vulnerable and less powerful. As a trauma-informed modality, RCT reflects the need for "connection" in relationship, explained as a growth-fostering phenomenon (Jordan, 2010, p. 25). RCT includes the notion of "mutuality" in impact, empathy and empowerment that is defined as a manner of relating to others that involves cognitive awareness and emotional recognition (p.24). RCT also emphasizes "fluid expertise" in which all people within a relationship participate and contribute valuable wisdom that supports growth and respect (p.103). The seven core concepts of RCT are based on the feminist premise that power dynamics are formulated around the dominant groups' needs and wishes, and that male–female relationships are predicated on inequality and male privilege (Jordan, 2010, p. 24). The seven concepts include:

1. People grow through and toward relationship throughout the lifespan.
2. Movement toward mutuality rather than separation characterizes mature functioning.
3. Relationship differentiation and elaboration characterize growth.
4. Mutual empathy and mutual empowerment are at the core of growth-fostering relationships.
5. Authenticity is necessary for real engagement and full participation in growth-fostering relationships.
6. In growth-fostering relationships, all people contribute and grow or benefit. Development is not a one-way street.
7. One of the goals of development from a relational perspective is the development of increased relational competence and capacities over the life span. (Jordan, 2010, p. 24)

West (2005) notes that 5 outcomes can be gained through employing RCT's core concepts. The 5 outcomes reflect positive and healthy interaction, including: zest, action, knowledge, sense of worth, and the desire to continue connection.

Method

Study design. The secondary analysis was conducted with data collected from a primary grounded theory study (Berman et al., 2014). This type of secondary analysis is described as "analytic expansion" involving a secondary interpretation of data to answer new or extended questions (Thorne, 1998, p. 548). Hinds, Vogel and Clarke-Steffan (1997, p. 409) describe the potential of secondary analysis to include “descriptively rich, yet underused, qualitative data that could become an important source of information for more than one study or one purpose.” Thorne (1998) agrees that the value of secondary analysis of qualitative studies allows for generation of new knowledge, new hypotheses, or support for existing theories. In this secondary analysis, the development of new knowledge related to the experience of women with past trauma has been created without adding stress to the participants by repeating interviews (Thorne, 1998) or recruiting new participants (Heaton, 2004).

With the need to create both emancipatory knowledge and the empowerment of the participants in this praxis-oriented paradigm, I acknowledge that in the secondary analysis I did not have direct contact with the participants that would allow me to interact with and

support them in creating change in their social situation. The question of whether or not a secondary analysis from a feminist perspective would or could "empower the researched" posed a potential deterrent to conducting the study.

However, in reading the work of feminist scholar, De Beauvoir (1976), who suggests that the core concepts of egalitarianism and empowerment must be applied to the disempowered group under study, I realize that these fundamental feminist research concepts could, in fact, be employed to create change through my analysis of existing data and confirmation of conclusions with the primary study interviewers and team. The results of my analyses may contribute to change on behalf of the study population at the policy level, in conjunction with improved nursing and healthcare practices.

This study has a strong fit with a critical feminist approach as it highlights the experience of women who have historically been oppressed and it aligns well with the primary study goal of examining how women who have experienced differing forms of trauma negotiate the transition to motherhood. This study data is also well informed by the 10 interview questions asked in the primary study.

Sample. In the primary study, 33 primiparous women from two Canadian cities, age18 or older, who self-identified as having experienced past trauma and belonging to one of the three groups were interviewed by trained members of the research team during the women's second trimester of pregnancy. In the primary grounded theory study, purposive sampling was used to recruit women participants from London and Toronto, Ontario. The sample consisted of 20 women in the child sexual abuse survivor group, 10 refugee women and 3 Aboriginal women. Within the three groups, there was considerable overlap in the women's past experience of trauma. For example, some Aboriginal and some refugee women also experienced CSA. Advertisements were placed in local newspapers, flyers were placed in public settings, and letters describing the study were sent to local health care professionals who provided services to childbearing women. The vast majority of women, however, responded to an ad posted on-line. The rationale for conducting interviews during the second trimester of pregnancy was the expectation that it is usually a stable time in pregnancy and if the woman became distressed as a result of participation, time would allow for counseling or other support. Each woman was provided with a letter of information (Appendix A) and consent to participate in the study was obtained (Appendix B). Culturally appropriate interpretation and translation procedures were

employed. Women who were currently engaged in psychotherapy were excluded.

The secondary analysis included 29 participants. Four participants were excluded due to insufficient data related to their experience with the healthcare system. The secondary study included 16 women with past CSA, 10 refugee women, and 3 Aboriginal women. Of the 16 women with past CSA, 3 were married, 1 woman was between 18-20 years of age, 7 were 21-25 years, and the remaining 8 women with past CSA were over 25 years of age. Of the 10 refugee women, 6 were married, 2 were between ages 21-25, and the remaining 8 refugee women were over 25 years of age. Of the 3 Aboriginal women, none were married, 2 were between 18-20 years of age, and one was over 25 years of age.

Data collection. Data were collected in the primary study by interviewing participants during the second trimester of pregnancy and again at four to six-months post-partum. The four to six-months post-partum period has been described by Goodman (2004) as a significant time in the transition to motherhood. Members of the primary research team conducted the interviews and the same interviewer assigned to conduct the first interview with a woman, conducted the second interview. Team members were trained to interview vulnerable women prior to conducting any interviews. Transcripts requiring translation into English were translated prior to using back translation. Women were offered choice of time and location for interviews. Data were collected until data saturation was reached, and women were provided with a $25 honorarium at each interview. Interviews lasted approximately two hours and were audio-taped followed by verbatim transcription. Data related to the topic of the women's healthcare experience were extracted using the qualitative data analysis software, NVivo, by the primary research team and was provided for the secondary analysis in the form of complete digital transcripts of all interviews conducted.

Consistent with the grounded theory method (Charmaz, 2005), the women were given the opportunity to reflect on and comment on emerging findings during the second interview. The research questions used in the primary study during the initial interview with each woman focused on the woman's healthcare experience during her pregnancy to date, her past experience of trauma, strategies used to get needs met, her social supports, and her strengths, thoughts, dreams and expectation related to the pregnancy (Appendix C). Along with questions asked in the first interview, additional questions in the second interview (Appendix D) explored the woman's perception of whether or not she received

the healthcare she needed at each stage of her pregnancy, along with her thoughts on feeling understood and listened to by healthcare providers, whether or not she felt in control of what was happening, and if her healthcare experience was different than she expected it would be.

Of the 16 women with past CSA included in the secondary analysis, 6 women completed interviews before and after their infants' births, 9 women completed interviews prior to the births and 1 woman completed an interview after the birth of her child. Of the 10 refugee women in the secondary study, 5 women completed interviews before and after their infants' births, 3 women completed interviews prior to the birth, and 2 women completed interviews after their infants had been born. Only one interview was completed with each of the 3 Aboriginal women who could not be contacted to arrange for a second interview. As well, only 3 Aboriginal women were included in the study as other primiparous Aboriginal women were under age 18, and therefore, did not meet participant inclusion criteria.

Data Analysis

The secondary analysis was guided by concepts from a critical feminist perspective including gender, race, and class that connect personal, social and institutional aspects of care (Aston, 2008). All of the participants` names were changed to pseudonyms for the purpose of anonymity. Data analysis first involved reading through the entire 33 interview transcripts and excluding transcripts that included little discussion of the woman's healthcare experience. A total of 29 transcripts were included in the secondary analysis. I categorized words and phrases and compared these words and phrases to the data extracted by the primary study team, and then focused on data within each transcript that reflected the women's past trauma experiences to enable me to answer the research question: How does past trauma (childhood, historical and / or pre-immigration / war) influence women's interactions with the healthcare system? I then focused on the women's interactions with healthcare providers to enable me to answer the research question: What were women's relational interactions with the healthcare system as they transitioned to motherhood? After identifying themes in the women's experiences to aid in the development of my interpretations of the findings, I compared the themes to concepts from critical feminist philosophy (gender, race, and class), and to the seven core concepts and five outcomes of RCT.

Findings

Guided by the research questions, four themes emerged from the interview data: *Birthing a healthy baby: the common relational thread; Receiving physical care over the emotional needs of the mothers; Moving beyond sharing information to meaningful relational interactions; and, Women's past trauma: little choice over their needs then and now.*

Birthing a healthy baby: the common relational thread. In this study, participant's experiences of past trauma often overlapped. For example, some women experienced both past CSA and were refugees. Some Aboriginal women also experienced past CSA. Therefore, the findings include all 3 groups together rather than a comparison by population. All the women regardless of group (child sexual abuse survivor group, refugee women and Aboriginal women) and their healthcare providers included in this secondary analysis shared the common goal of birthing a healthy baby. Healthcare providers assisted the women by providing physical care that was deemed necessary for the birth of a healthy infant. Women described the prenatal and delivery time as stressful and filled with worry and concern over the healthy development of their babies. Rosie a 36 year-old refugee from Brazil was living in Canada without the support of extended family. She described concern over her baby's health and her thoughts immediately after delivery of her son.

> It was a long delivery. . . . The nurse who took care of me; she was amazing. So much patience. . . . she didn't give up. First thing was . . . is he healthy? . . . and especially because it was a long push. . . . So all this stuff in mind. But then, after was just like ok, so now everything is fine. He's healthy.

Joanna, a 27 year-old refugee underwent fertility treatment and closely followed her prenatal medical care plan that included treatment of gestational diabetes. Joanna was willing to undergo any physical changes to her body for the sake of her baby.

