EXAMINING THE RELATIONSHIP OF CHILDHOOD TRAUMA TO THE ATTITUDES OF PREGNANT WOMEN TOWARDS MOTHERHOOD AND THEIR UNBORN CHILDREN IN NORTHWEST AND NORTHEAST FLORIDA

BY

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WE HEREBY APPROVE THE DISSERTATION

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AS PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

PHD IN HOLISTIC CHILD DEVELOPMENT

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ABSTRACT

This dissertation entitled "Examining the Impact of Childhood Trauma History on the Attitudes of Pregnant Women on Motherhood and their Unborn Children in Northwest and Northeast Florida" seeks to add to the growing body of research surrounding childhood trauma, specifically with pregnant women. This study seeks to do so by addressing the following questions: (1) What are the participant demographics in terms of the following: number of weeks pregnant, age range, race, socioeconomic status, educational status, marital status, and county of residence? (2) What is the extent of childhood trauma experienced in Northwest and Northeast Florida? (3) What are the most common instances of childhood trauma in Northwest and Northeast Florida? (4) Is there a relationship between Adverse Childhood Experiences and participant demographics? (5) What insights can be gained from the Pregnancy Related Beliefs Questionnaire regarding the attitudes of pregnant women towards themselves, others, pregnancy, their babies, and motherhood? (6) Is there a relationship between the ACE scores and types of the participants and the attitudes of pregnant women regarding themselves, others, pregnancy, their babies, and motherhood in Northwest and Northeast Florida?

This research was guided by a theoretical framework of trauma as it relates to the holistic development of the individual. Trauma relates to interpersonal relationships, attitude, cognitive, emotional, physical, and spiritual development. Bowlby's Attachment Theory, Piaget's Cognitive Development Theory, and Fowler's Theory of Spiritual Development work in conjunction to form the framework of this research. Additionally, the biological development of pregnancy was utilized to inform the research. Conceptually, the extent of trauma experienced by the individual

in development will influence this individual as a mother and her attitude towards mothering and her child.

In order to answer the questions posed, this research employed a mixed methods study using quantitative and qualitative measures. In Phase I of the research, fifty participants were offered the Adverse Childhood Experiences survey and the Pregnancy Related Beliefs Questionnaire. They also were given a survey of demographic information to answer. These results were scored and their responses categorized to determine possible attitudes. Frequency and percentage were used to answer questions one, two, three, and five, while Chi-Square Test was applied for question four. Question six was analyzed using analysis of variance (ANOVA) and standard deviation. A p-value of <0.05 indicates correlation. In Phase II, twelve participants were interviewed to gain additional insights into childhood trauma and attitude. These responses were examined for themes and integrated with the data to form a narrative surrounding attitude and trauma.

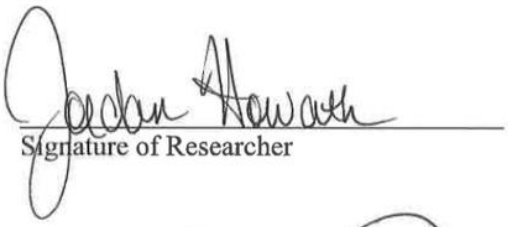
This research found that of the fifty participants, thirty-nine had an ACE score of at least 1 (72%). The majority of the fifty participants are between the ages of 18 and 26 (53%), while most participants are in the first or second trimester of pregnancy (65.4%). The ACE scores of the participants ranged from 0 to 10, with the most common ACE score to be 0 (28%) or 1 (28%). Twenty-six percent (26%) of participants had 4 or more ACEs. The most common ACE Type was Parental Divorce/Separation (52%) followed by Substance Abuse (32%). Using Chi-Square test, a correlation was found between length of pregnancy, sexual abuse, and mental illness. A correlation was also found between race, in particular white women, and verbal abuse, physical neglect, and mental illness. Marital status correlated with parental separation and divorce, domestic violence, and incarceration.

Based on frequency and percentage, when PRBQ results were examined, the overall responses of all participants indicated a positive attitude towards the Self (13 of 25), Others (5 of 8) and Pregnancy (2 of 2). The overall responses of all participants indicated a negative attitude towards the Baby (6 of 11), indicated by attitudes more likely to be change-resistant. The overall attitude towards Motherhood could not be determined because there was a tie between change-receptive and change-resistant attitude responses (4 and 4). Analysis of Variance (ANOVA) was used to determine the p-value (<0.05) when evaluating the correlation between ACE Type and Attitude. A correlation was found between Attitude Regarding the Self and physical abuse, sexual abuse, physical neglect, parental divorce and separation, domestic violence, substance abuse, mental illness, and incarceration. For Attitude Regarding Others, there was a correlation with physical abuse, sexual abuse, divorce and separation, domestic violence, substance abuse, mental illness and incarceration. For Attitude Regarding Pregnancy, a correlation was found with physical abuse, physical neglect, substance abuse, mental illness, and incarceration. For ACE score and attitude, it was found that as the ACE score of the participant increased, the attitudes regarding the self, others, and pregnancy became more negative.

The participant interviews demonstrated that although childhood trauma is pervasive and impactful, all women want to create a better life for their children than what they experienced.

CERTIFICATION OF PROOFREADING

I, Jordan Horvath, certify that this dissertation has undergone proofreading and editing by Stephanie Pippin, an authorized proofreader of the Asia-Pacific Nazarene Theological Seminar



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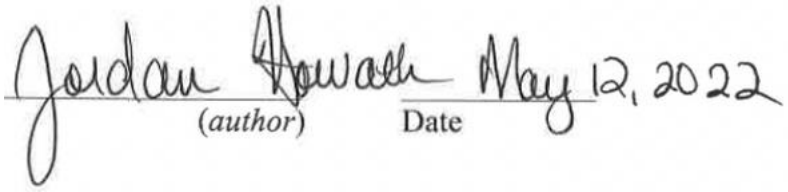

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DEDICATION

For David, Joshua, Jasper, Hannah, and Emily… the little ones who taught me how to love.

For the children of Gentle Hands in Metro Manila, Philippines… the little ones who taught me to pray.

For the children of the Graduation Assistance Program and Holmes County High School in Bonifay, Florida… the ones who have taught me that love is a choice.

For the brave women who have chosen to share their stories with me. . . . The ones who have taught me to persevere through trials and look forward to the joy ahead.

For Boaz Joseph, Piper Joy Llewelyn, and other children the Lord may choose to give us… being your mother is the honor of my life. You have taught me to give of myself as never before, and you are forever my heart. There will never be a moment when I am not grateful for the gift of loving you.

For Jesus… all honor and glory belongs to You. All my heart can do is say, "Thank you." You are worth it all.

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In 2014, I wrote in the Acknowledgments of my Master's Thesis, "I am a product of the word 'Yes.'" In 2022, this statement is truer than it has ever been. When I began this program, I had no idea of the twists and turns, the joys and losses, and the complete changes my life would undergo. This dissertation would not be completed without the "Yes" of many around me who have served to support, mentor, and encourage me.

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LIST OF ABBREVIATIONS

ACEs	Adverse Childhood Experiences
CDC	Centers for Disease Control and Prevention
HHS	U. S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
IPT	Interpersonal trauma
NIMH	National Institute of Mental Health
SAMHSA	Substance Abuse and Mental Health Services Administration

CHAPTER I

THE PROBLEM AND ITS BACKGROUND

Introduction

On May 4, 2020, my life changed forever. Before 10:01 p.m. on that day, I had only imagined the moment when I would hold my child in my arms for the first time (Throughout this study, the reader will note the choice of the researcher to use the word "he" most frequently when referring to a child. This is because this research was conducted and written with the researcher's son in mind and is not meant to exclude the idea of female children. This is simply the preference of the researcher based on personal experience). For most of my life, he had only lived in my imagination. A positive pregnancy test revealed the longing of my heart would finally be coming true. For forty weeks, as my body stretched and grew, I imagined his face. I watched his little body dance across the ultrasound screen and held my breath as I listened to the steady drum of his heartbeat. I imagined how it would feel to hold him in my arms and to kiss his cheeks. I dreamed of the first time he would smile, of giving him baths, and celebrating every new milestone. Finally, after twenty-two hours of labor and an hour and a half of pushing, my son was born. I wept as he was laid on my chest, and I heard his cries. "Finally," my heart cried as this longed for little boy was now resting in my arms. He was perfect in every way, already with chubby cheeks and a head full of blonde hair.

As meaningful as this day was for me, my journey of motherhood did not begin when my son was placed in my arms. It did not even begin the moment I found

out I was pregnant with him. This journey began long before. I would argue I have been preparing to be a mother my entire life. While common, well-meaning statements romanticize a mother being born along with her child, almost like a re-birthing of sorts, motherhood is not a blank slate. Just as one would not arrive at a new place without luggage, the destination of motherhood comes with baggage.

It is true that motherhood is a new beginning and does completely change one's life, but it does not occur in a vacuum. Any personal issues I had before I became pregnant did not immediately melt away. For example, two months before my due date, the world shut down with the emergence of the COVID-19 virus. While the pandemic has touched everyone in different ways, for me personally, it meant canceled baby showers, job uncertainty, and hospital restrictions. My husband and I isolated ourselves in our home, terrified of the possibility of contracting the disease and being separated from our son. Instead of being excited about the birth of my baby, increasing anxiety and fear threatened to overwhelm me. My own history of trauma pressed into my thoughts and behaviors. After his birth, the anxiety and stress still remain, and I have to fight not to allow the fear and anxiety to invade my heart and mind.

I am well aware of my potential as a mother to influence the life of my son. As he grew in my womb, I was careful of my words towards him, wanting him to hear blessing and joy. As his mother, I have the ability to instil courage and hope in him. I am the gatekeeper of my home, managing what I allow to influence him. However, even if I make sure unhealthy food never passes his lips and his entertainment choices are strictly monitored, it will all be for nothing if I as his mother spill out my own insecurities, struggles, and traumas.

As a school social worker, I interact daily with students who are working through mental health crises and the demands of academic and social pressures. They are often suffering the consequences of making bad choices, such as choosing to break the law by using drugs or committing acts of violence. A predominant problem, perhaps the most glaring of all, is the impact of the parents of my students on their lives. Over and over, students come to my attention due to behaviors such as self-harm, suicide attempts, grief and loss. These issues are often traced to issues in the home, particularly with the parents.

Many of the students I work with have parents who have made terrible choices that negatively affect their children, and this agrees with van der Kolk's (2005) findings that most trauma begins at the home. D'Andrea et al. (2012, 187) regard childhood exposure to these negative experiences, or trauma, as "extremely common" and an "epidemic." The negative experiences result from various choices including substance abuse and alcoholism. These children know their parents chose addictions over the safety of their own children. There are parents who struggle with mental illness. There are parents who are divorced, and the divorce did not end well, resulting in the child's divided loyalty and guilt over the family's situation. There are also parents in prison and parents who have chosen to leave their families. There are mothers who repeatedly choose partners who are neglectful and abusive towards their children, and they do not have the strength to leave. Surprisingly, I also see many children affected by parents who, on the surface, appear as though they have their lives together. Yet their children are suffering because of the expectations, anxieties, and fears of their parents and the burden this places on them.

Parents directly affect the health and well-being of their children. Parenting is an incredible responsibility where human beings are entrusted with the nurture and

care of other human beings. In this role, parents must not only provide for the physical needs of their children but also the emotional, cognitive, and spiritual needs, making sure their children can grow into functional adults. Phua et al. (2020) found that positive maternal mental health leads to improved birth outcomes, academic achievement, and socioemotional function. Wilson and Prior (2011) write those high levels of father involvement led to significant and desirable outcomes in the lives of their children. It takes time to become a parent and to learn how to parent well. The role of the parent must be one of constant willingness to evolve and grow. Parenting involves an incredible amount of self-awareness and a willingness to examine what is working and effective and what is not. Humility to admit when methods have failed and the courage to try new things, set boundaries, and be present for their children are qualities needed in order to be a successful parent. Parenting is not for the faint of heart.

Trauma

One of the greatest obstacles to self-awareness, and indeed one of the greatest obstacles to effective parenting is the parent's history of trauma. Trauma includes an experience that overwhelms the person to the point where he or she feels as though the nervous system is beyond the ability to cope. This can include having a parent with mental illness or substance abuse issues, experiencing multiple moves as a child, suffering from abuse, abandonment, or neglect, or even the parent's own experience in the womb. Trauma, especially trauma that is experienced early and frequently, has the capacity to rewire the brain and alter the individual's perception of the world. If an individual is unaware of how these experiences have impacted him or herself, there is danger of passing along negative coping skills and behaviors to his or her children.

I believe strongly that mothers have a tremendous responsibility to understand the ways we are impacting our children. Even if our own childhoods were less than ideal, we can change the directions of our families. Every day, I meet with students who are suffering mentally, emotionally, and sometimes even physically because their own mothers were not able to recognize and heal from their own trauma histories. Fortunately, this does not have to be the case. Just because a mother endures trauma as a child does not mean her children are destined to suffer a fate of abuse, abandonment, or neglect. Every mother has the tools needed to be a good parent, regardless of her social or economic status.

In order to create healthy families and ensure the next generation is healthier than the previous, there must be an opportunity for healing to take place. When I became pregnant, I became very aware of my own trauma and how this was impacting my ability to bond with my child, enjoy my pregnancy, and look forward to life as a mother. Trauma impacts the individual's belief system about herself and the world around her. Trauma can teach the individual she is not safe, those around her cannot be trusted, and she cannot trust herself. It can teach her that people always leave, and to be loved is to be abandoned. These beliefs, even if they are not conscious, can have detrimental consequences to the relationship between a mother and her child.

Personally, a lesson my trauma taught me is that I will negatively impact others around me, and something bad will occur at any moment. When I am not aware of my trauma, then I will subconsciously pull away from my child and not make an effort to bond with him, for fear that I will damage him or he will be pulled away from me. Because I am aware of my trauma and its impact, I have made personal steps to work towards healing and to protect my relationship with my son. These

decisions include seeking professional counseling, attending church regularly, surrounding myself with a positive community of other women who will encourage me, and pursuing self-care.

Interventions and Awareness

My desire is to help other women, especially young women, who are becoming mothers to be the best mothers they can be for their children. Our children display the symptoms of our trauma, and often help is not received until the child is demonstrating these symptoms such as disruptive behavior or signs of abuse. Even then, the child is still the one treated rather than the source of this issue, the parents, and for the purposes of this research, the mother. However, by understanding the impact of trauma on mothers even while they are pregnant, opportunities for healing and interventions can be provided to benefit the holistic health and well-being of the family. Further, this research will examine a small area where a woman's trauma history can impact her ability to parent: attitude. A woman's attitude towards pregnancy and her unborn child can affect how she views herself as a mother and how she parents her child.

If healthcare professionals, educators, and service providers have an understanding of how trauma impacts the mother's attitude about her pregnancy and unborn child, then there will be more opportunities created to provide well-informed teaching, healing, and hope for clients. Often, we are not aware of our own issues until someone helps us become aware. This research will seek to understand the scope of the problem so interventions can be created to best address the needs of clients in ways that are effective. The research can also be used to help identify where there are holes in the client's understanding and resources. First, there must be research to demonstrate trauma's impact on the mother's attitude about her pregnancy and child.