> I'll take anything that happens . . . for my baby. . . . I got pregnant with fertility medication . . . And the nurse called me and said my numbers and said "You're pregnant" . . . I was so happy. . . . I'm seeing three doctors now. Plus the gestational diabetes Dr. xxx, plus the nurse. I have to do the glucose test . . . four times a day. And if I'm a little bit over, I have to call for her and she will call me right back . . . she will take my updates and tell me what to do.

In the above excerpts, both participants expressed that the healthcare provider was working with them towards birthing a healthy baby. In the first excerpt, Rosie described her nurse as "amazing" and Joanna, in the second excerpt, explained that her nurse phoned her with updates on how she was doing during her pregnancy.

Most of the women in this study described coping with significant stressors prior to the birth of their child that originated from: attempting to ensure they received adequate prenatal care, financial and intimate partner relational stressors, and living far from family members and friends who could provide social support and comfort. Women also discussed their hopes and plans for being a mother to their child. Rikkie, an adopted 20 year-old homeless Aboriginal participant, explained the importance for her of the health of her child.

> Carrying the child inside of me . . . if it was just me I wouldn't care as much . . . I have a family doctor . . . so, my healthcare is pretty stable, and pretty good . . . I eat properly. I've taken maternity and iron pills. And vitamins. So hopefully the baby will be pretty healthy . . . I want to be the best single mom ever.

Rikkie and her healthcare provider held a mutual goal of birthing a healthy baby. She followed her family physician's advice despite living homeless and having questions about her pregnancy and prenatal care that she hadn't yet asked. She explained that she has been focusing on her nutrition and augmenting her diet with vitamins and minerals to aid in birthing a healthy baby.

Women in this study made decisions about their healthcare that were based on the information they had gathered from their healthcare providers, the internet, watching birth videos, or from family or friends. Donnalyse, a 24 year-old refugee from El Salvador, who experienced CSA, described her experience of coping with pain during labour and delivery.

> The only thing you can take if you don't know how to handle pain . . . it will help you a little bit . . . is morphine. So you ask your doctor if morphine is going to affect the baby . . . I had a nurse telling me . . . to "Take the epidural. Take the epidural." But I was thinking in my mind that this is going to be bad for me and my daughter's future, so I'm not going to do it. So I finally decided to take . . . morphine.

In the above excerpt, Donnalyse recalled making her decision to take morphine rather than have an epidural injection to help control her pain during labour and delivery. She was concerned about the effects of morphine on her baby's health and asked her doctor if

morphine would affect her baby's health. Donnalyse had decided she did not want to have an epidural injection because she knew of family members who developed chronic back pain after an epidural injection, therefore, despite the nurse's prompting she requested the morphine that she described as helping "a lot." Despite differences in choosing morphine or an epidural for pain control, Donnalyse, the doctor, and the nurse held the common goal of birthing a healthy baby.

The relational thread of birthing a healthy baby is common among all women regardless of whether or not there has been past interpersonal trauma. All women and health care providers strive to achieve this universal goal that may supersede the needs of the mothers. However, superseding the needs of the mother, especially those who have experienced past interpersonal trauma, may mean providing physical care over their emotional needs.

Receiving physical care over the emotional needs of the mothers. Women in this study described receiving physical care; however, most women stated that their emotional needs were not met within the healthcare system. During her labour, Donnalyse stated that "when they broke the water the baby's heartbeat stopped. So I was asking a lot of questions and they were being rude." The healthcare providers worked to ensure the baby's health after his birth; however, Donnalyse did not receive information about her infant's health for half an hour. Donnalyse remarked that "It was half an hour of you not knowing what's happening with the baby." Donnalyse explained that she was "scared. It was like your baby, what's going on with your baby? Or what's wrong with your baby? . . . They're stressed out and they don't think you're stressed out cause you don't know nothing about the baby, or anything." Although Donnalyse experienced stress while not knowing the state of her newborn's health, when asked if she felt she received the care she needed, she stated, "I actually did. In a way, I didn't. But I did. It was just like not perfect." Donnalyse received the physical care she needed to birth her child and physically recover from the birth however, in this excerpt she described her experience of not receiving the emotional support she needed.

Susan, a 36-year-old CSA survivor explained that she had multiple experiences of sexual abuse and was raped at age 13 or 14. Susan described having a good relationship, overall, with her family physician. However, her physical needs assumed priority with her family physician over her emotional needs:

> When I was bleeding everyday like that, I went to my family doctor . . . and we knew now that I was pregnant . . . She wanted to put that metal thing that they put inside you . . . but that is where the pain was. I was like I can't do it. So she forced me. I said "No, no, no! You have to take it out. You have to take it out! You have to take it out!" . . . My face was covered with sweat. Then she was mad. She took it out and slammed it down in the sink. Then she said, "OK, I have to put my finger in then cause I have to see what could be wrong with you." I said ok. And then she shows me which finger she was going to use. Well she's like five feet, but she has such power. She like RAMMED it. So, I'm saying . . . "I'm sorry."

Susan said she was, "getting the care that I need . . . but . . . not the way I wanted it." However, she believed that the doctor

> felt bad after, cause when I was leaving she . . . I can't remember what she said to me, but she acted like she wouldn't normally act. It was like her way of apologizing, she was overly nice . . . we're cool now. But the way she acted that day, I've never seen her act that way.

From Susan's perspective, her doctor provided physical care, but there was a lack of emotional care in her experience with her physician. The doctor showed concern for Susan's physical state and examined her to determine the cause of her bleeding without addressing Susan's emotional well-being in the moment.

Monica a 31-year-old refugee woman who arrived in Canada from Jamaica at age 6 after experiencing multiple traumas, described the type of emotional care she had hoped to receive.

> My doctor, she knew me growing up . . . she's so happy for me . . . But I thought it would be more hands on . . . So I guess I was looking forward to the whole interactive experience of it . . . And they don't do that much . . . like it's your first time. But it's the little things that you still have that you wish there was a class or something, go to once a week. Journal writing or something to do more engaging . . . or even to deal with the abandonment.

In the above excerpt, Monica expressed her desire for interaction with her healthcare provider and emotional engagement related to her pregnancy. Monica's wish for greater emotional support from her healthcare provider echoed that of other participants in this study who, while noting general satisfaction with care received, also expressed their wish

to share more of their emotional experience with the providers of their physical care.

In the excerpt below, Crystal, a 22-year-old, who experienced violence at home and CSA, revealed her thoughts and feelings about the lack of attention given to her emotional concerns during her pregnancy, delivery and the post-partum period.

> I'm never going back to (xxx) hospital. Even the OB didn't really care about me. She just measured my gut, listened to my heart. Asked me a few questions. Weighed me. That was it. I didn't really feel like I needed it . . . They did one ultrasound. I did my own ultrasounds . . . so if I could do it again I would . . . try and get a better hospital . . . And see if they pay more attention to me . . . Cause I felt they just . . . had this baby and you guys are doing whatever you want to him . . . like I'm a nobody . . . with the hospital it's like they're controlling you for your own good . . . but you kind of feel left out a little bit.

In this excerpt Crystal perceived a lack of emotional care by the professionals providing her healthcare. She described her interactions with the neonatal intensive care nursery as "not wonderful." Crystal stated that she "felt like these people were against me. Because my arms are covered in tattoos I think they prejudged me." Crystal's baby's physical needs were cared for over a four-week period in hospital after his birth. However, Crystal asserted that she was not provided with information about his condition until she complained to a hospital social worker. Crystal's physical needs were attended to after the birth, but her emotional needs were overlooked.

These excerpts reveal that although women in this study received the physical care they required to birth their infants, their needs for emotional healthcare received little attention.

Moving beyond sharing information to meaningful relational interactions. Women in this study described relational interactions that evolved into meaningful interactions with their healthcare providers. During interpersonal exchanges with their healthcare providers, the women experienced growth emotionally, relationally, and in their sense of competence as new mothers. The following excerpts illustrate interactions that progress from *sharing information* to *meaningful relational interactions.*

Tamara, a 24-year-old woman who experienced CSA and intimate partner violence explained that when she shared information about her history of abuse with her healthcare providers, their response "kind of rubbed me the wrong way." Tamara recounted

> When I was having my nose re-broken . . . the public health nurse that was in there that day she was like a counselor of some kind. And she said "You know, if he (partner) is going to hit you " and I'm like, 'Yeah, he's going to hit my baby too" . . . I already knew as soon as I got pregnant I was keeping it. So she says, "I'm just going to stick this in your purse." And she sticks it in . . . and it's an abortion paper.

The nurse offered unwanted advice and information that, from Tamara's perspective, was devoid of any meaningful positive relational interaction. As Tamara stated, "I mean anyone else, I don't know if they would be like 'Yeah, maybe I should have an abortion.' And not really decide themselves. But I was kind of insulted that they would do that." Tamara described being in numerous abusive relationships in her adult life and she could "understand where someone is coming from saying that . . . but they don't know . . . [the baby's father]. They don't know me. So they are just assuming . . . Which is fine. I'm not going to get mad at someone for . . . being judgmental."

As Tamara recounted her experience, she described a lack of understanding of her needs by the nurse. She considered the nurse's reply to her and explained that she was not angered by the nurse's comment. The interaction between Tamara and the nurse developed into a meaningful exchange as it prompted Tamara to evaluate her decision to keep her child and voice her belief that she had choice; she was in charge of her overall maternal healthcare experience; she set up her own healthcare appointments, attended prenatal programs, and explained that she "wanted to do this" and was "excited to do it" as she prepared for the birth of her child.

Mary, a CSA survivor, explained that despite things not proceeding according to her plan, in the end it worked out

> My doctor . . . I didn't really like her because she was so straight and to the point. . . . She made me feel bad about having any anxieties at all. So I didn't like her. . . . Originally I wanted a natural labour . . . I kind of realized that things don't always go to plan. I had to be induced and at that point, I was like "OK, I'm throwing my birth plan out the window. . . . Because she was there that day she made everything happen way faster."