Background of the Problem

In the United States, there are multiple resources for women when they become pregnant. The first resource is medical care, as pregnancy is typically classified as a medical event first. In a report completed by the Centers for Disease Control and Prevention (CDC), seventy-seven percent of pregnant women receive medical care in the first trimester of pregnancy, with only 1.6% receiving no care at all (Osterman and Martin 2018). Most American women receive their care in the office of a private physician who then oversees their labor and delivery in a hospital, with payments usually done through insurance, either government or private (Fetters and Srinivasan 2021). The typical schedule of check-ups and doctor appointments is once a month for weeks four through twenty-eight, twice a month for weeks twenty eight through thirty six, and weekly for weeks thirty six to birth (HHS 2019). These appointments include monitoring the health of the mother and the baby using procedures such as checking blood pressure and weight, checking the baby's heart rate, and measuring the growth of both mother and child. Ultrasounds are also included to further monitor the child's development and anticipate challenges.

In addition to medical interventions, there are economic and social interventions provided, and these are often administered at the state level. The state of Florida, where this research is located, has a Department of Health that can help women navigate the resources they need. These include Presumptive Eligibility for Pregnant Women, which is temporary coverage for medical expenses, and then Medicaid, federal insurance, to cover the woman for the rest of her pregnancy (Florida Health 2020). Another program available for eligible pregnant women and children up to age three is Healthy Start. This is a free home visiting program that provides education and care coordination to reduce the risk factors associated with

preterm birth, low birth weight, infant mortality, and poor developmental outcomes (Florida Health 2020). This program includes prenatal and parenting education, stress management education, care coordination, and reproductive planning.

Further, there are other programs which women can avail for assistance and support. These include the Women, Infants, and Children (WIC) program, which offers nutritional food and education (American Pregnancy Association 2021). Temporary Assistance for Needy Families (TANF) provides temporary financial assistance while helping the client find a job (American Pregnancy Association 2021). Supplemental Nutrition Assistance Program (SNAP) provides low-income and no-income families with assistance to buy groceries (American Pregnancy Association 2021). In regard to housing, the Section 8 Housing Program helps those with low income with rental expenses to be able to afford housing (Department of Housing and Urban Development 2021).

There is a wealth of information for women available regarding their pregnancy. Where women in previous generations would have needed to read books on their own or relied on their doctors and community to disseminate information regarding pregnancy, information is now abundant. There are apps available for downloading on a phone or tablet featuring week by week updates on the pregnancy's progression. Newsletters, blogs, websites, and social media provide insights and details about pregnancy, as well as additional sources for establishing community.

Indeed, information regarding pregnancy abounds. Rarely are pregnant women seen smoking or drinking alcohol because of public awareness regarding its dangers. Resources are available as well for women who struggle financially. Even if a woman is not in need of financial assistance, her community will often step in to celebrate and affirm the arrival of a new baby through the giving of gifts. Pregnancy is culturally

celebrated as a time of anticipation of new life, with the focus becoming increasingly placed on the mother and her changing life.

With the abundance of information about pregnancy comes an increased awareness of the darker sides of pregnancy. One of these includes Perinatal or Postpartum Depression. According to the CDC, one in eight women in the United States experiences symptoms of postpartum depression (CDC 2020). This is a mood disorder that occurs during or after pregnancy and includes symptoms such as feelings of extreme sadness, anxiety, and fatigue that make it difficult to carry out daily tasks, including caring for themselves or others (National Institute of Mental Health 2021). While women do experience tiredness and the effects of hormone changes during pregnancy and after giving birth, perinatal depression's symptoms last well past the early weeks following giving birth. In some instances, a woman may need the help of medication to overcome her symptoms. This illness can affect women from every economic, racial, and social background, and increased education has been geared towards de-stigmatizing the illness.

While pregnancy has been viewed predominantly as a medical issue, the economic, cognitive, and social resources available are providing a more holistic view. Yet, there is one issue that is not being addressed in intervention programs, education, and consideration for assistance. Poverty, unhealthy lifestyles, environmental factors, family conditions, and even mental health are all symptoms being treated. However, if the community desires to raise a healthy generation, then the root causes of the issues must be addressed.

One such root issue is trauma. While previously considered only to refer to physical wounding, the definition of trauma has been expanded to include emotional and psychological wounds. Trauma is described as an emotional response to a terrible

event (American Psychological Association 2021). The true definition of trauma is difficult to explain because there is no consensus definition of trauma. Trauma has been associated with Criterion A and trauma-related disorders under the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* which includes symptomatology, as well as a broader phenomenon including all human suffering (Krupnik 2019). Even though there is no consensus definition, it is important to consider that trauma includes the individual's experience as it can be physically or emotionally harmful or life threatening and can have lasting effects on the individual's functional, mental, physical, social, emotional, or spiritual well-being (American Psychological Association 2021). Trauma is rampant and not limited to a specific population. More than two-thirds of children have experienced trauma before the age of sixteen (SAMHSA 2019). Approximately 7.8 million children were involved in child abuse reports; however, only 3.3 million children received services (American SPCC 2021). Childhood trauma can lead to higher levels of substance abuse in adults, early onset adult depressive, suicidal, and personality disorders, and adverse cognitive development and academic performance (Delima and Vimpani 2011, 47). The effects of childhood trauma do not remain in childhood. These children grow up and become parents.

The highest rate of child abuse in children occurs under age one (26.7 per 1,000), when children are at their neediest, most dependent, and most vulnerable state (American SPCC 2021). While this is based on the general population, it leads to the question, what are we missing? Most women have experienced nine months of prenatal care, are attending regular pediatric appointments, and still, children in their first year of life are at their highest risk for abuse and trauma. We are offering a

wealth of training, resources, and education for women to become the best mothers they can be, regardless of income level. Still, our children are suffering.

This leads the researcher to examine the possibility for interventions to be provided to the pregnant mother before she gives birth to her child. While medical, social, and economic interventions are being offered, and screenings have been put in place to determine perinatal depression, the root issue of trauma is not being addressed even in the best of circumstances. On a personal note, this researcher experienced nine months of prenatal care, had private insurance, delivered at a small Catholic hospital with an attentive hospital staff and wonderful doctor, and never once was the issue of childhood trauma mentioned. Work must be done to understand the impact of childhood trauma on the attitude and outlook of a mother on her pregnancy and unborn child. Doing this will also help bring awareness to women who may not need financial assistance but are still at risk because of unaddressed childhood trauma. Many women may not even be aware of their own outlook toward their children and how their own histories affect their present reality.

Therefore, the researcher will explore this area in the hopes of gaining insights that will lead to interventions that can be implemented while a woman is expecting her child. This will help her gain awareness of her own deficits in emotional healing and preparedness. Further, it will help her be a better mother as she will be able to parent with hope and confidence, rather than anger, anxiety, and depression. She will also be able to recognize the potential for trauma to affect her children and provide interventions for them should they experience trauma. It will also help prevent abuse by empowering her to understand the impact of trauma on her own life and raise her children with brighter futures.

Further, from a spiritual perspective, healing from trauma is very close to the heart of God. Throughout Scripture, God rescues his people from trauma and restores them to healing. Since the original trauma of sin and separation in the garden of Eden, God has been weaving a story of rescue and healing for his people, culminating in His own Son experiencing the trauma of the cross. Isaiah 53 states it is those very wounds Jesus suffered that bring healing to all (Isaiah 53:5). Through His wounds and then resurrection, all men and women have the possibility of achieving spiritual peace. Yet, God does not offer only spiritual healing. He also restores holistically. Throughout Jesus's time on earth, he healed the sick and disabled, forgave sins, and restored people back to their communities. God is personally invested in the healing of His people. As followers of Christ, we also have the tremendous responsibility to provide opportunities to promote healing from trauma and influence the next generation.

Theoretical Framework

This study is guided by the assumption that there are multiple factors and theories determining a woman's attitude towards her pregnancy and unborn child, but childhood trauma relates to all of these factors. Trauma influences the development of the child. The child then grows up to become a mother. Pregnancy is a biological event, but it also includes emotional, cognitive, and spiritual transformations, wherein a woman is influenced by the events and relationships of her past, as well as her present. Her pregnancy is also largely influenced by her environment. A history of childhood trauma relates to all of these factors.

Trauma and Interpersonal Relationships

The interaction between trauma and the individual can be viewed through the context of relationships, with the self and with others. While trauma, depending on the event, can leave physical wounds and scars, trauma also influences the individual emotionally, cognitively, and spiritually. Terr states trauma occurs when a "sudden, unexpected overwhelming intense emotional blow or a series of blows assaults the person from outside… they quickly become incorporated into the mind" (Terr 1990, 8). Van der Kolk (1989, 393) expounds that both internal and external resources are inadequate to cope with the external threat. Bloom (1999, 2) takes these concepts further and explains that damage resulting from trauma is in how the individual's mind and body reacts in its own particular way to the traumatic experience in combination with the unique response of the individual's social group. The effects of childhood trauma are not only situated within the child, but also influence those around him or her (Lewis 2009, 14).

Trauma, especially of the sort arising from interpersonal violence and exploitation, can have a highly negative effect on its victims' capacity to develop and maintain relationships (Pearlman and Courtois 2005, 449). Betrayal trauma theory adds to the definition of trauma in that it includes occasions when the people or institutions we depend on for survival violate us in some way, including childhood physical, emotional, and sexual abuse. It posits that there is a social utility in remaining unaware of abuse when the perpetrator is a caregiver, and in some circumstances, detecting the betrayal may be counter-productive to survival (Freyd 2003). This can help the reader to further understand why a victim may be hesitant to name abuse when it has been done by a family member or caregiver, as this leads to a betrayal of trust by the caregiver, and also a betrayal of the victim in "snitching" on

the caregiver and acknowledging abuse has occurred. Betrayal trauma theory classifies these types of betrayal trauma into high, medium, and low betrayal (Freyd, DePrince and Gleaves 2007, 307). The lowest betrayal items include witnessing the attack or death of someone not close to the individual, and the highest betrayal includes emotional abuse and sexual abuse by a close adult.

Trauma and Attitude

This research is primarily concerned with trauma's relationship to attitude regarding a woman's pregnancy and her subsequent child. Attitude is the relationship between a person and an object or set of objects (Woelfel and Haller 1971, 75). This relationship is assumed to be conceptual, based on the person's concept of himself and the concept of the object (Woelfel and Haller 1971, 75). Eagley and Chaiken further define attitude as a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor. Attitude is not fully developed until the object is first encountered and then is responded to on an affective, cognitive, or behavioral basis (Eagley and Chaiken 2014, 414).

Attitude is essential to explore because attitude influences behavior. For the purposes of providing interventions to promote positive behaviors between mothers and their babies, attitude will serve as an important predictor of behavior. Fazio (1986, 212-213) proposes the following model for the impact of attitude on behavior:

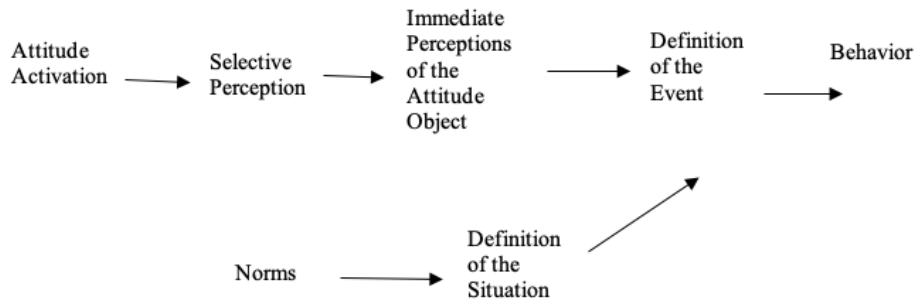


Figure 1. Fazio's Model for Attitude and Behavior (Fazio 1986, 212-213)

According to this model, the attitude must first be accessed and then serves as the filter through which the attitude object is perceived. Fazio (1986, 212-213) proposes that these perceptions can bias the individual towards a positive or negative view of the object. The immediate perception is then influenced by the normative guidelines, or definitions of what is or is not appropriate, around the situation, and these influence the behavior. For example, a woman visits her husband at work at the end of a long day. She regards him positively, and this incites a desire to express affection towards her husband. However, since he is at work, certain forms of expression, such as a kiss or long hug, may not be appropriate according to the guidelines of her husband's work setting. If she ignores normative guidelines, then her husband might not return the behavior, and her attitude regarding her husband can be altered from positive to negative.

When a woman becomes pregnant for the first time, she is encountering an experience she has never directly had before this time. Therefore, attitude will be newly developed. Siebler and Overwalle (2005, 232) propose a connectionist approach where information is encoded in the brain, is activated, and used for attitudinal judgments. Chaiken, Duckworth, and Darke (1999, 121) add that attitudes are a more complex, structural form wherein cognitive, affective, and behavioral associations also appear as object-association linkages. When these linkages are repeatedly consistent, attitudes are stronger. Strong attitudes are stored in object-valence associations that are easily accessible, whereas weak attitudes are stored in weaker associations and are therefore more susceptible to salient temporary information and context effects (Overwalle and Siebler 2005, 232). Attitudes are mostly implicit and non-conscious (Overwalle and Siebler 2005, 233). When an

individual is confronted with the object, their stored evaluation of the object will arise to guide thoughts and behaviors.

Trauma and Development

Trauma's impact must also be understood in conjunction with the guiding theories of development. Attachment theory closely works with attitude and trauma. Bowlby (Bretherton 1992) proposes the idea of the inner working model of individuals, the narrative by which individuals view the world and in particular, the caregiver. The secure inner working model says of the caregiver, "She/He is there for me when I need him or her" (Bretherton 1999, 347). This person responds when help is needed, and the child can rely on this individual to meet needs. The insecure model doubts or mistrusts the caregiver and his or her ability to care for the child. This inner working model affects the child's assumptions about the world around him, including future relationships. This child's attachment behavior will moderate the eventual adult's attitude towards forming relationships as the caregiver.

This research also relies on Piaget's Theory of Cognitive Development and an awareness of trauma's impact on cognitive development. Piaget (Piaget and Inhelder 2000) names four stages of development: Sensorimotor Stage (Infancy); Pre-Operational Stage (Toddler and Early Childhood); Concrete Operational Stage (Elementary and Early Adolescence); and Formal Operational Stage (Adolescence and Adulthood). Learning develops over time as the child begins interacting with his environment through the senses and then is eventually able to think in abstract concepts as an adolescent and adult. Trauma and stress can lead to long term memory deficits if the stress occurred during a time when the hippocampus is not yet fully mature and vulnerable (Nelson and Carver 1998, 804). Trauma can impact memory and brain development, which will be explored further in the review of literature.

Other theories guiding this research include Erikson's Theory of Psychosocial Development and Fowler's Spiritual Development Stages. Erikson based his theory on eight stages of growth from birth to late adulthood (Erikson 1980). Each stage revolves around a crisis that must be resolved in order to move to the next stage. Of particular concern for this research will be the first stage of development, which lasts from birth to about two years. During this stage, the primary task, or conflict to be resolved is whether or not the child can trust his caregivers and his environment. If the child is able to trust, then the child achieves "virtue." Each new stage is based on the strengths acquired as a result of the way in which the previous stage is negotiated and the way in which the self is regulated (Batra 2013, 256). The ability to develop trust relies heavily on the caregiver and how the caregiver meets the needs of the child. If the caregiver has a negative attitude towards the child based on her own negative experiences and inability to develop trust, then a cycle of an inability to develop full maturity occurs in the family.