Although their early relational exchanges were not meaningful in a positive sense, in time, Mary thought that the interactions between she and her doctor became meaningful. Mary explained that she often felt out of control with her maternal healthcare. She planned for a

natural childbirth, expressed her desire to avoid a caesarean section and worried that her doctor may be too "invasive." Mary explained that as her labor progressed, she needed to be induced. As a result, she was glad that the birth progressed faster than she had expected.

While most women in this study described their need for and openness to receive increased emotional support and relational connection with their healthcare providers, Katelyn, a 19-year-old CSA survivor, from Kenya recounted a meaningful relational interaction with her physician. She shared her concerns with him related to past trauma and current intimate partner violence.

> I called them and told them "I'm pregnant" . . . they hooked me up with my doctor two days later. So I met my doctor . . . after the "name, how old are you, pregnant? was, "Do you live with your fiancé? Do you feel safe being at home? Do you have any issues?" I told him about my rape case, and he's like "How is that affecting you?" . . . The day my boyfriend pinned me to the bed and screamed in my face I called my doctor and said I need to come and see you. He cancelled an appointment to see me . . . and he gave me all these resources.

Katelyn explained that her physician was "the only doctor I know who cares as much about your pregnancy as he does your mental health." Katelyn recognized that her needs were important to her physician. As a result, of the physical and emotional support she was offered, Katelyn was very satisfied with her care.

The following excerpt describes a beneficial relational interaction between Carling, a 32-year-old refugee woman from Mexico, and her nurses. During these exchanges Carling's sense of competence as a new mother caring for her infant changed in a meaningful way.

> My mom, she was scared he was not eating enough. . . . So one day the nurse comes in and offers a bottle. And I said "No. I want to try first breastfeed." But when she came she offered a bottle because the baby was crying, crying, crying . . . And my mom told them maybe you have to give him something because he is crying. So when she offered, I said "No. If I have something it’s because the first few days you have a little bit, not too much. We stick with that." And they say, "Ok, sure." . . . . So I think that was maybe me in control.

In the excerpt above, Carling recounted an interaction with her nurses in which she shared her preference to breastfeed her newborn. Their response provided her with a sense of

control. Carling reported that her healthcare providers "spoke softly" and reassured her by saying "beautiful things" such as, "You're gonna have a very happy, beautiful baby." Carling stated "That's exactly what you want to hear." Carling noted that she felt understood and listened to, and believed she received excellent care during her pregnancy.

These participants developed meaningful relational interactions over time with their healthcare providers. After birthing their infants, most of the women expressed gratitude for the help they received. As they transitioned to motherhood, the women considered their healthcare options and the factors that influenced the care that the healthcare providers' offered. However, their perceptions about their experiences with the healthcare providers were not unanimous. The women shared varied experiences in their interactions with the professionals who provided their healthcare and they shared varied expectations of the healthcare provider and patient experience.

Women's past trauma: little choice over their needs then and now. Women in this secondary analysis revealed that they felt little choice in the healthcare they received during their transition to motherhood. This current lack of choice was reminiscent of a lack of power and control that accompanied past traumas.

Kareena, a refugee woman from India talked about her feelings of stress and helplessness during her prenatal care.

> They said "Oh, we're not able to hear the baby's heartbeat. Which is quite sad, you might lose it." And we were like . . . six weeks? We asked the doctor "Is it possible to hear the baby's heartbeat at six weeks?" They said "Yes." And we were like ok. Then we consulted some other doctor. They said "No. It's never possible to hear the heartbeat so early" . . . you have to wait until 16 weeks, or 13 weeks to hear the heartbeat and a Doppler. So that just gave us another stress. . . . And we were like totally helpless at that point in time.

Kareena grew up in a war-torn border area in which she had little control over her safety. She and her family experienced violence and terrorism. Kareena stated that at "any time of the day you could expect anything happening there." She had little choice over where she lived and the war that surrounded her. She expressed similar feelings of being helpless when relating to the healthcare system during her maternal care. Kareena received conflicting messages about hearing her fetus's heartbeat, resulting in feelings of stress and worry about the health of her fetus. She explained that although she did receive care, she

did not receive the attention that she believed she needed and deserved. Early in her pregnancy Kareena developed abdominal pain and her physicians offered various explanations that were unsatisfactory to her. Kareena believed that in her country of origin, she could access the healthcare and receive the attention that she needed.

Several women described being sent home after arriving at a hospital dilated less than the four centimeters required for admission. Savannah, a refugee and CSA survivor from the Sudan, stated

> I said "Well, what am I going to do now?" She said "You have to go home and come back" but to tell you the truth, I only had $40 to my name and it already cost me $19 for a taxi from where I live to the hospital . . . when I was leaving I was so mad, I was crying . . . I was even trying to walk around the hospital to see if there was somewhere I could sit down and just stay there . . . as opposed to going home and coming back . . . because it was too much.

Savannah experienced a lack of choice and control in her past as a child who was sexually abused and later came to Canada as a refugee. Similarly, Savannah perceived little control over her situation in the emergency room as she interacted with the triage nurse. After leaving the hospital, she attempted to walk the several city blocks home; however, she could not walk that far and spent her last $20 to pay for a taxi ride. Later, in the day Savannah's extended family members offered to drive her back to the hospital to deliver her child. Savannah explained that because her three "aunties" worked at the hospital, she believed she would receive better care.

Most refugee women in this study expressed frustration at not being able to access the maternal care they believed they needed and were unable to influence the healthcare system to provide the care they believed they required. Nina, a refugee woman from India, described her frustration over the time it took her to access a healthcare provider.

> Getting the doctor was not easy . . . it's a long procedure . . . I was a little worried about my baby. I wanted to get checked fast. I just had to wait worrying and not knowing . . . It seems like receptionists, they hold the phone, and they will tell you maybe when you want to see the doctor. Yeah, this is the system . . . I haven't even tried to ask my questions here.

Nina worried about the health of her fetus and seemed to have little control over her healthcare. As an infant, Nina moved with her family to Sudan after her family fled from

Eritria, Africa to escape war. She spent her late teenage years and young adulthood in India and the United Arab Emirates, with fear each year that her visa would not be renewed and she would be sent back to the instability of a war-torn country. Nina had little control over her living circumstances and the war that affected her life in the past, and presently, she had little control as a woman attempting to make healthcare appointments that she hoped would ease her concern over her fetus's health.

In the following excerpt, Rosie, a CSA and physical abuse survivor, described her sense of lack of control over her needs in the past and in the present

> The ultrasound . . . that lady had to stop because she was like about to stick it in and I tensed up. She was like "Just think of it like sex." So then she saw how horrified I was. She's like, "Let's not think of it like sex" . . . Because I think they're so accustomed to having stuff stuck up there, you know . . . with the men that I'd been with they automatically assume that this is what you want. And even if it's not what you want, this is what you get, and you're going to be happy about it afterwards. And for me, it was the same sort of thing . . . this is what you came here to do. This is what you need to do. And you're going to be happy you did it afterwards.

Rosie had little control over the sexual and physical abuse she experienced in childhood. In the excerpt above, she described her belief that she had little choice about her maternal healthcare and would comply, even if she didn't want to, just as she had in past sexual relationships. This excerpt suggests that healthcare providers make assumptions about the care and procedures that patients want while failing to recognize that women with past trauma may not readily verbalize their preferences about their healthcare.

In the following excerpt, Debbie, a 19 year-old Aboriginal woman described a lack of care from her parents during childhood. Debbie's family physician provided her prenatal care, but Debbie was not sure she was receiving the care she needed.

> My parents had me pretty young. My mom wasn't in my life when I was little ... she was in jail a lot. She only had me 6 months and then I didn't see her until I was seven. . . . Both my parents do drugs. My grandparents raised me. So it was hard sometimes . . . I had a lot of neglect from both of my parents.

Debbie was not sure why she was not referred to an obstetrician. When asked if she felt listened to by her doctor in terms of her feelings and thoughts, Debbie replied "I don't really talk to her about . . . regular thoughts." She explained that her baby's heartbeat had

been monitored and her weight had been measured. At first Debbie wasn't sure if she was in control of her healthcare. She stated "I think they're in control cause they're the ones doing it really."

In the above excerpts the participants expressed a lack of control over their healthcare needs. The women were not able to ask for what they felt was needed in their care. While the women's birthing experiences were not the same as past traumas, this finding suggests that perhaps their feelings of lack of control and helplessness, and their inability to ask for what they needed, echoed a lack of control and helplessness experienced during past trauma. This finding can heighten the awareness of healthcare providers to the possibility that women with past trauma may experience a heightened sense of powerlessness during their healthcare encounters. It may encourage healthcare providers to increase their attention to the needs of women with past trauma who are transitioning to motherhood and to increase women's choices.

Discussion

Through the interviews, participants described varied experiences with the healthcare system. Consistent with the literature (Bowser & Hill, 2010; Goer, 2010), findings from this study revealed that relational interactions between women and the healthcare system are complex and often stressful. The interviews revealed that there is room for growth in the sensitive care that healthcare providers offer to women transitioning to motherhood. Participants described having their physical needs met, but the majority of participants described having unmet needs for emotional support.

This finding is consistent with results from the 2006 Canadian Maternity Experiences Survey in which over 6,000 new mothers were interviewed (Statistics Canada, 2009). Only 65% of respondents reported that they were very satisfied with the compassion and understanding they received from their healthcare providers. Compassion and understanding are similar to empathy, an aspect of healthy relational connection described in RCT (Jordan, 1999). The findings from the Maternity Experiences Survey suggest similarity to the findings of the present study, in which participants described having their emotional needs unmet during their interactions with healthcare providers.

In the present study, women reported that while their physical needs were met, they needed more emotional support and sensitive care than they received. This finding is consistent with findings from researchers that indicate a greater need for trauma- informed

care (Barker-Collo, 1999; Coles & Jones, 2009; Lukasse et al., 2009; Schachter et al., 2010). The healthcare provider interactions with Crystal, Susan and Tamara in the present study, are suggestive of the use of power and control by healthcare providers over women when they make unilateral decisions that treatment is in the best interests of the woman and child (DOliveira et al., 2002; Goer, 2010). Some women in this study also reported experiences that reflected the findings of Coles and Jones (2009) in which women CSA survivors described feeling blame, helplessness, and guilt during encounters with healthcare providers.

The Aboriginal women in this study had difficulty accessing healthcare services. These women described early childhood neglect and disruption in their relationships with their primary caregivers and a variety of difficult life events including, adoption, CSA, rape, abortion leading to feelings of guilt, poverty, homelessness, depression, feeling lost and alone, and the inability to access counselling services. These findings are similar to findings by Palacios and Portillo (2009) and Geronimous (2000) that suggest that Aboriginal women suffer from a multitude of stressors linked to social, cultural, and historical trauma.

For the refugee women in the study, the findings support the literature (McKeary & Newbold, 2010) that healthcare providers need to talk with refugees to gain an understanding of their needs. The fact that more refugee women expressed satisfaction with their care than did women in the other two groups may reflect the findings of DOliveira et al. (2002) that suggest violence against women in healthcare settings in developing countries may be common. The women may be accustomed to a lack of social egalitarianism, a lack of power and have lower expectations of their healthcare providers.

Trauma-informed care. The concept of trauma-informed care is relatively new (Elliott et al., 2005; Haskell, 2003; Hodas, 2006). Trauma-informed care developed from the understanding that children are more vulnerable to trauma than adults; that trauma threatens children's brain and psychosocial development and ability to cope with stress over their life span (Hodas, 2006; Schore & Schore, 2008). Elliott et al. (2005, p. 462) recognize the prevalence of interpersonal trauma by noting that "trauma survivors are the majority of clients in the human service system."

Trauma-informed care recognizes the pervasiveness of trauma and that its effects are cumulative over time (Hodas, 2006). Hodas also suggests that trauma-informed care is

based on an understanding of the impact that past interpersonal trauma has on the survivor's life. The trauma-informed care approach is committed to: (a) identifying and addressing trauma as early as possible, (b) identifying and understanding the connection between individuals' behaviour and past traumatic events, (c) considering the person's trauma history in the treatment and care plan in effort to promote healing and growth, and (d) providing services that do not harm the survivor but assists them to heal (Hodas, 2006). Saakvitne, Gamble, Pearlman, & Lev (2000) suggest that past interpersonal trauma creates less likelihood for survivors to access healthcare services due to symptoms related to fear. Common medical procedures may be retraumatizing to survivors if healthcare providers are not aware of this potential, and survivors may, as a result, fail to receive the care they need.

Trauma-informed care is important for, and particularly relevant to, the population in this study because the women experienced past interpersonal trauma, including, child sexual abuse, historical trauma and premigration trauma. The benefits of providing trauma-informed healthcare for survivors include interpersonal experiences that are emotionally safe, empowering, growth-enhancing, and encourage survivors' engagement with, and access to, healthcare services (Elliott et al., 2005; Schachter et al., 2009).

In a Canadian study of the relationships between healthcare providers and eleven women from diverse backgrounds as they transitioned to motherhood, Aston et al. (2010) noted more instances of sensitive relational care of women by nurses as compared to doctors. Possible reasons for the difference between this finding and the present study, in which no difference in the number of sensitive relational interactions between professional healthcare providers was noted, may be due to Aston et al.'s (2010) criteria for participant selection which did not focus on women who had experienced trauma.

Findings from this secondary analysis that are not noted elsewhere, suggest that women's past trauma may influence their relational interactions with the healthcare system. In particular, the findings suggest that perhaps the women`s feelings of lack of choice and power and the inability to ask for what they needed during the transition to motherhood was a reflection of the lack of choice and power experienced during past trauma. As well, when the healthcare system’s responsibility to be attentive to the women’s emotional needs is not met, a significant lack of emotional support befalls women with past trauma who are transitioning to motherhood.

Relational cultural theory as a framework for trauma-informed care. The majority of women in this study did not describe experiencing RCT's five good things: zest, action, knowledge, sense of worth, and desire for more connection (West, 2005), after relating to the healthcare system. While most healthcare providers ensured that the women's physical needs were met, emotional support, which may have required entering into emotionally demanding relational interactions, as mostly lacking.

RCT provides a useful framework for entering into relational interactions with women who have experienced trauma. For instance, as the nurse interacted with Carling, she promoted mutuality in respect and empowerment by supporting her to breastfeed successfully, which in turn, enhanced the nurse's practice of offering growth-enhancing care that all people in the relationship could benefit from. Carling's mother benefited by learning that her daughter is a capable mother. This validation of Carling's ability to successfully care for her baby allowed Carling to feel in control and capable.

Growth-enhancing encounters allow women trauma survivors to grow and heal in relationship. Although not described explicitly by participants, this positive relational interaction promoted RCT's five good things for the woman: (a) a sense of zest, implied in the woman's description of her encounter with the nursing staff and in her satisfaction at being heard, listened to and respected; (b) action, as Carling received validation for her ongoing care of her infant and her plan to continue breastfeeding; (c) increased understanding of her abilities as a mother; (d) a sense of worth, as noted in Carling's increased sense of self-confidence; and (e) a desire to continue the connection based on Carling's increased trust of HCPs. When Carling was beginning to breastfeed her newborn and the nurse interacted with her using the relational skills of empathy, respect, support, and validation, Carling responded with appreciation and healthy growth in caring for her newborn. The doctor who offered sensitive care to Katelyn also employed several of the principles of sensitive trauma-informed healthcare practice: respect, rapport, taking time, sharing information (Schachter et al., 2009). He demonstrated an understanding of CSA, noted by Coles and Jones (2009) as important in the care of women transitioning to motherhood.

The RCT core concept of growth through and toward relationship throughout the lifespan is reflected in the phenomenon that human infants are open to relational connections with caregivers (Schore & Schore, 2008). The findings in this study suggest

those women who experience CSA and other past trauma experienced less connection with nurses and physicians and support from the healthcare system. In light of the concepts of RCT, women, who sensed an inadequate amount of emotional support from their healthcare providers, did not grow through and toward relationship. The interactions were not mutual and the women failed to receive the health enhancing benefits experienced through reciprocity in relationship. Their suffering at both the individual and societal level continues.

As I analyzed the data, I considered the question: Did the women's perception of the healthcare providers' lack of connection on an emotional level repeat the women's past relational trauma or was the care provided merely sub-optimal? The interview data revealed that most of the women believed their healthcare providers did not adequately engage relationally. This may have occurred because of: (a) women's expectations based on past experiences of relational trauma, (b) a lack of healthcare provider education related to effective communication and relational strategies, and (c) a lack of trauma-informed care. Healthcare providers are confronted with multiple constraints imposed on them by the larger healthcare organizations for which they work. More time spent with the women results in additional healthcare costs. As well, staff members are often tired. Together, these may contribute to a reluctance to engage in authentic relational interaction. Authentic relating requires energy and can be emotionally draining (Jordan, 2010) or invigorating. Because many healthcare providers are women and may have their own histories of unaddressed past trauma, focusing on the task at hand and helping the woman give birth to a healthy baby, may be the simplest course of action.

Some of the women in this study did not perceive the relationships with their nurses and other healthcare providers to be as supportive as they would have liked. The second RCT core concept is "movement toward mutuality rather than separation as a characteristic of mature functioning’" (Jordan, 2010, p. 24). This core concept would be appropriate for nurses and other healthcare providers to adopt in their interactions with survivors of past trauma as a manner of professional relating that may lead to an increased sense of support by the survivors.

When I considered the core concept: relationship differentiation and elaboration that characterize growth, I realized that women who experienced a more satisfactory interaction with the healthcare system were empowered and grew in their capacity to

access healthcare to meet their needs. When supported emotionally by their healthcare providers, these women gained confidence and reported a maternal healthcare experience that enhanced their emotional health and could allow them to focus their energy on caring for and nurturing their newborn infants. Emotionally supportive interactions with the women by healthcare providers reflected the RCT principle that mutual engagement intersects on multiple levels, and acts to increase the capacity of healthcare providers and women's relational resilience.

In growth-fostering relationships, all people grow and benefit and therefore, may not necessitate emotional "draining" on the healthcare provider. Development is not a one-way street. Mutuality, described as a core concept of RCT, demands energy, caring and compassion and results in feeling the other's emotional pain. Both the lack of mutuality and the presence of it were reflected in the data. In general, there was less relational growth when mutual empathy and mutual respect were absent. When women were related to with empathy, they responded and reported a more positive experience during the transition to motherhood. When women expressed feeling emotionally supported, for example, when describing learning how to breastfeed, a sense of personal satisfaction and control over their care developed. They mentioned sensing honesty from the healthcare provider, being listened to, and feeling heard when voicing their concerns.

This data also supported the RCT concept of authentic relating. Healthcare providers who related with mutuality and caring were particularly helpful to women, while the women who experienced less authenticity in their interactions with healthcare providers described a less satisfactory experience. The concept of all people growing or benefitting from engaging relationally was not identified as having occurred in the majority of interviews analyzed in this study. The women and healthcare providers who remained relationally and emotionally disconnected from each other, benefitted less.