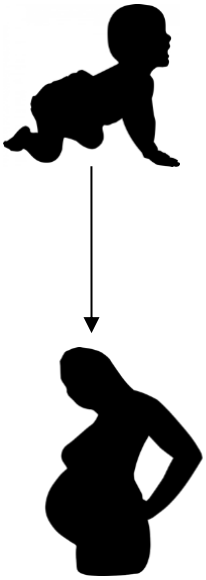
According to Fowler, individual faith development reflects a 'meaning-making" process in which individuals seek to understand their own lives and the values and commitments that guide them (Cartwright 2001, 216). Faith begins with basic trust … as the child matures, physically and emotionally, faith accommodates the development of an expanding range of object relations, and exposure to religious symbols and practices may nurture a sense of relatedness to the transcendent (Fowler 2006, 36). The goal of these stages is for the child to move from an initial stage of primal faith at birth to a universal faith as an adult where there is "exceptional in the strength of [his or her] passion that all creation should manifest God's goodness and that all humanity be in one peace" (Fowler 2006, 41). For the child to be able to

mature to this stage, there must be a foundation of trust with the caregiver so this trust and internal self reliance can be manifested spiritually.

Finally, this research will be guided by the exploration of biological development in both the body of the pregnant woman and her unborn child. This is important because the impact of childhood trauma influences the body and its ability to regulate. Children who have experienced trauma lack the perspective of seeing themselves in a larger context, and have no choice but to see themselves as the center of the universe (Van der Kolk 2005, 404). If this insight perpetuates itself to adulthood, then this will impact the mother's behavior towards her child during pregnancy. She may be unable to see the impact of her attitude, and thus behavior towards the child and make decisions to put the child at risk, including drinking alcohol or engaging in risky behaviors. The developing child is dependent upon the mother's ability to regulate herself. The mother's attitude towards her changing body and this pregnancy can also be affected by traumatic events such as a previous miscarriage or stillbirth, as well as her perception of a previous abortion.

Conceptual Framework

The following diagram illustrates the connection between childhood trauma and a mother's attitude towards her pregnancy and unborn child that will be explored through the course of this research:



Childhood Trauma Experience
Attachment
Biological Development
Cognitive Development
Spiritual Development
Relational Development

Maternal Attitude
Positive: More likely to experience healthy holistic development; change receptive
Negative: Less likely to experience healthy holistic development; change resistant

Figure 2. Childhood Trauma and Prenatal Attitude Conceptual Framework

This diagram focuses on Childhood Trauma Experiences as the umbrella covering the various facets of child development. Childhood trauma influences the biological, spiritual, cognitive, and relational development of the child. A higher number of traumatic experiences, especially those not met with interventions will lead to a higher negative outcome in the child's development.

As the child who has experienced trauma grows to become a woman and becomes pregnant, trauma's relationship to these areas of development will influence the woman's attitude towards her child. Her attitude can be positive, meaning she has a favorable attitude towards the child and her pregnancy signified by nurturing and affectionate thoughts, feelings, and behaviors towards the child and herself. This is also indicated by an attitude that is willing to change and remain flexible as she encounters new experiences with her pregnancy and child. In contrast, her attitude can be negative with the lack of nurturing and affectionate thoughts, feelings, and behaviors. This can be noted by a change-resistant attitude, which remains rigid and unwilling to bend when processing new information. The mother's attitude will influence her interactions. For example, a newborn baby cries because he is hungry. A

positive attitude regarding her child could be illustrated as the mother picking up the child and immediately feeding him to soothe his cries. This is attachment promoting and will lead to the child developing trust and security in the parent-child relationship. However, a negative attitude can be illustrated as the newborn baby crying because he is hungry and the mother delaying her response because she does not perceive his needs as important or assuming the child is crying because he needs attention and ignoring the cries. These are attachment diverting behaviors that are influenced by attitude and will lead to the child developing mistrust and insecurity in the environment.

Statement of Purpose

The purpose of this study is to explore the prevalence of childhood trauma history of pregnant women and the relationship of this history to their attitudes towards their unborn children. This research will provide insight into interventions that can be provided to pregnant mothers to increase their likelihood of positive attitudes about pregnancy and motherhood, ultimately resulting in secure and positive relationships with their children.

Statement of the Problem

This study investigates the question: What is the relationship of childhood trauma history to a pregnant woman's attitude toward motherhood and her unborn child in Northwest and Northeast Florida?

Research Questions

This research will employ a mixed methods study, utilizing qualitative and quantitative methods. The research will be guided by the following questions:

1. What are the participant demographics in this study in terms of the following:
    a. Length of pregnancy (in weeks at the time of participation)
    b. Age Range
    c. Race
    d. Socioeconomic Status (Annual Household Income)
    e. Educational Background
    f. Marital Status
    g. County of Residence
2. What is the extent of childhood trauma experienced by pregnant women in Northwest and Northeast Florida?
3. What is the most common instance of childhood trauma experienced by pregnant women in Northwest and Northeast Florida?
4. Is there a relationship between Adverse Childhood Experiences (ACE) and the reported participant demographics?
5. What insights can be gained from the Pregnancy Related Beliefs Questionnaire regarding the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves in Northwest and Northeast Florida?
6. Is there a relationship between the ACE score and ACE Type of the participant and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves in Northwest and Northeast Florida?

The demographic information in Question 1 will be used to enhance the overall data; Question 2 asks for the extent of childhood trauma experienced. This will be based on the ACE scores achieved by participants; Question 3 asks for the

most common instances of childhood trauma. This will be determined by examining the most common incidences of childhood trauma based on the types of ACEs indicated by participants; Question 4 asks if there is a direct relationship between ACE score and participant demographics. Demographic information will be used to establish patterns and connections; Question 5 asks what insights can be gained regarding the attitudes of the women in the counties listed. This will be determined by examining the results of the Pregnancy Related Beliefs Questionnaire; Question 6 asks if there is a correlation between ACE score, ACE Type, and the attitudes of pregnant women. This will be determined by comparing the results of the ACE survey with the results of the PRBQ. The results of participant interviews will be integrated throughout these responses to support the data.

Statement of Null Hypotheses

1. There will be no relationship between the participant's adverse childhood experiences and the following demographics: number of weeks pregnant, age range, educational background, socioeconomic status, race, marital status, and county of residence.
2. There will not be a correlation between the ACE type of the participants and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves.
3. There will be no correlation between participant ACE score and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves.

Significance of the Study

I am aware of the seeming contradiction between completing a doctoral program in Holistic Child Development, yet focusing the dissertation on adults, and in this case, pregnant women. This study will contribute to the field of Holistic Child Development and provide helpful information to those who work with children and their families in a myriad of ways. White (2014) notes that the principles of child development focus on the well-being of the whole child. This includes the spiritual, physical, cognitive, and emotional aspects that make up the child as a complete person. The child is not born unaffected by his time in the womb. Emerging through the birth canal does not mean the child is baptized into a new life. To practice holistic child development means to consider conception and pregnancy as part of childhood. This study will add to the growing body of research surrounding pregnancy and will help provide insight into methods that can be used to help the child and the mother.

To the extent of my knowledge, there is little scholarly research that has been done with a focus on participants in the counties of Northwest and Northeast Florida within the last ten years. I have consulted search engines Google Scholar, JSTOR, ERIC, EBSCO, and the digital libraries of Florida State University, University of Florida, and the University of West Florida. This will be discussed further in the review of literature. This is especially of note in regards to pregnancy and childhood trauma. There is a lack of representation in scholarly works regarding rural communities in the United States, and in this case, in Florida. This research will contribute to the study of women and pregnancy in rural communities in Florida and other similar regions.

Further, this research will seek to determine the relationship of childhood trauma history to the attitude of a pregnant woman towards pregnancy and her unborn

child. Pregnancy is a delicate time of change and transformation in the life of a woman, and this research seeks to honor this time and the role it plays in the shaping of a mother and child. It is well known that the mother passes her genetics to the child. Research has indicated that a mother's physical and psychiatric states during pregnancy have a significant impact on the development and function of fetal organs and can lead to long term adverse health outcomes (Page 2018). However, there is little research on the relationship between trauma and attitude, specifically of a pregnant woman. Just as the child does not emerge from the womb free of consequences, the woman does not become a mother without being affected by her past.

An additional significance of this study is the development of a deeper understanding in regard to Christian faith and the care of pregnant women as they grow their families. It is significant that Jesus, the central figure of Christianity, was born through a woman. He could have simply appeared; however, the plan for the redemption of mankind was set in motion with a pregnancy, indicating its significance in the holistic development of the person. Further, Scripture indicates that Jesus grew holistically in wisdom (cognitive), stature (physical), and in favor with God (spiritual) and man (social or emotional) (Luke 2:52). In order to do so, God placed Jesus in the care of a mother who would continue to be a significant figure throughout his life and up to his death. Scripture affirms the health of communities, and displays an understanding of the impact of choices on subsequent generations. From a spiritual perspective, the holistic health and well-being of the mother leads to the holistic health and well-being of the child.

Above all, this study seeks to honor the role of mothers in the lives of their children, as well as lend a platform to their voices and lived experiences. This study

also respects the holistic impact of trauma on the life of the individual, as well as the individual's potential for healing. In doing so, this research hopes to contribute to the growing knowledge of trauma so persons of faith and providers may introduce services and interventions to fully support women and their families. This research above all honors pregnant women and their children as individuals with inherent worth and value, made in the image of God, created and called with purpose and for purpose.

Brief Description of the Research Design

This research will seek to explore childhood trauma's relationship to the attitudes of pregnant women towards their unborn children utilizing a mixed-methods study. Participants will be recruited through doctors' offices and pregnancy centers in Northwest and Northeast Florida over a set time period. This research aims to recruit at least 50 participants. Each participant will be identified through her doctor and will receive the Adverse Childhood Experiences Questionnaire (ACE) and Pregnancy-Related Beliefs Questionnaire (PRBQ). Participants will also be given the opportunity to participate in semi-structured interviews related to pregnancy and trauma history. The results of the ACE survey and PRBQ questionnaire will be analyzed based on the appropriate scoring guides. The responses will be examined further in researcher-developed categories. The interview results will be used to create a narrative of responses to further illuminate insights in the data.

Assumptions of the Study

This study makes the following assumptions:

1. The women participating in this study are planning to carry their pregnancies to full term.

2. The women participating in this study are planning to parent their children or relinquish them for adoption or kinship placement.
3. The mother and her unborn child are two separate individuals whose well-being is dependent upon one another.
4. The participants in this study will be honest with their responses.

Definition of Terms

Acute trauma is also known as Type 1 trauma, and it refers to exposure to a single overwhelming event (Wamser-Nanney and Vandenberg 2013, 671).

Attachment refers to a specific aspect of the relationship between a child and caregiver involving the safety, security, and protection of the child (Benoit 2004, 541). Developed from Bowlby's attachment theory, attachment develops between caregiver and child, and the caregiver serves as a secure base for exploration (Bretherton 1997, 34). The child develops an internal working model of the self and caregiver that forms the basis for how an individual enters and maintains other relationships (Bretherton 1997, 35).

Attitude refers to a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor (Eagly and Chaiken 2007, 582). These evaluative responses can encompass a wide range of overt or covert responses expressing approval or disapproval towards the attitudinal object (Eagly and Chaiken 1998, 269).

Child refers to the definition ascribed by the United Nations Convention on the Rights of the Child, Amendment 1, which describes a child as any human being under the age of eighteen (UNHCR 1990).

Childhood Trauma refers to exposure to actual or threatened death, serious injury or sexual violence. This includes direct exposure, witnessing, or learning about

trauma that has happened to a close friend or relative. In children, this also includes motor vehicle accidents, bullying, terrorism, exposure to war, child maltreatment (physical, sexual, and emotional abuse; neglect), and exposure to domestic and community violence (De Bellis and Zisk A. B. 2014, 185-186). Other traumatic events include life-threatening illness, school violence, unexpected death of a friend or family member, and natural disaster (Wamser-Nanney and Vandenberg 2013, 671).

Complex Trauma refers to chronic, interpersonal traumas that begin early in life (Bath 2008, 17). It is also known as Type 2 or developmental trauma, resulting from extended exposure to traumatizing situations (Bath 2008, 17). Child survivors of complex trauma were observed to have greater levels of behavioral problems when it occurs earlier in life than children who experience acute trauma or complex trauma later in childhood (Wamser-Nanney and Vandenberg 2013, 671).

Pregnancy refers to the period when a fetus develops in the uterus of a woman. This time takes about 40 weeks and is measured from the last menstrual period to delivery. There are three segments of time during development known as trimesters, divided from week 1 to week 13 (first trimester), week 14 to week 26 (second trimester), and week 27 to week 40 (third trimester) (National Institute of Health 2017).

Trauma does not have a conclusive definition (Krupnik 2019). For the purpose of this research, the definition provided by SAMSHA will be utilized as it is broad and easily understood. According to SAMSHA (2022), trauma refers to an event or circumstance resulting in physical harm, emotional harm, and/or life-threatening harm.

Scope and Delimitations of the Study

This study was conducted with women from Northwest and Northeast Florida. However, this researcher was not able to interview all currently pregnant women in these areas. Women with the ability and willingness to drive further distances will select doctors and hospitals in various counties. Women also visited pregnancy centers for a variety of reasons including access to prenatal ultrasounds, counseling, and parenting education. This research was conducted with women across all trimesters of pregnancy and will not exclude those who have been pregnant before this study. Women over the age of eighteen who are pregnant were included in the scope of participants. Further, this research welcomed women of all races, marital, and socioeconomic status in order to have a diverse research population for study.

Due to time constraints, this research was limited to the specific time and location of the participants of the study. The data gathered will not be generalized to reflect the attitudes and experiences of all pregnant women throughout all time. This research was also limited to women who voluntarily participate and those who agree to be interviewed. This research hopes to have a diverse research base with participants of various ages, races, and economic status. However, this researcher is limited based on the clientele of the research locations and the willingness of clients to participate.

Overview of the Dissertation

Chapter II represents the critical review of literature related to the following: 1) An overview of trauma and attitude, and theories influencing the development of the child; 2) Empirical studies exploring trauma, pregnancy and attitude formation; 3) the biblical and theological perspectives surrounding trauma, pregnancy, and attitude.

Chapter III presents the research methods and processes involved in conducting this study. It will explain the mixed methods design of the study, along with the Adverse Childhood Experiences Questionnaire (ACE) and the Pregnancy-Related Beliefs Questionnaire (PRBQ), as well as accompanying studies. It will also include the methods used to conduct the research, the results of pilot testing, and a timeline for its completion.

Chapter IV highlights the results of the study, the analysis of data, and their correlation to the hypothesis.

Chapter V gives the summary, recommendations, conclusions, and future directions as a result of the research conducted.