Findings suggest that diverse forms of trauma influence women's interactions with healthcare providers in the healthcare system at the micro relational-cultural level. Findings also suggest that inter-sectoral factors such as gender, race, and class of these three groups of participants affect the women's relational-cultural interactions with the healthcare providers. Thus, the women's past trauma and the inter-sectoral factors of gender, race and class may influence the care women receive and the lack of emotional engagement they sense in their healthcare providers. Whether it is the nurse in day surgery

who slips abortion information into her client's purse, the family physician who uses her position of power to influence her patient's compliance to treatment, or the policies created for women's admission to the labour and delivery unit, a disconnect between the objectives of healthcare in Canada (Health Canada, 2013; Ministry of Health and Long Term Care, [MOHLTC] 2011), and the experience of women in this study, was evident. Of particular concern was the women's perceived lack of sensitive, trauma-informed care by their healthcare providers. The provision of trauma-informed care that considers the personal, social and institutional aspects of care (Aston, 2008) could be beneficial to women, their families, the healthcare system, and our communities.

Implications and Recommendations

Findings of this study suggest that there is significant room to improve the care of women who have experienced past interpersonal trauma as they transition to motherhood in the healthcare system by enhancing the relational care they receive from their healthcare providers. Women in this study offered suggestions for care that would meet their needs, including: being listened to and having more time to talk with their healthcare providers, not being rushed through appointments, having choice about their care, and more access to counseling. While healthcare providers are well-versed in obstetrical technical skills, their relational expertise with women transitioning to motherhood is often lacking (Bowser & Hill, 2010; Goer, 2010; Richmond, 2005).

Healthcare providers must be willing to engage in relationships in order to offer growth-enhancing experiences and their benefits to women transitioning to motherhood. When the therapeutic relationship incorporates the concepts of safe relational engagement outlined in RCT, the healthcare provider is able to effectively communicate to the woman that her concerns and pain matter, thus opening up the possibility of relational growth. RCT can be incorporated by healthcare providers into their everyday encounters with women who have experienced trauma, as they transition to motherhood. The education of healthcare providers can include RCT thereby preparing them more fully for their work with women after trauma. Healthcare policy that reflects an understanding of the benefits and use of a trauma-informed approach is needed. Research to increase our understanding of effects of RCT as a method of relating to women with past trauma who are transitioning to motherhood, should continue in order to fulfill the World Health Organization's (WHO) recommendations of governmental funding to support women's human rights (WHO,

2011), Health Canada's core value of caring for people by providing quality services (Health Canada, 2013), and the MOHLTC's promotion of a patient-focused healthcare system and excellent care for all (MOHLTC, 2011).

In his discussion of the asymmetry in the healthcare system often encountered by patients as they relate to medical institutions, ethical traditions, practices, vested interests, and healthcare providers, Sadan (2001) explored the use of Bunge's (1996) systemic ethical approach to this complex issue. A systemic ethical approach considers the individual, the system and the links between them. While Sadan (2001), describes the two principal players in healthcare as the patients' health services and individual healthcare providers, in this study the principle players in healthcare consist of the patients and healthcare providers, and the healthcare system. Both patients and healthcare providers are affected by the 5 essential elements described by Sadan (2001): (a) society, (b) the healthcare system, (c) the medical profession, (d) healthcare organization, and (e) healthcare organization subsystems (medical wards, clinics, laboratories).

Healthcare providers' values can be classified into personal, professional, organizational, and social spheres (Sadan, 2001). In the personal sphere, healthcare providers' personal values influence their decisions at work. In the professional sphere, the profession's values bind healthcare providers to act within its regulations. Organizational values reflect organizational goals and also influence actions of the healthcare provider, while social values and goals affect both the healthcare providers and clients. The influence of values from these five spheres results in a lack of clarity for behaviours and actions of healthcare providers especially when values conflict (Sadan, 2001).

The concepts of RCT (Jordan, 2010; Miller, 2008; Miller & Stiver, 1993) can be applied to Bunge's (1996) systemic ethical approach to gain clarity about the responsibilities of, and need for change in, the healthcare system related to the interactions of women with past trauma during their transitioning to motherhood. At the personal level, the failure of interaction, mutuality, and support of women by healthcare providers during women’s transition to motherhood shows a lack of consideration and respect of women. In the professional sphere, healthcare providers fail to engage in positive mutual behaviour and do not honour the caring values of healthcare professions in Canada, including the mandate of caring of Health Canada (2013), the historic Hippocratic oath, a basic premise of medical care in Canada (Foxman, 2010), and the nurse-client therapeutic relationship

standard of caring (College of Nurses of Ontario, 2006). In particular, nurses are in the opportune position as frontline healthcare providers to be leaders in providing trauma-informed care by offering women a sense of safety in relationship in which to share their healthcare needs and to grow as women and new mothers. In each interaction with women who have experienced trauma, nurses can relate in an attuned and caring manner that provides a sense of safety to, and validation of, the woman that will serve to build the woman's capacity to care for her needs and those of her infant and family.

At the organizational level, healthcare organizations would rarely, if ever, encourage their healthcare providers to avoid connection and emotional support of women transitioning to motherhood. At the social level, the healthcare system may consider a revision in education of healthcare providers and to enforcing standards of care, after recognizing that mutuality and connection can be helpful to both healthcare providers and to women transitioning to motherhood after trauma. The healthcare system can increase trauma-informed care for women seeking maternity care after experiencing trauma by including additional training in communication, ethics and in the learning and practicing of RCT for healthcare providers.

Conclusion

Findings from this study suggest that: (a) birthing a healthy baby was a common relational goal held by healthcare providers and women with past trauma as they transitioned to motherhood; (b) the healthcare system placed emphasis on ensuring that women's physical needs were met to enable the birth a healthy baby, however, less focus was placed on addressing women's emotional needs during their transition to motherhood; (c) when women shared information with healthcare providers, meaningful relational interactions developed which indicated a need for increased trauma-informed care of women with past trauma as they transition to motherhood; and (d) women's past trauma may have influenced their ability to voice and make clear their choices and needs for emotional, as well as, physical care.

A lack of trauma-informed care in the healthcare system was identified. Offering such care would allow both women and healthcare providers to grow in their relational competence, interact authentically, and allow all people in the interactions to benefit by increasing each individual's relational competence over time. Past trauma is poor preparation for interacting with the healthcare system in adulthood and leaves the woman

in need of healthcare providers who are attuned to and supportive of her emotional experience. When the healthcare system attempts to care for women after trauma during the transition to motherhood, but does not offer relational engagement and is not trauma-informed, effective holistic care is not achieved. Rather than choosing to engage with women who have past trauma on an authentic and demanding relational level, the healthcare system overlooks the emotional needs women present with, and focuses instead, on the birthing process. Findings from this analysis reveal that the healthcare system must consider all of the needs women present with and adjust their approach to fit the clients they serve. RCT, as a trauma-informed way of relating to women, offers an approach for growth-enhancing care that fits the needs of women and can be incorporated into interactions with women after trauma as they transition to motherhood. By incorporating the trauma-informed approach of RCT (Jordan, 2010, Miller, 2008; Miller & Stiver, 1993) into the maternal care of women after CSA, historical trauma and premigration trauma, the healthcare system and individual healthcare providers could offer optimal care that allows everyone involved to reap the benefits of zest, action, knowledge, a sense of worth, and the desire to continue the connection.

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CHAPTER 3

Implications for Nursing

The purpose of this secondary qualitative analysis was to critically examine the experience of three groups of women with a history of past interpersonal trauma as they access healthcare during the transition to motherhood. The study was guided by a critical feminist philosophy informed by Relational Cultural Theory (RCT) that promoted an understanding of women's interactions with the healthcare system in light relational interactions, culture and trauma-informed care. Through interviews, three groups of women with past experience of: (a) childhood sexual abuse, (b) Aboriginal women (historical trauma), and (c) refugee women (premigration / war trauma), shared their perceptions of their healthcare encounters. The interview data shed light on the challenges that women with past trauma face as they seek the maternity care they need and deserve.

The overarching themes that emerged from the data included: *(a) birthing a healthy baby: the common relational thread; (b) receiving physical care over the emotional needs of the mothers; (c) moving beyond sharing information to meaningful relational interactions; and (d) women's past trauma: little choice over their needs then and now.* The participants' experiences of accessing healthcare were made explicit. The findings reveal the complexity of relational interactions in the healthcare system for women transitioning to motherhood after experiencing interpersonal trauma. Their need for trauma-informed care was embedded within their stories of relating to their healthcare providers. In this chapter implications for nursing policy, practice, education, and research are presented.

Summary of Findings

The findings reveal that women's interactions with the healthcare system are complex and that there is a need for increased trauma-informed relational care of women with past trauma who are transitioning to motherhood. The women reported various interactions with healthcare providers that were linked to growth-enhancing behaviours that align with concepts of RCT (Jordan, 2009; Miller, 2008; Miller & Stiver, 1993). However, the findings also revealed that women's physical needs were met but their needs for emotional support were often overlooked. Practicing trauma-informed care as outlined in RCT can aid healthcare providers to meet the emotional needs of women who have experienced trauma as they transition to motherhood. In the remainder of this chapter, implications of

study findings for policy, nursing practice, nursing education and nursing research are discussed.

Implications for Policy

While satisfying interactions with the healthcare system are important to the growth and well-being of women and their infants during the transition to motherhood, women's voiced experience of interacting with the healthcare system and healthcare providers contain messages for those who provide services to women prenatally, during birth, and the postpartum period. The healthcare system, medical profession, healthcare organizations, society and healthcare organization subsystems (Sadan, 2001) are in positions of power-over when relating to women with past trauma. The gravity and ethical responsibility inherent in providing care to women seeking maternity care after trauma must be acknowledged, understood, and reflected in the actions taken by all involved to change relational practices and to increase trauma-informed care of women who access maternal care in the healthcare system. Policy makers must become aware of the effects of systemic demands on healthcare providers that leave them too little time or energy to offer emotional support to women with past trauma transitioning to motherhood. Without changes in policy to increase organizational and individual competency in providing relational connection and support as outlined in RCT to women after trauma seeking maternity care, the negative effects of a lack of trauma-informed care will continue to be felt in higher healthcare costs and suffering in women.