CHAPTER II

REVIEW OF RELATED LITERATURE AND STUDIES

Overview

This chapter provides an exploration of literature related to this study. This research aims to understand the significance of the attitude of a pregnant woman towards her pregnancy and unborn child and to examine the relationship of childhood trauma on her attitude. This study intends to examine this relationship in order to offer insight into the interventions and services that can be provided to women as they prepare to become mothers and raise the next generation. This study assumes that healthy mothers will raise healthy children, and the literature will support this. This review will begin with an exploration of pregnancy itself and end with a discussion of the Bible's narrative of trauma. However, before diving into these topics, there will be a review of scholarly research related to pregnancy, trauma, and the state of Florida. In the following section of this review, "Pregnancy," pregnancy will be summarized regarding the development of both the fetus and the mother of the child. Pregnancy involves the stretching, growing, and changing of both the mother and the fetus. In the next section, "Attachment Theory," the origins of attachment theory and its development across the lifespan will be discussed. As the task of pregnancy also involves bonding, a review of the process of attachment will explore the bonding and connection between the mother and child. In the fourth section, "Trauma," the literature will discuss trauma and its holistic impact in the life of the individual, as well as its impact on pregnancy. The fifth section entitled "Attitude and Pregnancy"

will discuss attitude as it relates to pregnancy and literature regarding how a negative attitude can impact the health and safety of the child. These sections will also demonstrate there is a gap in the literature regarding how trauma history impacts the attitude of a mother regarding pregnancy and her child. The sixth section, "Pregnancy and Children in the Bible" will give an overview of Scripture as it pertains to children and pregnancy. "Trauma in the Bible," the seventh section will explore the narrative of trauma in Scripture and various stories pertaining to this theme. Finally, "Trauma and Healing" will discuss the various ways an individual can work towards recovery from trauma and the unique role the Church can play in helping survivors.

Related Literature in Northwest and Northeast Florida

Based on the efforts of this researcher, it appears that little research has been done in the state of Florida, and Northwest and Northeast Florida specifically, in relation to pregnancy and trauma. There is literature concerning adolescent pregnancy (Pete-McGadney and Heights 1995; Lee and Grubbs 1995; Stoddard 1989). This research involves the experiences of adolescents in regards to seeking prenatal care and the pregnancy experience. Other research involves complications in maternal health related to nutrition (Lyons 1980), sexually transmitted disease (Matthias et al. 2020), and maternal mortality (Roussos et al. 2021). One study was found by Spence and Huff-Corzine (2021) in which the experiences of pregnant versus nonpregnancy-associated intimate partner homicides were studied. Search engines for "trauma and Florida'" yielded results related to physical trauma or trauma units, but this researcher did not find studies related to Florida and childhood trauma specifically.

Pregnancy

Babetin states, “There is no experience in a woman’s life that is more impactful, profound, all-encompassing, and life-altering than becoming a mother” (Babetin 2020, 410). The experience of pregnancy involves the psychological, physical, emotional, cognitive, and spiritual natures of a woman. During this time, a woman’s body becomes a vessel for the growth and nourishment of another human being. Pregnancy is a process of being and becoming that defies the rationalization of temporality and demands a different logic beyond conceptions of individualism, productivity, and efficiency (Matambanadzo 2014, 119). Whether planned or unplanned, all human life begins within the womb of a woman.

Fetal Development

Every month, a woman experiences a cycle of ovulation that ends with either menstruation or pregnancy. Oocytes, or a group of eggs within the ovary of a woman, prepare for ovulation when the mature egg is released from the follicle. The follicle develops into a structure called the corpus luteum. From here, hormones progesterone and estrogen prepare the lining of the uterus to receive a fertilized egg. The Cleveland Clinic (2020) describes the process of fertilization and embryonic development. Fertilization occurs when a sperm penetrates the egg. Within twenty-four hours after fertilization, the egg begins rapidly dividing into many cells. The fertilized egg becomes a blastocyte and continues dividing. As the blastocyte travels down the fallopian tube, it continues to divide until implanting in the wall of the uterus. Within about three weeks, the blastocyte forms into an embryo and the baby’s first nerve cells form. Within about three to four weeks, the hormone human chorionic gonadotropin (hCG), will be detected in the bloodstream of a woman and can be recognized in a pregnancy test.

A full-term pregnancy lasts about forty weeks or 280 days. Pregnancy is divided into three stages, or trimesters, marking different developmental stages for the growing child and mother. During the first trimester, or twelve weeks, the child will develop from an embryo to a fetus with distinguishable baby features. Within the first month, a fluid-filled sac, the amniotic sac grows to cushion the embryo. The placenta will also develop, transferring nutrients from the mother to the baby and transferring waste away from the baby. By the end of the fourth week, the heart tube will beat sixty-five times a minute. Blood cells and circulation will begin. Of significance during the second month is the neural tube, which consists of the brain, spinal cord, and other tissues of the central nervous system. The digestive tract and sensory organs begin to develop, and bones start to replace cartilage. By the end of the third month and first trimester, the arms, hands, fingers, feet, and toes are fully formed. The baby is fully formed as all organs and limbs are present and will continue to grow in order to become functional.

During the second trimester, or weeks thirteen to twenty-six, the baby starts to develop facial features. The mother can also feel the baby's movements and the gender can be distinguished. During month four, the heartbeat can be heard using special instruments, such as a Doppler. The nervous system is functioning, and the reproductive organs are fully formed. The fifth month sees the development of muscles. By the sixth month, the baby can respond to sounds and hiccup. By the twenty-third week, the baby could survive outside of the womb with intense medical intervention. During the seventh month, the baby continues to grow. Hearing is fully developed, and the baby responds to stimuli such as sound, pain, and light.

The third trimester, weeks twenty-seven to forty, is the final stage of fetal development. During the eighth month, the brain is developing rapidly and internal

systems are well developed. By month nine, the lungs of the baby are close to being fully developed. The baby can use his reflexes. Finally, in the tenth month, the baby will adjust in position to be ready for labor, which can occur at any time. Ideally, the baby will be head down in the uterus and will drop into the pelvis to prepare for delivery.

Labor begins either naturally or by being medically induced with the cervix dilating from zero to ten centimeters. It begins when contractions become strong and regularly spaced at approximately three to five minutes apart (Hutchison et al. 2020). The baby moves into the pelvis, and the cervix thins completely to 100 percent effacement. The second stage of labor begins when the cervix reaches ten centimeters, and the baby is delivered. The fetus descends into the vaginal canal and passes from the birth canal through the seven cardinal movements known as engagement, descent, flexion, internal rotation, extension, external rotation, and expulsion. With expulsion, the child fully emerges from his mother's body and is born. The third stage of labor is marked by the expulsion of the placenta. The neonatal cardiovascular system takes over responsibility of vital processes (Tan and Lewandowski 2020). If a vaginal delivery is unable to be performed for various reasons, such as the health and safety of the mother and baby, the baby's positioning in the womb, or mother's choice, then a cesarean section will be performed (Mayo Clinic 2020). This is when the doctor will surgically open the woman's abdomen and remove the child from the uterus.

Labor and delivery transition the mother and child into life outside of the womb. It is an exhausting experience for a baby to be born, especially if interventions and complications occur during birth (Righard 2001, 1). Righard adds that after birth, the baby needs time to recover through skin-to-skin contact or in a bath. The experience of being on the mother's skin, safe and secure, and feeling her caressing

hands is soothing and comforting to the baby. Making the outside world resemble the womb as closely as possible eases the exhausting and difficult transition. This includes dim lighting, quiet, and allowing the infant to nurse after labor (Righard 2001, 1).

Maternal Development

While pregnancy is considered primarily as a medical event, pregnancy is not an illness; it is a physiologic and emotional state of being that is associated with hormonal changes and physical changes brought about by an enlarging uterus (Davis 1996, 80). The female body endures its own process of growing and stretching to make way for the developing infant. The pregnant woman is easy to distinguish by the sight of her growing abdomen. However, the abdomen is not the only growing place. The entire body is changing and making way for the new life being formed. Maternal blood volume increases with a forty to fifty percent increase in plasma. Red blood cell volume also increases by fifteen to twenty percent (Datta et al. 2010, 1-2). Cardiac output increases by about thirty to forty percent, and the maximum increase in heart rate occurs by twenty-four week's gestation (Datta et al. 2010, 2). The increasing size of the uterus puts pressure on the digestive system of the mother, often causing constipation and slower movement of food through the intestine (Datta et al. 2010, 8-9). Other changes include enlargement in breast size and hyperpigmentation of the skin (Datta et al. 2010, 12). In addition to the physical changes, the hormonal changes of pregnancy contribute to mood swings and instability (Davis 1996, 75). Numerous discomforts include weight gain, back aches, stretch marks, nausea, and vomiting (Martin and Varner 1994). The process of creating and bringing a child into the world is not easy on the mother's body.

Pregnancy involves a delicate dance of development between the mother and child that goes beyond the physical changes. Just as the child is formed and must be born, a mother is formed as well. The experience involves what Babetin (2020, 414) describes as "emotional labor," the painful process of leaving behind the woman she once was as her pre-motherhood identity undergoes a death. Inwardly, the pregnant woman tries to identify who she is, the changes that will take place in the family, and the nature of her new role (Davis 1996, 75). Slade and Sadler (2019, 26) describe the changes in this way:

> For the bulk of women, even when they are consciously thrilled to be pregnant, regression, conflict, anxiety, transient depression, emotional lability, and ambivalence are inevitable—and profoundly adaptive, as they prepare the mother for the enormous task before her. . . . Throughout, the mother must grapple with the fact that the child is both a part of and separate from her, a reality she will have to negotiate for the rest of her life (Slade and Sadler 2019, 26).

Changes in personality also occur. Bailey and Hailey (1987) found personality differences in pregnant vs nonpregnant women. In pregnant women, they found stronger introversion, inward personality orientation, and lower levels of self-acceptance and independence. Hennekam (2015) found these changes in personality and identity are better mediated when there is a role model, such as a mother or mentor, involved for the expectant mother.

The Fourth Trimester

Due to the continuous changes in the mother and child, one would be remiss to end the discussion of pregnancy before including the Fourth Trimester, a period of recovery, restoration, and re-imagination (Matambanadzo 2014, 124). It is a transition time, recognizing the physical, social, and psychological aspects of pregnancy that continue beyond birth (Matambanadzo 2014, 127). It begins when labor is complete, and it ends when the woman's reproductive system returns to its nonpregnant state,

usually six to eight weeks after birth (Gruis 1977, 182). Hormonal changes include a sudden drop in estrogen and progesterone once the placenta is delivered (Hendrick et al. 1993, 93). Whether the mother chooses formula or breastmilk to feed her child, this baby is completely dependent upon the mother for survival. Brink adds, "When it comes to time, infants need both quality and sheer quantity. There are no shortcuts. A parent or a consistent, loving caretaker must be there when infants need them. During the fourth trimester, that's all the time" (Brink 2013, 13).

Time is needed as the infant brain is only at twenty-six percent of its full development upon birth (Brink 2013, 13). Almost immediately following birth, the infant brain is busy developing neural connections by laying down a network of dendrites and forming new synapses. Whatever synapses are not used fall by the wayside (Brink 2013, 20). Brink further describes, "A neuron in the eye gets its signal from light… a message travels, via electrical signal from neuron to neuron to the part of the brain specializing in, say, seeing… Then the output side kicks in, sending an outgoing signal to the retina, or the tongue, or a muscle, complete with instructions on how to move, extend, or contract" (Brink 2013, 20).

Survival for an infant in the fourth trimester means being constantly close to a nurturing caregiver. "Human babies pick up on movement patterns, breathing sounds, and body heat, all of which begin to regulate hormonal releases" (Brink 2013, 25). The connection between the mother and her child extends to outside of the womb. While the environment has changed, the need for the infant to be connected and nurtured by the mother does not. The infant relies upon the mother or caregiver to negotiate the world around him. This time of transition from womb to the world requires a close, consistent, responsive relationship between the infant and the mother

(or one caregiver if the mother is not present) that mirrors the biologically binding closeness of the pre-birth relationship (Matambanadzo 2014, 133).

The fourth trimester is a time of intense change for the infant and the mother as well. Pawluski et al. state, "Early motherhood is often a time when women experience a unique sense of happiness, serenity, and personal fulfillment. It is abundantly clear, however, that a significant number of recently parturient women cannot attain these positive states because they struggle with elevated anxiety and depression" (Pawluski et al. 2017, 106). With this intense change comes great risk to the mother and additional stressors. A mother must confront the changes to her body. While the pregnant body is often celebrated, the postpartum body is not. Fox and Neiterman (2015) found that women's perceptions of their bodies were influenced by how well those bodies performed maternal functions. Dubus (2013) elaborates that new mothers experience motherhood and the postpartum period differently than mothers of other times. This is because new mothers must negotiate a change in roles, affiliations, and expectations within societal institutions and social relationships (Dubus 2013, 44). The new mother's life has been completely re-arranged in ways she has never before experienced. She must physically recover from giving birth, care for this human being who is completely dependent upon her for survival, and discern who she is in this new role. Misri et al. (2010) demonstrated that antenatal depression and anxiety, especially in the third trimester, directly impact postpartum parenting stress.

Much research has been done surrounding postpartum depression and anxiety. Postpartum depression occurs in at least one in seven new mothers, usually within the first six months after delivery and the risks to the mother and infant include poor bonding with the infant, lack of self-care, infant neglect, and infanticide (Friedman and Rednick 2009). Postpartum depression predisposes a woman to future

psychopathology, particularly following subsequent deliveries (Hendrick et al. 1998, 99). Symptoms of postpartum depression include excessive worrying, tearfulness, loss of appetite, feelings of inadequacy, insomnia, and a depressed mood. To receive a diagnosis, these symptoms must be present for at least two weeks and interfere with the mother's everyday functional living (McCall-Hosenfeld et al. 2016). Kirkan et al. (2015) found risk factors for postpartum depression include depressive disorder in the first trimester of pregnancy, previous mental disorder, somatic disorder, exposure to domestic violence during pregnancy, the baby staying in an incubator following birth, and not breastfeeding. Other risk factors include depression or anxiety during pregnancy, family history of depression, stressful life events, financial problems, hormonal changes, and lack of emotional support (Friedman and Rednick 2009). Race and ethnicity, pre pregnancy body mass index, lower educational status, and lower socioeconomic status are factors in the development of postpartum depression (McCall-Hosenfeld et al. 2016). Postpartum depression can play a role in the development and nurture of the child, as well as in the mother-child relationship during these critical first few months outside of the womb.

Attachment

Attachment refers to the context in which infants and children seek comfort and protection in distress and the way in which the parent or caregiver responds to this need (Goldberg 2000, 8). This section regarding attachment will explore the theory of attachment, as well as attachment development across the lifespan and relevant literature. Attachment is important to understand as a piece of holistic development and its impact on attitude as well.

Development of Attachment Theory

Attachment theory resulted from the combined work of John Bowlby and Mary Ainsworth. Bowlby originated the theory, and Ainsworth provided a method of testing the theory. According to Bowlby, "Successful parenting is a principle key to the mental health of the next generation" (Bowlby 1988, 1). Bowlby's research began in the 1930s after his graduation from the University of Cambridge. His early research experiences in psychiatry and medicine led him to focus on maternal deprivation and child maladjustment. In one of his earliest papers, Bowlby studied forty-four cases of maladjusted children at the London Child Guidance Clinic, and he was able to link their symptoms to histories of maternal separation. At the end of World War II, Bowlby was named the head of the Children's Department of Tavistock Clinic, which he renamed the Department of Children and Parents (Bretherton 1992, 760). He was then able to begin his own research and clinical practice.

In his 1951 paper for the World Health Organization, Bowlby hypothesized that the mother is the child's psychic organizer as observational studies of children showed the absence of a mother's love had disastrous consequences on the child's emotional health (Vicedo 2011, 25). Bowlby defined attachment behavior as any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is perceived as better able to cope with the world (Bowlby 1988, 27). Attachment behavior serves the purpose for the infant or child of achieving safety when the world is perceived as unsafe. To say a child is attached to someone means he or she is strongly disposed to seek proximity to and contact with that individual, especially in certain situations (Bowlby 1988, 28). It is important to be aware of the definitions Bowlby uses in his work in terms of early childhood, childhood, and infancy. Infancy consists of the first twelve to fifteen months of life. Early childhood is the first three to four years, but especially the second and third

years (the toddler period). Childhood consists of the time from birth to adolescence (Bowlby 1960, 11). The relationship with the attachment figure forms the internal working model of the child, the internal base which reflects the security or insecurity of his attachments and incorporates the modes of relating and exploring he has learned. Difficult relationships lead to dissociation and disjointed models within the child (Gomez 1997, 156).