Greenhalgh, Robert, Macfarlane, Bate, and Kyriakidou (2004) illustrate that organizational and individual competencies and competency / capacity building strategies are reciprocal with a complex interplay between them. As they applied concepts described by Greenhalgh et al. (2004) to their Family Practice Health Team study in Ontario, Rush, McPherson-Doe, Behrooz, and Cudmore (2011) suggest that competencies on the individual level reflect organizational-level competency. These authors comment that the training of one key person, or the cumulative impact of training several staff, contributes to shifts in organizational culture while existing organizational factors affect how the person carries out the new skill or learning (Rush et al., 2011). This possibility suggests that the interplay between hospital organizational factors and the training of key nursing staff in the RCT approach could result in the improved relational connection of nurses and the healthcare organization to women with past trauma transitioning to motherhood.

Implications for Practice

In her article discussing the relevance of social justice within a nursing relational ethic, Woods (2012) suggests that nurses care for, and care about, patients within their life situations. The author argues that this caring ethic reveals a moral commitment by nurses to care about the welfare of patients within difficult and changing socio-cultural contexts (Woods, 2012). Despite the relational care emphasis within the nursing profession (Bishop & Scudder, 2001; Fry, 1989; Leninger, 1990; Tschudin, 2003; Tuck, Harris, Renfro, & Lexfolds, 1998; Watson, 1990) findings from this study suggest that the majority of women with past trauma transitioning to motherhood did not receive the emotional support from their nurses that they needed. Factors related to policy beyond the organizational level that may prevent or impede nurses from offering relational care and connection to women transitioning to motherhood are: overwork, too little time for patient care, burnout, and a task oriented approach to care.

In their article discussing the practice of RCT in a non-relational work world, Hartling and Sparks (2002) adapted Ward's (2000) four-step model for developing healthy resistance and resilience in African American adolescents confronted with racism, to the work of therapists in non-relational work settings. As a framework for building healthy resistance and resilience, they describe RCT as an approach for building healthy resistance and resilience within:

1) traditional hierarchical workplace cultures;
2) pseudo-relational workplace cultures; and
3) survival workplace cultures.

The authors discuss the inherent challenges and opportunities for creating change using the RCT approach in each workplace setting (Hartling & Sparks, 2002). Although the authors focus on the workplaces of therapists, the model can be adapted to the workplaces of nurses' who engage directly with women as they access healthcare during the transition to motherhood. Because practicing according to RCT can offer all involved in the interactions zest, empowerment, clarity, a sense of worth, and a desire for more connection (Jordan, 2010), it is reasonable to suggest that nurses employ an RCT approach as they interact with women with past trauma transitioning to motherhood.

Most hospital settings, and academic and research institutions can be described as hierarchical workplace cultures that have traditionally reflected non-mutual, dominate-

subordinate relationships where information flows from the top down and conflict is often submerged, suppressed, denied, and perpetuated (Miller, 1976). Miller and Stiver (1993) suggest that the phenomenon of a central relational paradox can be identified in this situation, because in order to maintain working relationships, individuals are forced to leave significant aspects of their experience out of the relationship or risk some form of reprisal. Healthy opposition to change in hierarchical workplace cultures offer opportunities of: (a) making relational practice visible and valued; (b) making micro movements toward mutuality; and (c) gradually creating conditions for greater authenticity by building mutual empathy and supported vulnerability (Hartling & Sparks, 2002, p. 6).

Hartling and Sparks (2002, p. 2) cite Collins (2000) who advised that practitioners working from an RCT perspective think as "visionary pragmatists"; practitioners who realistically acknowledge obstacles that impede change. For nurses in the workplace, this can mean holding onto the vision of change while knowing and responding to the obstacles to relational connection that reinforce disconnection and separation from other nurses, healthcare providers, the organization, and from the clients served.

Hartling and Sparkes (2002) suggest that Ward's (2002) framework can be adapted to the workplace by including the 4 steps to changing non-relational and disconnecting practices: a) read it; b) name it; c) oppose it; and d) replace it. The first two steps in this process are emphasized as the means to create change in the workplace. Assessing the nursing workplace situation involves looking for evidence of growth-fostering relationships or the positive relationships that result in RCT's 5 good things. Some conflict is to be expected, but this is worked through and staff disconnections are repaired adding to relational resistance and resilience for those involved in the interactions (Hartling & Sparks, 2002). The authors warn against simplifying the workplace into a good or bad place to work, to avoid derailing efforts to create constructive change. Naming the practices that promote or impede connection in the workplace can reveal the complexities of healthcare workplace dynamics. In pseudo-relational workplace cultures, such as community agencies, grassroots organizations and religious organizations, differences and conflict are often denied and suppressed, and nurses can be confronted with the conflict of having to maintain compassion and caring in relationships without the necessary confrontation of conflict and working through it (Hartling & Sparks, 2002). Healthy opposition to changing non-relational and disconnecting practices in the pseudo-relational

workplace holds opportunities to: (a) recognize the value of relationships at all levels, (b) build mutually beneficial relationships at all levels, and (c) take action collectively to challenge social / cultural / political devaluation of relationships (Hartling & Sparks, 2002, p. 10).

Workplaces that reflect a survival culture leave nurses overworked, without built-in structures to support relational behaviour, demand self-sacrifice, and lead to high incidence of burnout. Administration and staff in survival culture workplaces need to recognize that relational-cultural practice can reduce stress, increase staff satisfaction, and reduce burnout (Hartling & Sparks, 2002). Healthy opposition, suggested for step 3, to non-relational practices in workplaces that function in a survival culture manner contain opportunities for: "(a) constructive change; (b) movement in relationship; (c) increased mutual empathy, mutual empowerment; and (d) new, better connection" (Hartling & Sparks, 2002, p. 11, figure 6). Expressing healthy opposition leads to constructive movement toward change (Hartling & Sparks, 2002) and a way to practice good conflict (Miller, 1976). Ideally, opposition aids in moving toward growth-fostering relationships that increase authenticity, mutual empathy, and empowerment for nurses, clients, and organizations.

The nursing practice implications of employing a RCT approach with women transitioning to motherhood are profound. All of the women in this study delivered their infants in a hospital with nurses attending to their care. Because there are risks associated with attempting to change hierarchical workplace practices, nurses need to consult with other nurses and healthcare providers informed in RCT to determine possibilities for initiating change. This may include making care by nursing staff employing the RCT approach more visible to physicians and management. Nursing care that attempts to connect with and support women transitioning to motherhood and that reflects the seven core concepts of RCT, offers the possibility of growth-enhancing relational interactions to women that are consistent with the CNO (2006) concepts of therapeutic communication and client-centered care. Delivering nursing care informed by RCT to women after trauma who are transitioning to motherhood reflects ethically responsible nursing care that not only links growth-enhancing connection to multiple levels and relationships within the healthcare system and society, but offers women with past trauma transitioning to

motherhood, their infants, families, and the nurses who serve them, validation, empowerment, and opportunities for relational growth.

Implications for Nursing Education

The provision of trauma-informed care should be emphasized in nursing education. The study findings revealed that women with past interpersonal trauma who are transitioning to motherhood need sensitive, trauma-informed care. The women benefited when nurses talked to them in a safe, informative, and caring manner. When nurses offered mutual respect and attention, the women thrived. Nurses also benefit from understanding and using an attuned, authentic, caring relational approach that is founded in the conceptual framework and guiding concepts of RCT (Jordan, 2009; Miller, 2008; Miller & Stiver, 1993). As a trauma-informed approach, RCT is supported by recent neuroscience research related to mind / body / brain (Briere & Scott, 2006; Schore & Schore, 2008; Van der Kolk, 2010) and can be employed as a means to provide the best possible care of women during the transition to motherhood. Focusing on relationally sensitive trauma-informed care may allow nurses to become expert in relating to women during the transition to motherhood and may provide more holistic care and less harm producing care of this vulnerable population.

Incorporating feminist, critical, social justice, and interpersonal relationship-informed curricula is dependent on the choice of faculty members, but may assist students to gain an understanding of how to relate to patients with past trauma that extends beyond the traditional medical model. Nursing curriculum that includes feminist theory and critical philosophy can help illuminate social injustice and the next steps for positive healthcare change. A focus on the effects of interpersonal trauma, social justice and empowerment of women can build on students' understandings of health. and challenge them to embrace an advanced understanding of the meaning of and requirements of health for marginalized groups. RCT, as a trauma-informed approach to care, can be taught to nurses to aid in promoting the therapeutic relationship through building sensitive care practices that will benefit both nurses and patients in their healthcare encounters. RCT can be added to teaching curriculum to aid nurses in learning to oppose non-relational practices in the workplace. Building strong relational skills among student nurses can lead to greater relational capacity for connection with women who have experienced past trauma and are transitioning to motherhood.

Implications for Nursing Research

Findings from this study indicate varied perceptions of their healthcare encounters by women with past trauma as they transition to motherhood. The findings also suggest that most women may benefit from increased emotional support during healthcare encounters. However, further research is needed to gain a more comprehensive understanding of the healthcare encounters of women with past interpersonal trauma. Future studies could include evaluation of healthcare providers' experience when providing maternal care to women with past trauma. Research that explores trauma-informed maternal care within the healthcare system is needed. Studies could be completed using critical perspectives to ensure that women's voices and perspectives are heard and they are empowered to access the care they need and deserve. Future quantitative and qualitative nursing research should focus on measuring the effects for both nurses and women of positive growth-enhancing connection in relationship between nurses and women with past trauma as they access maternal care.

Through frontline work, nurses have direct impact on women's relational health and on the early relationship the woman has with her infant, a time of critical time of neurobiological growth in the infant as it begins to sense whether or not the world is safe (Schore & Schore, 2008). Nursing research guided by RCT as a theoretical framework could prospectively examine the effects of meaningful interactions in the mothers' healthcare encounters by considering the effects of increased zest, action, knowledge, a sense of worth, and the desire to continue the connection as it affects their infants, by completing longitudinal studies.

As nurses work to make the value of RCT practices more visible to organizations, nursing research can evaluate the impact of RCT care and develop evidence of the benefits of relational connection that can better serve clients and "may save the organization money, time or reduce the organization's liability" (Hartling & Sparks, 2002, p. 6).

Limitations

As this was a secondary data analysis, I did not have the option to ask additional questions of participants, which limited the support I could provide for participants' insights and potential change, integral aspects of critical feminist research. As well, Thorne (1998) argues that being unaware of the features of the primary study context and of original representational problems in the primary study sample can lead to exaggerated or distorted

assumptions. I addressed these potential limitations by sharing conclusions about themes and outcomes with the primary study researchers and by including a critical account of the nature of the primary study sample to provide the reader with a full understanding of the sample base. Another potential limitation of this study is the credible interpretive capacity of myself as a master's student early in my research career. Sandelowski (2011) suggests that less than optimal interpretive capacity can negatively impact the ways the data can be seen and treated. I attempted to offset this potential limitation with ongoing communication with the primary researchers and my thesis committee for review of potential areas of interpretive concern.

Another limitation to this secondary analysis is the lack of perspective from healthcare providers, which if included, may have allowed further understanding of how RCT relates to healthcare providers as they serve women with past trauma who are transitioning to motherhood. Notwithstanding these limitations, this study makes an important contribution to the consideration of options to increase relational connection of the healthcare system and healthcare providers with women after trauma accessing maternal health care.

Rigour

Lather (1987) argues that in praxis-oriented critical feminist research it is essential to develop skills of self-critique, of reflexivity that will help prevent the researcher from becoming impositional and reifying. The goal of emancipatory research is to lessen oppression; therefore while incorporating a strong theoretical base, I focused on maintaining a self-critical and reflexive approach by continuing to question my analysis of the data and returning it to the primary research team for clarification of themes and conclusions reached. Reliability was enhanced as I disclosed my decisions regarding analysis of the data, the conclusions reached, the study's limitations and, my researcher bias (Davies & Dodd, 2002). Use of the term "validity" is included, rather than the term "transferability" which bridges both reliability and validity (Guba & Lincoln, 1994) because the post hoc confirming criteria of transferability is not applicable to feminist and critical theoretical approaches (Morse, Barrett, Myan, Olsen, & Spiers, 2002). Rigor is defined as applying consistency and care in the application of the research practices (Davies & Dodd, 2002). Attaining rigor includes strategies that will enhance reliability and validity (Morse et al., 2002) and to attain rigor in this study I responsibly worked to ensure

that reliability and validity, as they pertain to the secondary analysis of a qualitative data set, were achieved by using verification strategies during the research process. Achieving the verification strategies of: methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis, thinking theoretically, and theory development in this secondary analysis is dependent on considering major concepts and not using a thin and incomplete data set (Morse et al., 2002). I maintained ethical responsibility in this work by applying carefulness, openness, honesty and respectfulness as I worked with and responded to the data. To enhance accountability in the research process and the credibility of findings, I considered the disorder of the research process and kept track of, and discussed, alternative explanations by systematically searching for alternative themes, patterns or rival explanations. Data findings and conclusions were reflected back to the research team who conducted the primary study in order to gain further clarification.

Conclusions

The findings from this study revealed how women with past trauma transitioning to motherhood interact with the healthcare system. Interviews with the women provided rich data containing the themes: (a) birthing a healthy baby: the common relational thread; (b) receiving physical care over the emotional needs of the mothers; (c) from sharing information to meaningful relational interactions; and (d) women's past trauma: little choice over their needs then and now. The exemplars revealed a variety of experiences the women confronted as they interacted with the healthcare system and those who work within it. Women's experiences suggest the need for increased use of RCT as a relational approach with this population. Nurses can consider choosing to offer relational connection with women with past trauma to increase trauma-informed care that is needed to meet the healthcare needs of this population. Together with the healthcare system, nurses can work to increase growth-enhancing relational connection to women who seek out maternity care in Canada.

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APPENDIX A

LETTER OF INFORMATION

Centre for Research & Education
on Violence against Women and Children

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

Letter of Information for Participants

Principal Investigators: Dr. Helene Berman, Dr. Robin Mason

Sponsor: Canadian Institutes of Health Research

Introduction

I would like to invite you to participate in a research study about the transition to motherhood. This study is about how past trauma may shape and affect women during the transition to motherhood. This study is conducted by Dr. Helene Berman from the School of Nursing at the University of Western Ontario, and Dr. Robin Mason from Women's College Hospital and the University of Toronto.

If you are in the second trimester of a first pregnancy, over the age of 18, and belong to one of the following groups: (1) a survivor of childhood sexual abuse; (2) a refugee woman; or (3) are Aboriginal, then we would like to invite you to participate in the study.

Overview

The transition to mothering may be a challenge for women who have experienced past trauma, yet little research has been conducted to fully explore this idea. It is our hope that the information we learn through this research will help us to develop programs and policies to better meet the needs of women during the transition to mothering, who have experienced past trauma.

If you take part in this study, you will participate in two separate interviews with a member of the research team. The first interview will be conducted during your second trimester and the second interview within four to six months after your baby is born. The

interviews will last about 1½ hours. You will be asked questions about your life today, your experiences related to your history of trauma, and your thoughts about becoming a mother. The interview will take place at a location of your choice (a private location in a community agency, your residence, or at the researcher's office) and at a time that is convenient to you. The interview will be audiotaped so that the Research Assistant can pay careful attention to what you are saying. The audiotape will be transcribed into written format and erased upon completion of the study.

Risks to Participation

As with all research, there may be some risk to participation. For example, you may experience difficult memories and emotions and your fetus may react to your stress. However, there is no medical evidence that your participation will result in harm to you or your fetus. There are also several ways in which being in this study may be helpful to you. Most likely, the issues we will raise are ones you have thought about before, but may not have had an opportunity to discuss with others. In the event that uncomfortable thoughts and feelings do arise, the research team has taken steps to assist you. First, you will receive a package of community services and resources and when required, we can link you directly to the service of your choosing. Second, if you would like further support, you can participate in a support group, focusing on women and trauma and lead by experienced professionals. Third, we will contact you by telephone several days after the interview to see how you are feeling and to determine if you would like any follow-up services.

Potential Benefits

To Individual Participants. There are several ways in which being in this study may be helpful to you. For many women who have experienced trauma, just having a chance to talk about important experiences may be helpful. It is also possible that, by talking about things that have happened to you, you will begin to understand them in new or different ways.

To society. It is our hope that the information we learn through this research will help us to develop programs and policies to better meet the needs of women during the transition to mothering, who have experienced past trauma.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time. So if you change your mind and decide that you do not want to take part in this research, you may do this at any time. If, after our discussion, you would like to talk more with someone, such as a counselor, we will provide you with names of people or agencies whom you may wish to contact.

Confidentiality

We will respect your privacy. Any of your personal information (information about you and your health that identifies you as an individual) collected or obtained, whether you choose to participate or not, will be kept confidential and protected to the fullest extent of the law. All personal information collected will be kept in a secure location. The study staff, the WCH and UWO Research Ethics Boards, employees of the Sponsor, CIHR or the regulator of the study may look at your personal information for purposes associated with the study, but will only be allowed to see your records under the supervision of the Principal Investigator and will be obligated to protect your privacy and not disclose your personal information. None of your personal information will be given to anyone without your permission unless required by law. For example, the law could make us give information about you if a child has been abused, if you have an illness that could spread to others, if you or someone else talks about suicide (killing themselves), or if the court orders us to give them the study papers. Following completion of the research study the data will be kept as long as required then destroyed. Published study results will not reveal your identity.

If you would like, a summary of what we have learned from this research it will be sent to you when the study is over. In appreciation of your assistance with the study, you will be given $25 for each interview. This letter is yours to keep for future reference. Thank you for your interest.

Sincerely,

Helene Berman, RN, PhD
Associate Professor, School of Nursing
Scotia bank Research Chair, Centre for Research and Education on Violence Against Women and Children University of Western Ontario

Robin Mason, PhD
Women's College Research Institute,
Women's College Hospital

APPENDIX B

Consent

Centre for Research & Education
on Violence against Women and Children

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

Informed Consent

Principal Investigators:

Dr. Helene Berman, Dr. Robin Mason

Sponsor: Canadian Institutes of Health Research

I have read the Letter of Information describing the study, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

____________________ ____________________ __________

Participant's Name | Participant's Signature | Date

____________________ ______________________________

Person Obtaining Informed Name | Person Obtaining Informed Consent Signature | Date

____________________ ____________________

Translator's Name (if applicable) | Translator's Signature

________________ ________________

Date | Date

Appendix C

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

Interview Guide #1

Conceptual Model and Guidelines

Prior to the start of interviews, all participants will receive a Letter of Information and be given the opportunity to ask any questions. After questions are answered to their satisfaction, the women will give written Informed Consent. Both the Letter of Information and the Consent forms will be translated into the woman's preferred languages for the purposes of the research (this information will be obtained during the pre-interview screening during which their eligibility to participate is determined). Although formal Consent will not be obtained after the first interview, the women will be reminded about the terms of Consent, including limits of confidentiality and reporting requirements, and availability of supports.