There are five behaviors Bowlby described as "instinctual responses," which are activated beginning in the infancy period when the attachment system is activated in order to achieve proximity to the caregiver. These responses serve the purpose of moving closer to the caregiver in order to increase the possibility of survival, comfort, security, and to soothe anxiety. Included in these responses are smiling, sucking, clinging, following, and crying. Sucking, clinging, and following serve the purpose of achieving closer proximity to the mother and obtaining food, both of which require minimal maternal reciprocation. Smiling and crying are dependent on the maternal response for resolution and relief (Bowlby 1958). He proposes that pending the desired outcome, his mother's closeness, the child experiences primary anxiety, and when the mother is close, he experiences comfort (Bowlby 1960, 267). When frightened, infants and young children look to their mothers for security and comfort, and if she is not to be found, then the level of anxiety continues to increase.

When the mother figure is not to be found, separation anxiety and protest behavior follow. This protest behavior can include crying, yelling, what might be considered as a "tantrum," and can result from physical or emotional separation from the mother. Separation does not have to be detrimental to the child, as a well-loved child will protest separation but will later develop more self-reliance (Bretherton 1992, 763). Excessive separation anxiety is due to adverse family experiences, such as

repeated threats of abandonment or rejection by parents, or a parent's or sibling's death or illness for which the child feels responsible (Bretherton 1992, 763).

The loss of the mother figure leads to grief and mourning, which infants and young children are capable of demonstrating. Bowlby also states this is pathologically detrimental especially between the ages of six months and three to four years. The term "mourning" he defines as a wide array of psychological processes set in motion by the loss of a loved one, and grief as a series of subjective states following a loss that accompany mourning (Bowlby 1960, 11). Sooner or later, when the protest behavior does not work, despair sets in, when the child appears to have lost hope that his mother will return (Bowlby 1960, 15). He believed that as the despair and withdrawal phase subsides, the child will then try to find another person to relate to as the mother figure. If no such person can be found, or if there are multiple people to whom the child forms brief attachments, then the child becomes increasingly self-centered and prone to make transient and shallow relationships (Bowlby 1960, 25). The loss of the attachment figure signifies a possibility for pathology if the child's attachment figure is not returned or restored.

The loss of the attachment figure is of particular importance because the attachment figure, whether the mother or another consistent caregiver, serves as what Bowlby described as the secure base. The attachment relationship begins with the mother interacting with the child. The cycle consists of initiation, in which the mother or child seeks contact with the other, interaction, and then subsiding. For example, the infant cries, the mother comforts the child and meets the need, and then the interaction is complete (child falls asleep, plays, etc.). The sensitive mother adjusts and regulates her behavior to mesh with the baby's behavior (Bowlby 1988, 7). Attachment develops as the need arises, the need is met, and the child is soothed. The attachment

figure becomes the secure base, the one from which a child can venture into the outside world and to which he can return, knowing for sure that he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, and reassured if frightened (Bowlby 1988, 11). To be a secure base means this individual is known by and trusted by the child. It is from here the child explores his environment with confidence, knowing he always has a safe place to land. He has someone to whom he can seek proximity when situations arise, such as perceived anxious or frightening circumstances. To lose the attachment figure is to lose the secure base.

Bowlby's attachment theory was bolstered by the work of, and actually would be incomplete without, the research of Mary Salter Ainsworth. While Bowlby produced the theory, Ainsworth produced the evidence. Ainsworth attended the University of Toronto, where she was introduced to Blatz's security theory, which, similar to Bowlby's theory, states that infants and young children need to develop secure dependence on parents before launching out into unfamiliar situations (Bretherton 1992, 760). After marrying Leonard Ainsworth, she traveled to London where she began working with Bowlby in his research clinic. Ainsworth worked with Bowlby until she moved to Uganda with her husband in 1954. She then settled in Baltimore in 1956. Her observations of infants interacting with their mothers in Uganda and Baltimore led her to the development of the Strange Situation Procedure.

Her interactions in Uganda led to the first notes of classification for attachment styles. Children were classified as secure if they cried little except on separation, hurt or ill, and they were able to use their mothers as a secure base. Infants were insecure if they cried a great deal, even when close to their mothers, fussed, and seemed unable to use their mothers as a base for exploration. The third term was non-

attached, used to describe the absence of or differential displays of attachment behavior (Main 1999, 688). From this study, Ainsworth noted that maternal sensitivity played an important role in determining the child's security. Mothers who seemed imperceptive of their infant's behavior appeared to have infants who were insecure (Bretherton 1992, 764).

Once in Baltimore, Ainsworth investigated attachments further, leading her to develop a research tool to test mother-infant attachment, named the Strange Situation Procedure. Ainsworth pioneered this study to determine the relationship between maternal sensitivity and infant attachment. The subjects of the study were from white, middle class, Baltimore area families, who were contacted through pediatricians. There were 106 infants in total, divided into four samples. The infants were observed at approximately one year of age. In Sample One, twenty-six infants were visited in intervals of three weeks from three to fifty-four weeks of age. In Sample Two, thirty-three babies were given cognitive tests at home three times between the ages of eight and a half and eleven months, and were observed in the strange situation after the third testing session. In Sample Three, twenty-four infants were observed in the strange situation twice, with a gap of two weeks in between the observations. Finally, in Sample Four, researcher Mary Main, a mentee of Ainsworth, added twenty-seven infants to further explore the relationship between mother-infant attachment and later exploration, cognitive development and play. Samples One and Two were observed at home before the strange situation procedure was begun, and Samples Three and Four were observed in the laboratory only.

The Strange Situation Procedure is a twenty-minute procedure consisting of eight episodes designed to be mildly stressful for children and induce attachment behavior. The mother and child are first introduced to the experimental room, which

consists of two chairs and toys. The child then is allowed to explore the room with the mother present but not participating. The stranger then enters the room and is silent for the first minute, and then converses with the mother for the second minute. The stranger then approaches the child, and after the third minute, the mother leaves quietly. The stranger continues to engage the child. In episode five, the mother returns, greets and/or comforts the child and then tries to settle the child back into play. The mother then leaves again, this time saying "Bye-bye" before leaving. This time, the child is left completely alone for a few minutes. The stranger then enters and directs her attention to the child. Finally, the mother re-enters, greets and picks up the child, and the stranger leaves the room quietly (Ainsworth et al. 2015). In Ainsworth's initial procedure, the stranger was always female. However, this procedure can be duplicated with male strangers as well.

The children were observed and classified based on their separation and reunion behaviors, especially how the child responds to the mother upon return after these separations. These classifications were secure (B), insecure avoidant (A), insecure ambivalent (C), and another category was later added by Mary Main, disorganized (D) (Rosmalen et al. 2015, 265). Group A children display avoidance of proximity to or interaction with the mother upon reunion. A Group A child tends to mingle his interaction with avoidance responses such as turning away, moving past or averting his gaze. He is not distressed when the mother leaves, and he appears more distressed at being left alone. Distress does not occur if left alone with the stranger, and he is calmed when the stranger returns. He does not appear to be particularly concerned with the presence of the mother and could do without the mother when exploring the environment. Group B children displayed security, in that they sought proximity or interaction with the mother upon her return. If he achieves contact, he

seeks to maintain it. He may or may not be distressed during separation episodes, but he is more distressed by the mother's absence than by being left alone. He also may or may not be friendly with the stranger, but he prefers the mother above all else. Group C children displayed ambivalent behaviors upon reunion. He shows moderate to strong seeking of proximity to maintain contact and then displays ambivalence towards his mother. He shows little or no tendency to avoid his mother in reunions, but he generally displays "maladaptive" behaviors, either being more angry (angrier) than other children or conspicuously passive (Ainsworth et al. 2015).

Main and Solomon (1990) later elaborated on a group of infants who were more difficult to classify and were given the title Group D, or Disorganized. While the term disorganized would seem to infer chaos, it actually refers to a pattern of behaviors displayed by the child upon separation and reunion. The disorganized child displayed behaviors such as freezing, stilling, and slowed movements or expressions when the parent entered the room, direct apprehension towards the parent, and intensity in the display of conflict and fear in the presence of the parent. These children are also given secondary classification, such as disorganized or avoidant (Granqvist et al. 2017). Ainsworth's study led to a research method that has been able to be tested and replicated for the purposes of discerning attachment relationships between parent and child.

Prenatal Attachment

Infant attachment is critical, both because of its place in initiating pathways of development and because of its connection with so many critical developmental functions-social relatedness, arousal modulation, emotion regulation, and curiosity (Sroufe 2005, 365). While Bowlby believed there must be reciprocity in the mother-infant dyad in order for attachment to develop, recent research has begun to explore

whether attachment can begin to develop even during the prenatal period (Brandon et al. 2009). Around the same time Bowlby was investigating attachment, there was an increasing interest in pregnancy and the developmental process taking place as a woman becomes a mother. It was theorized that prenatal attachment (although attachment language was not used), was the process in which a pregnant woman's psychic energy becomes emotionally invested in the fetus, and the fetus becomes more human as the pregnancy progresses (Bibring et al. 1961). Much like how Bowlby's theory looked at loss and grief, interest in the relationship between a mother and her unborn child was highlighted by observations of mothers who grieved intensely over their stillborn children, regardless of whether or not they had been able to hold their children (Kennell, Slyter, and Klaus 1970).

Rubin, a nurse specializing in maternity care, is credited with beginning a theoretical process for attachment development. Rubin developed four tasks a mother must go through during pregnancy, including seeking safe passage for self and baby, ensuring that baby is accepted by her partner and other significant relationships, binding in, and giving of herself to the role of mother (Rubin 1975). Rubin theorized that by the second trimester, a woman is aware of and assigns value to the child's life. Lumley added to this theory by determining the developing baby was imagined as a human more and more over time. Attachment was defined as an established relationship with the fetus in imagination (Lumley 1982). Lumley determined that maternal-fetal attachment was present in sixty-three percent of women by eighteen to twenty-two weeks gestation and in ninety-two percent by thirty-six weeks gestation.

As the theory developed, methods for measuring prenatal attachment developed as well. Mecca Cranley created a measure called the Maternal Fetal Attachment Scale, which studied the following six aspects of attachment:

differentiation of the self from the fetus, interaction with the fetus, attributing characteristics to the fetus, giving of the self, role-taking, and nesting (Cranley 1981). Cranley defined attachment as “the extent to which women engage in behaviors that represent an affiliation and interaction with the unborn child” (Cranley 1981, 281-284).

Muller (1993) was critical of Cranley’s model, believing she focused too much on the mother’s behavior and failed to take into account thoughts, fantasies, feelings, or emotions that went into the developmental process. Muller defined prenatal attachment as “the unique relationship that develops between a woman and her fetus. These feelings are not dependent on the feelings the woman has about herself as a pregnant person or her perception of herself as a mother” (Muller 1993). Muller theorized the expectant mother’s early experiences with her own primary caregiver led to the development of her own internal representations, and as a result, influenced her relationships with her partner, friends, and ultimately, her child (Brandon et al. 1990). This led Muller to develop the Prenatal Attachment Inventory, focusing on expressed feelings and not just emotional elements. This measure consisted of twenty-nine items used to measure the personal relationship the mother develops with her fetus during pregnancy (Muller 1990).

John Condon added to the work of prenatal attachment theory by simplifying the definition to include “the emotional tie or bond which normally develops between the parent and her unborn infant” (Condon and Corkindale 1997). Condon believed that existing measurement instruments inadequately differentiated between the mother’s attitude toward the fetus and her attitude toward the state of pregnancy itself and motherhood. Thus, he created the Maternal Antenatal Attachment Scale with nineteen items. These items focused on the mother’s thoughts and feelings about the

baby. It measured quality (affective experiences) and intensity (amount of time spent interacting with the fetus). Results were separated into four quadrants: strong attachment, positive quality of attachment but low preoccupation due to distraction or avoidance, uninvolved or ambivalently involved with low preoccupation, and anxious, ambivalent, or affectless preoccupation (Condon 1993).

While there is no general consensus of a working definition for prenatal attachment, this author prefers the multidimensional definition developed by Helen Doan and Anona Zimerman (2003). According to their definition, prenatal attachment is an abstract concept, representing the affiliative relationship between a parent and fetus, which is potentially present before pregnancy, is related to cognitive and emotional abilities to conceptualize another human being and develops within an ecological system." This definition takes into account the mother's relationship with the fetus, as well as its potential to be influenced even before the pregnancy is developed. It is influenced by the mother's thoughts and feelings, which will in turn influence her behavior. Further, this relationship develops within the mother's relationship with her surroundings, and is influenced by her social system and support network.

Doan and Zimerman (2008) provided an integrative framework for prenatal attachment. This model is based on three aspects: when prenatal attachment begins, level of prenatal attachment (high, medium, low), and form of expression (cognitive, emotional, behavioral). The skills and strategies that may be a foundation for prenatal attachment begin in childhood, are evident during the teenage and early adult pregnancy years, and continue through adulthood after becoming pregnant. They theorized that the skills needed to form attachment should be cognitive, being able to visualize a relationship with the baby, emotional skills and strategies, the ability to be

sensitive to and focus on the needs of others, and attachment style. During pregnancy, situational factors may also affect the attachment.

One possible factor is a history of prenatal loss. Armstrong (2002) studied 103 couples in their second trimester of pregnancy, forty of whom had a history of perinatal loss. While she found that couples with a history of loss had a higher level of pregnancy-specific anxiety and depressive symptoms, prenatal attachment levels did not differ. However, Armstrong used unspecified structured questionnaires to conduct the study. In another consideration of the topic, O'Leary (2004) hypothesized from observation that attachment to an unborn infant who dies can lead to unresolved grief, which will in turn affect prenatal attachment in subsequent pregnancies. Her hypothesis was based solely on observation and has not been thoroughly researched with a study. Through interviews conducted with eighteen mothers, she later determined three tasks needed for families to move on from their grief and loss. These tasks include coming to terms with the death of their baby, continuing their bond with that baby, and finding a place for both babies in their family (O'Leary and Thorwick 2008, 305).

Other aspects have also been studied. Kemp and Page (1987) sought to determine if risk during pregnancy influenced prenatal attachment. After conducting a study with fifty-three women with normal pregnancies and thirty-two women with high-risk pregnancies, no significant difference in prenatal attachment was reported. Another element studied is the comparison between in-vitro and naturally conceived pregnancies. In this study by Hjelmstedt, Widstrom, and Collins (2006), there was no difference found in prenatal attachment between in-vitro and naturally conceived pregnancies. Among both groups, prenatal attachment increased as gestational age increased.

In another study, Krisjanous, Richard, and Gazley (2014) demonstrated there is a correlation between pregnancy body image dissatisfaction that leads to a reduction in prenatal attachment. However, these researchers used their own research tool, rather than a pre-existing tool for measuring prenatal attachment. Prenatal screening through blood or ultrasound also did not make a measurable difference in prenatal attachment (Kleinveld et al. 2007). Fetal movement counting was also shown not to make a measurable difference in prenatal attachment (Saastad et al. 2011). However, Heidrich and Cranley (1989) did find that feeling fetal movement earlier in the pregnancy was positively related to attachment to the fetus.

Prenatal attachment potentially impacts postnatal attachment. The stronger the prenatal attachment, the greater the likelihood of a range of positive prenatal and postnatal outcomes in the mother, and of positive developments in the child and in the child-mother relationships (Slate and Sadler 2019, 31). Muller (1996) noted a small correlation by studying a sample of 196 pregnant women during the second half of pregnancy and one to two months after delivery. Muller utilized the Prenatal Attachment Inventory before birth and the Maternal Attachment Inventory, the How I Feel About my Baby Now Scale, and the Maternal Separation Anxiety Scale after birth. A small correlation was found, but not enough to isolate prenatal attachment from other positive factors. For example, most of the women in the study were white, educated, and married. Women's prenatal attachments have also been shown to be influenced positively by their own relationships with their mothers. Tani, Castagna, and Ponti (2018) recruited 201 first time mothers in the maternity ward of a hospital in Italy. At 32 weeks gestation, their participants filled in the Parental Bonding Instrument and the Prenatal Attachment Inventory. They were also observed in the nursery with their babies during the first two days after birth. Having a good

relationship with their own mothers was shown to be a positive predictor for prenatal attachment to their babies and attachment behavior to their newborn infants. In a study with Portuguese mothers, prenatal attachment was influenced by age, education, socioeconomic status, pregnancy planning, previous pregnancies, pregnancy interruptions, and gestational age (Carmarneiro and Justo 2017).

One area of study has included the role of prenatal attachment in regard to pre and postnatal depression and anxiety. Lindgren (2001) investigated a conceptual model in which depression was proposed to have direct negative effects on positive health practices, as well as indirect negative effects in maternal-fetal attachment. She found that higher education, lower parity and being partnered predicted more positive health practices. Depression was found to have a significant impact on maternal-fetal attachment; however, maternal-fetal attachment had a positive relationship with positive health practices. In another study, the mother's attachment style was analyzed in relation to predicting the role of pre and postnatal depression and the mother's interaction with her child. Participants were analyzed based on the Adult Attachment Interview during pregnancy and then assessed again at four to five months postpartum and fourteen months postpartum. Secure adult attachment was shown to have a positive effect on the mother-infant relationship. Pre and postnatal depression together was shown to have the greatest effect on maternal unresponsiveness. Prenatal depression had a greater impact on the mother-infant relationship than postnatal depression (Flykt et al. 2010). Armstrong and Hutti (1993) found that anxiety in women who had experienced pregnancy loss was higher than in women who had not, and their prenatal attachment levels were lower than first-time mothers. Hart and McMahon (2006) found that higher symptom levels of anxiety were related to less

optimal maternal-fetal quality of attachment, more negative attitudes towards motherhood, and the self as a mother.

In regard to prenatal attachment among adolescent mothers, there is limited information available. However, one study was conducted by Deborah Koniak-Griffin (1988). Using the Maternal Fetal Attachment Scale to measure attachment, along with other instruments, the research was conducted with ninety culturally diverse adolescents between fourteen and nineteen years of age. Four key factors were identified to predict prenatal attachment, including total functional support, total size of network, planning of pregnancy, and intent to keep the infant. In another study conducted by Tate and Wayland (1993) with sixty-one Mexican-American, African American, and Caucasian adolescents between thirteen to forty weeks gestation, maternal-fetal attachment was significantly correlated with the pregnant mother's perceived close relationships with her mother and the baby's father, frequency of contact with the baby's father, gestation, and marital status. Their research indicated maternal-fetal attachment was lower with Mexican-American adolescents than Caucasian adolescents, but more research is needed with diverse participants.

Trauma

One would be remiss to ignore exploring the role of trauma and trauma history in the life of the mother, as it will potentially affect her relationship with her unborn child. While this research has adopted the definition of trauma provided by SAMSHA (refer to the Definition of Terms), the discussion of trauma in the literature is broad. Trauma comes from the Greek word meaning "wound" and can cover a vast array of human experiences of suffering, including mundane disappointments to catastrophic violence (Frechette 2015, 22). Difficult experiences and stress are a part of life and the growing process. These stresses can be managed with little need for professional

intervention. However, childhood traumatic events, though less ubiquitous, are also common and are more likely to be psychologically overwhelming because they potentially threaten a child's sense of safety and security and lead to subjective feelings of terror, fear, shame, anger, helplessness, and/or worthlessness (Cohen, Mannarino, and Deblinger 2012).

Levine and Kline (2007) describe trauma as any experience that stuns us like a bolt out of the blue, overwhelms us, leaving us altered and disconnected from our bodies. Trauma is brought about through adverse experiences such as natural disasters, terrorism, violence, medical events, the death of a loved one, accidents, and sexual assault (NCTSN 2020). It can also be brought about through other threatening events such as bullying, witnessing or experiencing physical and sexual abuse, neglect, and community violence (NCTSN 2020). According to the Center for Disease Control (2019), more than sixty percent of American adults have, as children, had at least one adverse experience, which can lead to trauma. Almost a quarter of adults have experienced three or more adverse experiences as children, which means these people have experienced significant trauma from a young age. Statistically, this means that in a church congregation of one hundred members, approximately sixty will have experienced an event leading to trauma.

Trauma does not reside in the event itself but in the nervous system of the human body (Levine and Kline 2007, 4). The likelihood of developing traumatic symptoms is related to the level of shutdown as well as to the undischarged survival energy originally mobilized to fight or flee. Prenatal infants, newborns, and very young children are the most at risk of stress and trauma due to their underdeveloped nervous, motor, and perceptual systems (Levine and Kline 2007, 7-8). Especially during gestation, the mother's mental, physical, and spiritual health impacts the baby

and determines in large part the health of the baby (Levine and Kline 2007, 278). While all trauma is significant, there are two different classifications important for distinction: acute (type one) and complex (type two) trauma. Acute trauma results from exposure to a single, overwhelming event. Complex trauma, also known as developmental or relational trauma, results from ongoing exposure to overwhelming situations (Bath 2008, 17). To elaborate, the example of a natural disaster such as a hurricane or tornado would be acute trauma because it happens (typically) once. A child experiencing sexual assault multiple times at the hands of a relative would experience chronic trauma.

In 1998, Felitti et al. (1998) examined the connection between adult health outcomes and childhood exposure to emotional, physical, or sexual abuse, and household dysfunction. A total of 9,508 respondents answered a questionnaire including the following categories: psychological, physical, or sexual abuse, violence against mother, living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. More than half of the respondents had at least one ACE. The study found that participants with four or more ACEs had a four to twelve-fold increase in smoking, poor self-related health, and sexually transmitted diseases. A relationship was found between the number of exposures to ACEs and the presence of adult diseases such as heart disease, cancer, lung disease, and liver disease. The following illustration (CDC 2011) was developed to explain how the prevalence of ACE's impact the individual across the lifespan:

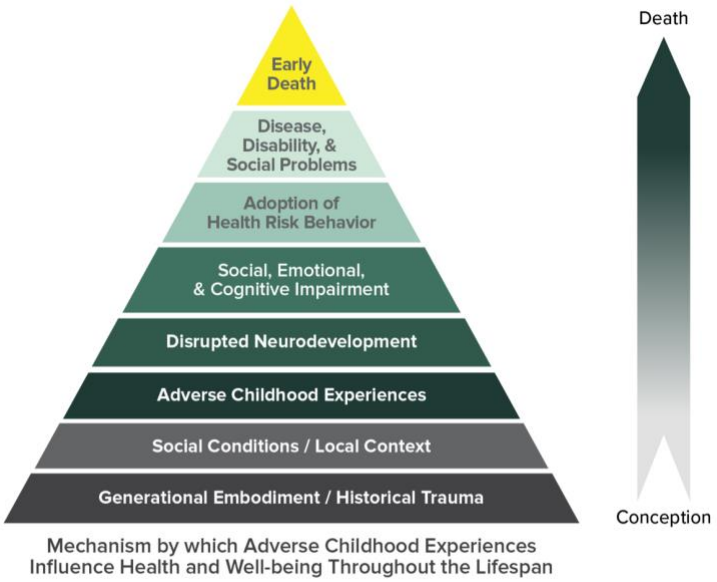


Figure 3. The ACE Pyramid

This pyramid illustrates that ACEs can affect the individual even during pregnancy, and pregnancy does not insulate a child from adverse experiences. From conception, the child is impacted by historical trauma, or the trauma experienced by the parents, and the social conditions in which she or he is born. ACE exposure can lead to disrupted neurodevelopment, which can then lead to impaired social and cognitive functioning. For example, a husband and wife are having marital and financial difficulties. The wife learns she is pregnant, and she is faced with anxiety during the pregnancy. After the child is born, the couple divorces. This leads to more stress and managing conflict, and the child is impacted by the stress of the parents. This leads to neurological disruptions. Maybe the child has issues focusing in school or begins to develop anxiety. This will then impact how the child interacts with other students, teachers, and learns in school. To manage anxiety and stress, the child could turn to food, a peer group, drugs, vaping, etc. While these decisions can help the child cope, they have the potential to be harmful and increase risk for early death. In this case, the child could turn to food, leading to obesity, which can result in diabetes, heart problems, or other negative health outcomes.

From the research, it is apparent that multiple trauma experiences over the child's lifespan can be detrimental. One element lacking in the research, which would be difficult to determine, is the number of times an ACE was experienced. For example, the study did not ask how many times a participant was sexually abused or a mentally ill family member had a violent or manic episode. This research was able to gather this data from scratching the surface. It is also important to note this research was conducted with participants who were mostly white (83.9%), were middle aged (average of 56.1 years old), and had been educated an average of fourteen years (Felitti et al. 1998, 247). These respondents were not the poorest of the poor, lower class, or mostly minorities, and their number of ACEs was significant. Imagine even more so the presence of ACEs for children and adults from more difficult circumstances.

The impact of ACEs has been demonstrated to impact individuals and their behaviors or decision making. The ACE study demonstrated strong associations between ACEs and mental health or psychosocial-related risk behaviors and outcomes (Brown et al. 2009, 394). A strong correlation was also found between alcohol abuse, illicit drug use, sexual promiscuity, and suicide and the ACE score (Brown et al. 2009, 395). A study done in Florida compared 102 offending youth who were arrested for trading sex to 64,227 youth arrested for other crimes. It was found that youth who have violations related to sex trafficking had higher rates of each ACE as well as number of ACEs, particularly sexual abuse and physical neglect (Naramore et al. 2015). Baglivio and Epps (2015) examined the prevalence of ACEs among 64,329 juvenile offenders in Florida. They found that prevalence for each ACE ranged from 12%-82% of the youth who had experienced at least one ACE, 67.5% reported four or more additional exposures, and 24.5% exposure to six or more additional ACEs. Only

three percent of males and two percent of females had not been exposed to any type of neglect or abuse. In regards to the number of ACEs, forty-seven percent of males and sixty-two percent of females had an ACE score of four or more. This is in contrast to the original study where only thirteen percent of respondents had a score of four ACEs or more (Felitti et al. 1998). These studies demonstrate that ACE exposure can lead to an increased likelihood of unsafe and risky behaviors or decision making. On a personal note, as a school social worker, each of the students I work with involved in the Department of Juvenile Justice have at least one ACE.

Interpersonal trauma (IPT), trauma occurring within the context of a close relationship, has an impact on the cognitive development of children. In one study, 206 children were assessed prospectively for interpersonal trauma exposure between birth and sixty-four months. IQ was assessed at twenty-four, sixty-four, and ninety-six months of age. By sixty-four months, 36.5% of the sample had experienced interpersonal trauma exposure. By ninety-six months of age, the average IQ for children who had not been exposed was 107.08. Children who experienced IPT in infancy only had an average IQ of 95.91. In preschool only, IQ was 101.11, and children who had experienced IPT in infancy and preschool had an average IQ of 93.89 (Enlow et al. 2012). Children who have experienced IPT are also more likely to have severe post-traumatic stress disorder symptoms (Enlow, Blood, and Egeland 2013). Additionally, these children are at higher risk for chronic and severe coexisting problems with emotion regulation, impulse control, attention and cognition, dissociation, interpersonal relationships, and attributions (D'Andrea et al. 2012, 188).

Trauma can occur during the prenatal period. Physical traumas such as automobile accidents, suicide attempts, assaults, and fires can lead to injuries to the developing baby, as well as lead to preterm delivery and fetal death (Towner 2004,

1662). Intimate Partner Violence and war-related trauma are also included as examples of prenatal trauma (Keren and Tyano 2019).

In addition to Adverse Childhood Experiences, Mead (2020) added to the discussion of trauma with the proposal of the Adverse Babyhood Experiences, which consists of ten categories occurring before a child's third birthday that have profound impact on the child's short and long term health. These remind us that trauma can occur and have lasting impact before a child can remember. For babies, the mother is their environment, and to an extent, the father and other caregivers are as well. The ten ABE's begin with maternal loss or trauma, which includes events from the mother's life before she conceives until the child's third birthday (Mead 2020, 288). This extends to adverse experiences of the mother throughout her life. The second category, low or loss of support, begins two years before conception to the third year of the child's life. Maternal physical stress includes the use of drugs and alcohol, but also excessive sickness and gestational diabetes. Maternal emotional stress is an ABE, as well as complications during pregnancy, labor, birth, and beyond. These include hemorrhage, caesarean, vacuum extraction, and being close to death during delivery.

Another ABE is developmental complications in children from conception until the third birthday. The next ABE is separation from the mother or either parent due to emotional separation resulting from trauma, the baby in newborn intensive care, foster care, adoption, hospitalization, or parent travel within the first two years. Low birth weight and difficulty breastfeeding are ABEs. The final ABE includes early signs and symptoms in the mother, baby, or father, indicating a need for support and repair such as postpartum depression, lack of affection for the infant, and PTSD. In babies, this also refers to low eye contact, being sickly or easily irritable, and being difficult to comfort. Unwanted pregnancy is also a risk factor that does not fit into the

ten categories Mead provides. These ABEs lead to increased risk for infant mortality, low birth weight, prematurity, and labor complications.

Further, high rates of maltreatment occurring in the first three years of life have life-long consequences. Hargen and colleagues (2016) summarize the ways in which maltreatment in the first three years of life has lasting effects. Maltreated children display dysregulated and atypical patterns and levels of cortisol production, important for mitigating stress response. Children who experience physical and sexual abuse show dysfunctional development in frontotemporal and anterior brain regions (Hargen, Buller, and Parra 2016, 369). Maltreated infants and toddlers have higher rates of physical injuries and illnesses than their older and non-maltreated counterparts (Hargen, Buller, and Parra 2016, 369). Infants who have experienced adversity, such as maltreatment, are at higher risk for developing psychological disorders in later childhood, such as depression, anxiety, dissociation, and PTSD (Hargen, Buller, and Parra 2016, 371).

The mother's childhood trauma history can impact her pregnancy, both physically and emotionally. For some childbearing women, pregnancy and birth is the first time that awareness of previous abuse surfaces, and childhood abuse has been associated with substance abuse, depressive and anxiety complaints, and fear of childbirth (Lukasse et al. 2009). Pregnancy can be retraumatizing in the ways it summons past memories of abuse and trauma (Slate and Sadler 2019, 31). Women with a history of childhood sexual abuse are more likely to have high risk sexual behaviors, an unplanned pregnancy, and later accessing of prenatal care (Leeners et al. 2006). Abuse survivors reported more health problems during pregnancy and used more health care services than their non-abused counterparts (Leeners et al. 2006, 345). In a study conducted by Grimstad and Schei (1999) regarding low birth weight

and a history of child sexual abuse, it was found that low birth weight was not associated with a history of child sexual abuse, but those who had experienced abuse had a higher rate of risk factors, such as smoking and unemployment. They reported more health complaints and use of health care services.