Introductory Comments Prior to the First Interview During Pregnancy

General Statement about the Research. You have volunteered for this research project that is exploring how the transition to motherhood may be affected by trauma from your past. We're particularly interested in your experiences during pregnancy and in the first few months of your child's life.

Every woman has a story to tell. There is no right or wrong stories, and no right or wrong emotions. We are interested in learning how you think past trauma affects your thoughts, feelings, and actions, as you become a new mother. We would also like to know who has been helpful, or has not been helpful, and what your encounters with the healthcare system have been like. As well, we would like to know what you think healthcare agencies and other people who might be helping women in situations similar to your won should know about women who have experienced trauma and are making the transition to motherhood.

Support for Participants. You may find talking about your experiences to be helpful and healing but it may also cause some distress. Before we say goodbye at the end of your talk today, we'll talk about how you are feeling. If you would like more support at that time, we will discuss possible options. These can include a referral to a counselor or

traditional healer, or if you are interested, we can refer you to a support group for the women taking part in the research. If you ever feel you require urgent help, please call XXXXXXX.

Do you have any questions at this time?

Interview Questions (asked with flexibility)

Introductory Comments

We all have a story to tell about our lives and I am interested in listening to and documenting your story. You can begin where you like and say as much or as little as you feel comfortable sharing. There is no pressure to respond to a question if it makes you feel uneasy or if you do not feel ok about revealing your thoughts, feelings or actions. Is that clear?

Most importantly, I would like to hear your story and to have the opportunity to take record it so that we do not lose any information that you are sharing. I also want to remind you that your story will be shared only within the research team and that your real name will not be used or ever appear in print. After the interview, we will have the full interview typed out onto paper. During the interview, I may ask some questions or make some comments so that I can better understand what you mean.

1. An important part of your experience of being pregnant/having a baby/ and becoming a new mother is the kind of = and quality of your - contact with the healthcare providers helping you during this time (doctors, midwives, nurses, social workers and so forth). Perhaps we could begin with you telling me about the care you received.

   Prompts

   - Have you been able to get the care that you believe that you need in terms of health provision?
   - If yes, in what way? (describe your experience)
   - If no, can you help me understand what happened and in what way your needs were not met?

   - Did you feel understood and listened to by different healthcare providers in terms of your feelings, thoughts and behaviours? Please explain your

answer.

- Did you feel that you were in control of what was happening to you in your interactions with the health care providers and the healthcare system? Can you discuss what you mean, and the ways in which you did or did not feel in control?

2. What strategies did you use to get what you needed (emotionally and materially) during your pregnancy, childbirth, postpartum and during the 1st few months of your child's life?
3. In what ways were your experiences with pregnancy / childbirth and postpartum / during the 1st few months of your child's life similar to, or different from, your hopes, dreams and expectations?
4. Can you tell me your story about your past experiences with trauma, to the extent that you feel comfortable?
5. What has it been like for you to become a new mother?
6. Who do you consider your most important sources of support (friends, family, health/social service professionals, spiritual/religious leader)? Can you describe how they have been helpful?
7. What strategies have you used that you have found most helpful?
8. Can you describe your strengths as a mother?
9. 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?
10. Is there anything you'd like to discuss that we haven't yet addressed?

Appendix D

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

Second Interview Guide

Conceptual Model and Guidelines

Prior to the start of the first interview, all participants will have received a Letter of Information and be given the opportunity to ask any questions. After questions are answered to their satisfaction, the women will give written Informed Consent. Both the Letter of Information and the Consent forms will be translated into the woman's preferred languages for the purposes of the research (this information will be obtained during the pre-interview screening during which their eligibility to participate is determined). ***Although formal Consent will not be obtained after the first interview, the women will be reminded about the terms of Consent, including limits of confidentiality and reporting requirements, and availability of supports during any subsequent contact.***

REMINDER TO INTERVIEWERS: Use your discretion to check-in with participant throughout the interview, for instance after a particularly emotional moment.

Before we continue, I would like to check-in with you.

How are you feeling?

Are you comfortable continuing?

I Introductory Comments Prior to Second Interview

General Statements about the Research: Hello, my name is _________. I am a member of the research team looking at the transition to mothering for women who have trauma histories. I will be conducting the second interview with you today. Is this still a good time for you to complete the interview?

IF YES continue with guide.

IF NO schedule alternate interview time.

One last point. I will be checking in with you throughout the interview to ask you if you are still comfortable continuing, or if you would like to take a moment before continuing. As before, I would like to tape record it so that we do not lose any information that you are sharing. I also want to remind you that your story will be shared only within the research team and that your real name will not be used or ever appear in print. After the

interview, we will have the full interview typed out onto paper. During the interview, I may ask some questions or make some comments so that I can better understand what you mean.

Okay, let's begin.

We're particularly interested in your experiences during pregnancy and in the first few months of your child's life.

Support for Participants: You may find talking about your experiences to be helpful and healing but it may also cause some distress. Before we say goodbye at the end of your talk today, we'll talk about how you are feeling. If you would like more support at that time, we will discuss possible options. These can include a referral to a counsellor or traditional healer, or if you are interested, we can refer you to a support group for the women taking part in the research. If you ever feel you require urgent help, please call XXXXXXX.

Do you have any questions about the project at this point?

II Interview Questions (asked with flexibility)

Introductory Comments:

A lot has happened since the last time I say you. Can you tell me how the birth went? You can begin wherever you like and say as much or as little as you feel comfortable sharing.

1. An important part of your experience of being pregnant / having a baby / and becoming a new mother is the kind of = and quality of your - contact with the healthcare providers helping you during this time (doctors, midwives, nurses, social workers and so forth). Perhaps we could begin with you telling me about the care you received up to labour and delivery.

   Prompts

   - Have you been able to get the care that you believe that you need in terms of health provision?
   - If yes, in what way? (describe your experience)
   - If no, can you help me understand what happened and in what way your needs were not met?

- Did you feel understood and listened to by different healthcare provider in terms of your feelings, thoughts and behaviours? Please explain your answer.
- Did you feel that you were in control of what was happening to you in your interactions with the health care providers and the healthcare system? Can you discuss what you mean, and the ways in which you did or did not feel in control?

2. During Labour and Delivery?

Prompts

- Have you been able to get the care that you believe that you need in terms of health provision?
- If yes, in what way? (describe your experience)
- If no, can you help me understand what happened and in what way your needs were not met?
- Did you feel understood and listened to by different healthcare providers in terms of your feelings, thoughts and behaviours? Please explain your answer.
- Did you feel that you were in control of what was happening to you in your interactions with the health care providers and the healthcare system? Can you discuss what you mean, and the ways in which you did or did not feel in control?

3. The last time we spoke you told me about the trauma in your life. Thinking back over your pregnancy now, did you experience any physical sensations that made you recall any past traumatic experiences?

Prompts:

- Thinking back over your pregnancy, in what ways do you think these traumatic experiences may have influenced you during your pregnancy?
- In what ways do you think these traumatic experiences may have influenced the experience of childbirth?
- Can you talk about your thoughts and feelings regarding childbirth and the postpartum (after birth) period?

4. What has it been like for you to become a new mother?

   Prompts:

   - In what ways if any, do you think these traumatic experiences influence your ability to care for the baby?
   - Can you talk about your thoughts, feelings, and behaviours related to becoming a new mother?
   - Can you tell me about how becoming a new mother has affected you?
   - In what ways were your experiences with pregnancy/ childbirth and postpartum / and during the 1st few months of your baby's life similar to or different from what your hopes, dreams and expectations?

5. Can you talk to me about your baby?

6. Can you talk to me about the strategies to get what you needed (emotionally and materially during your pregnancy?

7. Can you talk to me about the strategies to get what you needed (emotionally and materially during the first few months of your baby's life?

8. Can you describe your strengths as a mother?

9. Who do you consider your most important sources of support (friends, family, health/social service professionals, spiritual/religious leader)? Can you describe how they have been helpful?

10. What strategies have you used that you have found most helpful?

11. 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?

12. Is there anything you'd like to discuss that we haven't yet addressed?

Before we end the call, I'd like to see how you are feeling now?

Thank you for sharing this information with me and for taking the time to participate in this study. Should you have any concerns, please do not hesitate to contact myself or the research co-ordinator at: _________________

Goodbye.

CurriculumVitae

Name:	Karen Haines
Post-secondary Education and Degrees:	Western University London, Ontario, Canada 2005 - 2011 BScN
Honours and Awards:	Province of Ontario Graduate Scholarship 2011, 2012 The Edith M. McDowell Entrance Award for Highest Academic Achievement 2011
Related Work	Consultation Liaison Psychiatry Clinical Nurse Specialist St. Joseph's Healthcare Hamilton 2014
	Mental Health Counselor, Hamilton Family Health Team 2013
	Teaching Assistant, 3rd year undergraduate nursing courses. Western University 2011, 2012
	Research associate delivering a health intervention for women after intimate partner violence. Western University 2010, 2011
	Trauma Stabilization Group Facilitator serving homeless women. My Sisters' Place, London, ON 2006, 2010, 2011
	Case Manager, Canadian Mental Health Association Chatham, ON 2007, 2008, 2009
Publications:	Ray, S.L., Haines, K.E., & Longo, M.S.S. (2013). The paradox of military training: Survival on the streets among homeless veterans. In A. B. Aiken & S. A. H. Bélanger (Eds.). *Beyond the line: Military and Veteran Health Research.* (pp.291-306). Montreal, Quebec: McGill - Queen's University Press.