Toepfer et al. (2017) share that maternal early life stress such as child abuse and neglect can affect the next generation. This can occur through pre and postnatal pathways, such as alterations in maternal-fetal-placental stress physiology, maternal depression during pregnancy and postpartum, the quality of mother-child interactions. Toxic stress during the fetal and early childhood periods can affect developing brain circuits and hormonal systems, leading to poorly controlled stress response systems that can become overactive or slow to shut down when faced with stress across the child's lifetime (National Scientific Council on the Developing Child 2014). Cheng and colleagues (2016) conducted a longitudinal survey to determine if maternal exposure to stressful life events prior to conception impacts the infant's birthweight and health. Researchers examined 6900 mother-child dyads in the Early Childhood Longitudinal Study-Birth Cohort and assessed health at 9 and 24 months. Their analysis found a chain-of-risk model in which women's exposure to PSLEs increases the risk for giving birth to a very low birth weight infant, which predicted poor health at 9 and 24 months of age. Blackmore and colleagues (2016) found that women with antecedent trauma were more likely to have a history of depression, were younger at their first pregnancy and had a higher number of previous pregnancies. They also found childhood trauma history increases vulnerability for low birth weight delivery associated with prenatal mood disturbance.

Racial Trauma and Pregnancy

In the United States, minority women are shown to have higher disadvantages and risks associated with pregnancy and positive health outcomes than white women. Historically, Barber et al. (2015) list reproductive abuse levied against black men and women in the United States. This includes the Tuskegee Syphilis Study, where the U.S Public Health Service conducted experiments on poor black men with advanced stages of syphilis. From 1932 to the 1970s, men were observed, but were never treated for their illnesses. Forced sterilization of poor women in the U.S and Puerto Rico was documented up to the 1970s (Ko 2016). Between 2005 and 2013, many female prisoners in California received tubal ligations without informed proper consent. Even in 2020, allegations have emerged of the Immigration and Customs Enforcement (ICE) agency performing sterilization procedures on women in custody without their knowledge or consent (Amari 2020).

This history of racial discrimination leads to a mistrust of care providers. Poor patient-provider interaction among racial or ethnic minorities is associated with disparities in health care (Dahlem, Villarruel, and Ronis 2015). Further, black women have a higher maternal mortality rate than white women. Lister et al. (2019) report that the black maternal mortality rate is four times higher than that of white women, and reducing this rate involves a multi-tiered approach of addressing pregnancy complications such as cardiovascular issues, increasing positive patient-provider communication, and modifying public policy to provide continuity of care. Dominguez et al. (2008) assessed fifty-one African American pregnant women and seventy-three non-Hispanic White pregnant women for maternal health, sociodemographic factors, and three forms of stress (general stress, pregnancy stress, and perceived racism). They found that perceived racism across the lifetime and

perceived racism vicariously experienced as a child predicted birth weight in African Americans and may help to account for racial differences in birth weight. Hilmert et al. (2014) explored a possible link between lifetime experiences of racism and blood pressure during pregnancy in African American women. They found that increases in diastolic blood pressure between the second and third trimesters predicted lower birth weight when racism exposures in childhood were relatively high.

Trauma and the Mother's Attachment

It must be noted that the mother's attachment style has been shown to be a predictor of the child's attachment style at one year of age. Fonagy, Steele, and Steele (1991) conducted a study with ninety-six mothers using the Adult Attachment Interview successfully predicted whether an infant would be securely or insecurely attached in seventy-five percent of infants at one year of age. This research demonstrates the connection between a mother's attachment style and its impact on her relationship with the child, as well as the child's attachment. Therefore, if trauma is in the history of the mother, then it is possible the effects of this trauma on the mother can be transmitted to affect the child.

Complex trauma does impact attachment. When the child-caregiver relationship is the source of the trauma, the attachment relationship is severely compromised (Cook et al. 2005). When attachment is severely disrupted, this often engenders lifelong risk of physical disease and psychosocial dysfunction such as increased susceptibility to stress, inability to regulate emotions without external assistance, and altered help-seeking (Cook et al. 2005, 393). Betrayal Trauma Theory proposes that trauma occurring within the context of an attachment relationship is qualitatively different then trauma that takes place outside of one. The closer and more necessary one's relationship with the perpetrator(s) and the greater the degree of

betrayal involved (Bernstein and Freyd 2014). Mothers who have experienced betrayal trauma are predicted to have children with both internalizing (mood) and externalizing (behavior) symptoms to dissociation at the elementary age (Fenerci, Chu, and DePrince 2016). Their trauma histories will impact their children.

There are few studies done regarding how trauma impacts the attachment of the mother, especially during the prenatal period. Berthelot et al. (2019) conducted a study with 322 participants, including those with and without a history of adverse childhood experiences. Using the Maternal Antenatal Attachment Scale, Child Trauma Questionnaire, and others to measure mental health, the study found that both groups reported similar levels of prenatal attachment and parental confidence. Poor mental health, not child maltreatment, was associated with low prenatal attachment. However, the demographic was not varied. The average age of the mother was 28.25, 238 (94.8%) female participants were white and, in a relationship, and 236 female participants had at least a high school diploma. Therefore, even if they had experienced childhood trauma, there were buffers in place including education, race, and relationship presence to mask trauma symptoms.

In another study, conducted by Schwerdtfeger and Goff (2007), trauma history in general did not appear to negatively impact the mother's current prenatal attachment with her unborn child. However, interpersonal trauma history does appear to have negative effects on prenatal attachment and development. This could be because interpersonal trauma involves attachment figures, such as parents, siblings, and spouses. This may account for the perceived difference Schwerdtfeger and Goff found. Also, it is possible this study clarified the difference in types of trauma identified by participants, rather than the number of traumatic experiences. In this study, they found the type of trauma (i.e. interpersonal) had a more significant impact

than the amount of trauma experiences (Schwerdtfeger and Goff 2007, 48). Interpersonal trauma was found to have an impact on newborn IgE levels (IgE is an antibody produced in the blood). Infants with mothers who have experienced chronic trauma had increased levels in infants at birth (Sternthal et al. 2009). Interpersonal trauma history was shown to impact mental health outcomes in pregnant women. In a community sample of 1,581 pregnant women, twenty-five percent of respondents displayed symptoms of mental health disorders. Women with histories of interpersonal trauma were overrepresented in four sub-groups categorized by PTSD comorbid with depression, PTSD comorbid with affect or interpersonal dysregulation, somatization, and generalized anxiety disorder.

Attitude and Pregnancy

Attitude provides an indication as to the thoughts, feelings, and potential behaviors of a pregnant woman towards herself and her child. Eagly and Chaiken (1998, 269) describe attitude as follows:

> Attitude expresses passions and hates, attractions, and repulsions, likes and dislikes. People have attitudes when they love or hate things or people and when they approve or disapprove of something. Because people express their likes and dislikes in many ways, all aspects of responding, including emotions, cognitions, and overt behavior, are infused with evaluative meaning that attitudes impart (Eagly and Chaiken 1998, 269).

From this description, it can be understood that attitude consists of emotions or feelings, cognitions or beliefs, and acts towards an object. Attitude is important because it is believed that attitudes directly influence behavior (Jain 2014). Because attitude is not directly observable, it must be inferred based upon the beliefs, feelings, and actions of the individual (Eagly and Chaiken 1998, 269). According to Vries et al. (1988, 273), attitude is determined by the expectations of various consequences, beliefs about the behavior, and the corresponding evaluations of those consequences.

It is generally believed that attitude consists of three components: Affect (feelings), Cognitive (beliefs), and Behavioral (acts) (Jain 2014). Individuals do not have an attitude until they encounter an object or information about the object and respond evaluatively to it on an affective, cognitive, or behavioral basis (Eagly and Chaiken 1998, 270).

Fishbein and Ajzen (2000) state that attitudes follow spontaneously and consistently from beliefs accessible in memory and then guide corresponding behavior. Beliefs express positive or negative evaluation or greater or lesser extremity and occasionally are exactly neutral in their evaluative content (Eagly and Chaiken 1998, 271). Beliefs are the basic building block of attitude (Eagly and Chaiken 1998, 274). Keeping this in mind, maternal beliefs have the ability to influence health outcomes for her child and for herself. Thomason et al. (2015) explain that flexible beliefs, such as understanding that being a mother may not always be a positive experience, may facilitate maternal well-being during pregnancy and postpartum. More rigid beliefs, such as believing one must fix all parenting difficulties oneself, may be negatively associated with less optimal maternal health, such as an increase in depressive symptoms.

Beliefs, as a component of attitude, influence attitude strength. Strong attitudes lead to selective information processing and are resistant to change, persistent over time, and predictive of behavior (Eagly and Chaiken 1998, 287). Those holding extreme attitudes are more likely to resist changes in behavior (Eagly and Chaiken 1998, 287). Extreme attitudes have been shown to be less susceptible to persuasion attempts, and the resulting behavior is more difficult to change (Judd and Brauer 1995).

Much of the research around attitude and pregnancy has revolved around the age of a woman during time of pregnancy, in particular, adolescence. Jaccard and colleagues conducted a study in which 4869 adolescent females in grades nine through eleven completed two interviews at a one-year interval. Fifteen to thirty percent of respondents displayed a degree of ambivalence toward becoming pregnant relative to their peers, and this ambivalence was predictive of pregnancy occurring one year later. They also conducted a cross-sectional study of 350 African-American females between the ages of fourteen and seventeen in the Philadelphia area. Adolescent females and their mothers were both interviewed. They found that maternal communication about the negative consequences of pregnancy and the quality of the mother-daughter relationship had a greater impact on adolescent attitudes toward pregnancy (Jaccard, Dodge, and Dittus 2003). There may also be external factors influencing the attitudes of adolescents towards pregnancy. Bruckner, Martin, and Bearnman (2004) conducted two rounds of interviews with 14,738 adolescents, ages fifteen to nineteen. Respondents with the anti-pregnancy attitudes had the highest mean maternal education, maternal closeness, cognitive ability, self-esteem, positive attitude towards contraception, and had the highest number of those who reported living with two biological parents. Those who were among the pro-pregnancy respondents reported being poor or low income, and had the lowest mean maternal education, cognitive ability, and knowledge of pregnancy avoidance.

The mother's attitude towards her developing child may profoundly impact the physical health of her baby. Bustan and Coker (1994) state that infants who are unwanted are at an increased risk for child abuse, delayed cognitive and emotional development, lower birthrate, and infant mortality. They found that women who reported their pregnancies as unwanted were 2.4 times more likely to have an infant

who died within the first twenty-eight days after birth. These results are contested, however, as Joyce, Kaestner, and Korenman (2000) found other factors such as family income, mother's education and cognitive ability, and family structure were more significant than whether or not the child was intended. Sable et al. (1997) might have discovered a link between the two, as they found a statistically significant association between both very low and moderately low birth weight and unwanted pregnancy as measured by unhappiness about the pregnancy and by denial. This association was particularly strong among Medicaid recipients. In the United States, Medicaid is government-provided insurance for low-income individuals and families. In a later study, Sable and Wilkinson (2000) confirm these findings, stating that unhappiness and denial about the pregnancy, as well as perceived stress, relationship struggles, and major illness or injury also increased the risk of low birth weight. Deave (2005) found that a woman's positive attitude towards pregnancy and motherhood have been linked to higher cognitive development scores in children. At two years old, children whose mothers, during their pregnancy, were aware of changes that motherhood might entail had higher cognitive scores, compared to children whose mothers were less aware. This indicates that attitude during pregnancy can influence the holistic well-being of the child.

The attitude of the mother can influence the child's emotional health, as well. Kokubu, Okano, and Sugiyama (2012) found that a mother's negative attitude towards pregnancy predicted bonding failure after delivery. Fraiberg coined the term "ghosts in the nursery" to describe the burden placed on babies by the oppressive past of their parents from the moment they enter the world (Fraiberg, Adelson, and Shapiro 1975, 388). "The parent, it seems, is condemned to repeat the tragedy of his childhood with his own baby in terrible and exacting detail" (Malone et al. 2010).

These early experiences affect her understanding of and interactions with her infant (Malone et al. 2010).

Pregnancy and Children in the Bible

The significance of God coming to earth through an embryo to become a fetus, develop within the womb, and then pass through the birth canal and emerge as a baby cannot be understated. When Adam and Eve were expelled from the Garden of Eden after disobedience to God, the curse placed upon the woman stated, "I will make your pains in childbearing very severe; with painful labor you will give birth to children" (Genesis 3:18, NIV). For generations, this curse would ring true as children would be brought into the world with joy, but also fear, knowing the pain that would come. The pain of childbirth reminds us of the sin that has touched every aspect of life, including the bringing of a child into the world, and the groaning of creation for redemption and relief. The people of Israel longed for the promised Messiah who would ease the burden of sin and oppression. This redemption and relief, ironically, came through the pain of childbirth. Luke 2:31-32 narrates the news given to Mary, "You will conceive and give birth to a son, and you are to call him Jesus. He will be great and will be called the Son of the Most High" (Luke 2:31-32, NIV).

Through a pregnant woman and unborn child, God set in motion his plan to redeem the world. While this might be unusual, it is in line with God's view of pregnancy and birth. The writer of Psalms beautifully describes the presence of God as intimately aware of his comings and goings, including in the womb. He states,

> For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be (Psalm 139: 13-16, NIV).

The psalmist describes the womb not as a place of darkness, but as a place of purpose. He emphasizes "how individual this process is; every human being has been individually created by God. Human beings have been set apart. They are indeed distinctive creatures. Therefore, Yahweh ought to be praised" (Mare 2010, 701). While the psalmist is not able to speak of the details of biology, he is aware of the mystery and intricacy of his own creation, and it leads him towards praise. Indeed, the creation and birth of a child leads to praise, and ultimate praise towards the one who came to earth as a baby.

Keeping this in mind, reverence and honor are attributed to unborn and newborn children in Scripture. The Old and New Testament direct the reader to the following observations: Children indicate God's blessing. While childbirth in itself was cursed with pain, the presence of a child indicates the blessing of God. After their expulsion from the garden, Adam gave the woman her name, Eve, because she "would be the mother of all the living" (Genesis 3:30). She then became pregnant and gave birth to her son Cain, saying "With the help of the Lord, I have brought forth a man" (Genesis 4:1, NIV). Eve might have been cursed, but she was not abandoned. The presence of her son indicated that God had not forgotten nor completely forsaken her. After Cain kills his brother Abel, she becomes pregnant again and gives birth to her son Seth and says, "God has granted me another child in the place of Abel" (Genesis 4:25, NIV). God continues to remember her and continues the blessing. Later in Genesis, God calls Abraham, promising to make him a great nation, which would include the improbable birth of a child in his old age (Genesis 12:2). The child of the promise, Isaac, is delivered to Abraham and his wife, Sarah.

Children continue to be a blessing throughout Scripture. When the children of Israel were taken as slaves in Egypt, their oppression did not remove the blessing. The

more they were oppressed, the more they were blessed. “But the more they were oppressed, the more they multiplied and spread” (Exodus 1:12, NIV). After their release from the bondage of slavery, God gave them instructions on how to live in the freedom of obedience to Him. Pregnancy and birth were included as the blessing of obedience. He says, “No one will miscarry or be barren in your land. I will give you a full life span” (Exodus 23:26, NIV). In Deuteronomy, God promises “The fruit of your womb will be blessed” (Deuteronomy 28:5, NIV), as a reward for following in obedience.

Examples in the Bible also include the lack of children as an example of the removal of blessing. In Second Samuel, King David is recorded dancing before the Lord as the Ark of the Covenant returns to Jerusalem. Rather than rejoice with him, his wife Michal, “despised him in her heart.” As a result, the reader is told, “And Michal daughter of Saul had no children to the day of her death” (2 Samuel 6:16, 23, NIV). Her refusal to rejoice in the blessing of God’s presence removed the blessing of children upon her life. Isaiah also prophecies the barrenness of Israel as a result of her disobedience. He says, “And in that day seven women shall take hold of one man and say, ‘We will eat our own food and provide our own clothes; only let us be called by your name. Take away our disgrace!’” (Isaiah 4:1, NIV).

Indeed, the lack of a child in the Bible indicates disgrace and the removal of blessing. It is no wonder the Psalmist states, “Children are a heritage from the Lord, offspring a reward from him” (Psalm 127:3, NIV). To welcome the child is to welcome the presence and promise of God himself. Jesus, a child welcomed by his parents, charged his followers, “And whoever welcomes one such child in my name welcomes me” (Matthew 18:5, NIV). The welcoming of a child indicates the acceptance of the blessing of God.

Children are redemptive. Throughout the Bible, children are a welcome source of hope and comfort. As stated above, Eve welcomed the birth of Seth after the loss of her son. Tamar is blessed with twins after she is cheated of the right to children by her husband's brother Onan and her right to a husband by her father-in-law Judah (Genesis 38). When Ruth marries Boaz, she is given a son, Obed, and her mother-in-law Naomi is given a close relative again (Ruth 4). Solomon is born to Bathsheba after the loss of her first child with King David (2 Samuel 12:24). At the end of Job's tribulation, he is given ten children, thus redeeming the children he had lost (Job 42). The coming of children indicates hope and the promise that God is not finished with the story. As discussed above, the redemption of mankind began with the birth of Jesus.

Children are a fulfilment of desire. Children in the Bible are wanted and desired. Sarah longed for the birth of a son, so much so that she sent her servant Hagar to her husband in order to gain a child. Rachel famously told her husband Jacob, "Give me children, or I'll die!" (Genesis 30:1, NIV). Hannah wept before the Lord at Shiloh and pleaded for a child (1 Samuel 1). Elizabeth receives a son in her old age as well and says, "The Lord has done this for me" (Luke 1:25, NIV).

Additionally, the Bible does not leave the attention solely to children and the baby within the womb. Pregnant women are included in Scripture. Pregnant women are to be protected. In the book of Exodus, the often-quoted verse, "eye for eye," is precluded by protections given to women who are pregnant. It states, "If people are fighting and hit a pregnant woman and she gives birth prematurely but there is no serious injury, the offender must be fined . . . But if there is serious injury, you are to take life for life, eye for eye, tooth for tooth . . ." (Exodus 21:22-23, NIV). Pregnant women in the Bible are viewed as vulnerable and defenseless, and serious injury

requires serious consequences. Hagar, when she was pregnant with Ishmael, tried to flee her mistress Sarah. The angel of the Lord intervenes to send Hagar back to her mistress telling her, “I will increase your descendants so much that they will be too numerous to count” (Genesis 16:10, NIV). It is after this encounter that Hagar calls the Lord, “The God who sees me” (Genesis 16:13, NIV) signifying God’s closeness to her and attention towards her in her most vulnerable state.

Social protection for pregnant women was important as well. When Mary conceived Jesus of the Holy Spirit, her betrothed, Joseph, had it in mind to divorce her quietly. However, he is visited by an angel of God to encourage him to remain with Mary. In doing so, she is offered the protection of a husband, and she is spared the consequences of a pregnancy outside of wedlock (Matthew 1:18-25).

Pregnant women are given a prominent place in the story of God. Women who become pregnant are not excluded and written away from the story of God. In some cases, their pregnancies are their entry point into the story of God. For example, it is Tamar’s pregnancy with Judah’s children that ensures her place in the lineage of Christ. Bathsheba’s pregnancy sets the plan in motion for David to murder her husband Uriah, but she also becomes the eventual mother of Solomon, the next king.

Two pregnant women are also featured prominently in the story of God’s redemption of mankind. When Mary learns of her impossible pregnancy, she makes her way to another impossible pregnancy, her cousin Elizabeth. When Elizabeth hears the greeting of Mary, “The baby leaped in her womb, and Elizabeth was filled with the Holy Spirit” (Luke 1:41, NIV). A pregnant Elizabeth and her unborn child are the first to recognize the Messiah and his mother. Luke tells us that Mary stayed with Elizabeth for about three months (Luke 1:56), no doubt receiving encouragement and wisdom from one going before her.

Trauma in the Bible

The heart of God is also on display regarding trauma in the Bible. Herman states, “To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature . . . it is morally impossible to remain neutral in this conflict” (Herman 2015, 8). Throughout Scripture, God is not neutral when it comes to the subject of trauma. He enters the story and embraces the victim. While this research has already spoken of Hagar, the servant of Abraham and Sarah, another story illustrates God’s intervention to rescue those experiencing trauma. In the book of Genesis, Sarah sends her handmaid, Hagar, and her son Ishmael away from Abraham’s camp. The mother and son are left to wander in the desert. They have been abandoned, and now, without water, they are facing the possibility of death. Rather than abandon them as well, an angel of God spoke to his mother, “Do not be afraid; God has heard the boy crying as he lies there. Lift the boy up and take him by the hand, for I will make him into a great nation” (Genesis 21:17-18, NIV). Further, Scripture tells us “God was with the boy as he grew up” (Genesis 21:20, NIV). Not only does God provide relief for the immediate suffering, he further provides his presence and safety to continue the healing. While he might be abandoned by his earthly father, God steps in to care for Ishmael.

It is also important to understand that a trauma history does not disqualify someone from being used by God to further his kingdom. Indeed, in another example from the Old Testament, God chooses to use a traumatized child to bring a leader to his knees. In 2 Kings 5, God uses a slave girl. This young girl was kidnapped and sold into slavery, an experience similar to those of children in our modern context who are trafficked, have been separated from their parents at the United States-Mexico border,

or are refugees who have experienced displacement. She has suffered an unimaginable tragedy in the separation from her family, her community, her home, and must now live the uncertain future of a slave. Her master Naaman, who led the army that separated her from her home, is now suffering from leprosy, a crippling and debilitating disease.

Rather than rejoice in the suffering of her master, the slave girl approaches her mistress, Naaman's wife, and says, "If only my master would see the prophet who is in Samaria! He would cure him of his leprosy" (2 Kings 5:3, NIV). Naaman then takes this advice to the king who agrees with the girl. Naaman eventually goes to Samaria and is healed by the prophet Elisha. We never learn the young girl's name, but we know of her trauma. Had she allowed her master to suffer and die, no one would have blamed her. However, "The godly Israelite slave girl apparently had a child's ability to forgive. With her own heart still aching for home, she watched the agony of her mistress and the lady's increasingly hideous husband. These people were the enemy who had devastated her young life; yet still she cared for them" (Stafford 2007, 2019). This young girl, in spite of her pain, was able to demonstrate kindness and compassion. Using the humblest of children, God humbled a leader and demonstrated His power to a nation. She was not forgotten or unusable.

From the example of Jesus, we gain an even deeper glimpse at the heart of God for the traumatized. The New Testament gives many accounts of Jesus healing men, women, and children. However, Jesus did not simply heal the physical bodies of the traumatized. He healed them socially, emotionally, and spiritually. To the man born blind, Jesus removed the shame and stigma of his blindness. When asked who sinned to result in his blindness, Jesus responded, "Neither," meaning this man did not have to live under the shame of sin (John 9:3). When this man is later cast out of the

synagogue, Jesus seeks him out and reveals himself as the Messiah (John 9:35-38). Jesus offers him a better community, an eternal community. Jesus also welcomed children, took them in his arms, and blessed them (Mark 10: 13-16). He did not walk past or ignore them for greater things. The children, the most vulnerable, were the greater things to Jesus.

Bunge elaborates, "The Bible depicts many ways that children suffer and are the victims of war, disease, or injustice. In the New Testament, Jesus also healed, touched, and blessed children. These and other passages clearly show us that all children, like all adults, are our neighbors, and caring for them is part of seeking justice and loving the neighbor" (Bunge 2009, 18). The New Testament also demonstrates God's heart for those who have experienced trauma through the work of the early church. As the church was just beginning, there were men appointed to look after the needs of widows (Acts 6:1-7). Women lost their husbands to all kinds of events such as war, famine, disaster, and were in danger of losing everything. Caring for the traumatized was the work of the church. James also admonishes believers that a true demonstration of their faith was to look after orphans and widows (James 1:27). The work of caring for those who had experienced trauma went hand in hand with the work of the Church and the heart of God.

Above all, it must be remembered that Jesus himself suffered trauma. Isaiah 53 narrates, "He was despised and rejected by mankind, a man of suffering, and familiar with pain. Like one from whom people hide their faces, he was despised, and we held him in low esteem" (Isaiah 53:3, NIV). Jesus not only healed those suffering from trauma, but also experienced trauma himself. Jesus was born to an impoverished family, forced to flee for his life at a young age, and possibly lost a parent, as Joseph is not mentioned when he is an adult. He is one who empathizes with broken people.

Hebrews 4:15 tells us that we do not have a High Priest who is unable to empathize with our weaknesses. Instead, He, too, walked in trauma and was able to move toward wholeness while helping others.

Pregnancy and Trauma in the Bible

The Bible contains examples of pregnancy, and it also includes the experiences of women with childhood trauma history. While the Bible offers more glimpses than full pictures of a woman's story, there are indicators that allow the reader to make general assumptions about the woman and her story. One example of this lies in the story of Hagar, the slave of Abram and Sarai, found in Genesis 16 and Genesis 21. Hagar is one such character about whom it can be assumed she experienced childhood trauma, and she also endured trauma in her pregnancy.

Hagar enters the narrative of Abram and Sarai when Sarai, who cannot have a child, gives her Egyptian slave to her husband for the purpose of bearing a child on her behalf. Rix outlines the realities of what is being commanded of Hagar. "As an Egyptian in the position of servitude to a wealthy patriarch and his wife, Hagar was essentially powerless and had no real choice, but to comply with an act that could kill her given the high mortality rates of women in childbearing during that time" (Rix 2015, 172). It should not be assumed Hagar had any real choice in bearing the child of her master. Okeye describes, "Hagar is seen as a possession, a disposable commodity that can exchange hands at the will of the owner" (Okeye 2007, 167). Her voice is not heard. Her opinion is unnecessary.

When Hagar becomes pregnant, she becomes the object of Sarah's wrath. Abram, the father of her child, does nothing to stop the abuse and instead is complicit in Hagar's maltreatment. The abuse becomes unbearable to the point where Hagar runs into the wilderness to escape, rather than stay and endure. Okeye adds, "With

Hagar abandoned by Abram and scorned by Sarah the status of the innocent child at birth would be that of its mother–a slave" (Okeye 2007, 167). Hagar's trauma is now not only affecting her but also the well-being of her baby.

It is here in the wilderness where she is met by an angel who instructs her to return. However, bearing Abram's son Ishmael does not provide lasting protection. After the birth of Isaac to Sarai, who has now been renamed as Sarah, Hagar and Ishmael are sent away to the wilderness. The narrative of Hagar ends with another moment of trauma in the wilderness. Her son nearly dies, and God once again intervenes to provide water for them. It is assumed that Hagar and Ishmael return to Egypt, as we are told she finds a wife for him.

It can be assumed from the text that Hagar is a victim of childhood trauma, as well as trauma during her pregnancy. Yildiz (2018) states that women in ancient Egypt were enslaved for the purpose of becoming concubines. It is possible Hagar was purchased in Egypt for this purpose. In ancient Egypt, property rights passed through the female line (Watterson 2011). In light of this, it can also be assumed something happened in Hagar's family in that she became a slave and did not inherit the property or possessions of her family. In Genesis 37:36, Joseph is kidnapped by his brothers and taken to Egypt to be sold to Potiphar's house by the Midianites. This story also leads to a reasonable assumption that Hagar was kidnapped or forcibly taken from her home or family to become a slave. Hagar, as a victim of childhood trauma, also is a victim of trauma in her pregnancy. As the property of her master with no agency, Hagar's pregnancy results from rape, as she is not in a position to give consent (Gaiser 2014, 275). The Genesis account also tells of Sarah abusing Hagar, causing stress in her pregnancy.

While Hagar is an example of a woman experiencing trauma in her childhood and pregnancy, she is also an example of the possibility of hope. There is hope that can be gleaned from Hagar's story regarding trauma and healing, and it also serves as an example that healing or restoration may not match the earthly perspective of healing or restoration. In the modern eye, healing would be assumed to be a safe haven away from Abram and Sarai; however, her story unfolds differently. It is also significant that Hagar's story is told, and she is named in the Bible when many women (i.e. the wife of Noah, the wife of Potiphar) are not.

Hagar might be abandoned by the father of her child, but she is not abandoned by God. When Hagar flees to the wilderness and the angel of the Lord speaks to her, she gives Him the name "El-Roi," meaning "The God who sees me." Thus, she is the first person in the Bible to give God a name. Hagar is also promised that her offspring will be multiplied, and he would be given the name Ishmael (Genesis 16:10-11). In the midst of her trauma, God proves to Hagar that He is with her, and she is not left to suffer alone. She is to return, possibly to the safest place for her at that time where her son can be afforded protection as Abram's child.

Hagar's suffering is recognized by God, and later, the suffering of her son is recognized as well. While in the desert, she is visited once again by El-Roi, the God who sees her, who commands her to see the life-giving water before her. Gaiser narrates, "When God calls, her eyes are opened, her actions are obedient, and the result is life" (Gaiser 2014, 279). Hagar's example also demonstrates the ability of God to life the survivor of trauma out of generational trauma. God could have allowed Hagar and Ishmael to die in the desert or to be sold into slavery again. However, her story, while it ends abruptly, ends with hope and Hagar finding a voice. Genesis 21:21 tells us that Ishmael grew up, and Hagar took a wife for him from her people in

Egypt. Claassens states, “It is significant that the last thing we see of Hagar is an act of agency on her part as she chooses an Egyptian wife for her son– so securing his (and her own) future” Claassens (2013, 5). Hagar’s story evolves from the slave and victim to mother and survivor. She is an example of God’s presence with the survivor of trauma.

Trauma and Healing

Healing from trauma is possible. However, it is important to have a working understanding of what healing may mean in the life of the individual. As human beings, we want healing to be similar to the experience of repairing a broken arm. After the break occurs, the arm is casted, and within a few months, the arm is “good as new,” and can return to its previous function as if the break never occurred. However, healing from trauma is not the same as healing from a break. Sieff states, “Healing does not necessarily mean that we will reach a place where trauma no longer has any effect on our lives. We cannot change the past” (Sieff 2016, 3). Human beings are wired to remember. Yet it is possible to grow beyond the trauma. Sieff goes on to explain, “We can reduce the impact of earlier trauma to create more fulfilling, authentic and meaningful lives” (Sieff 2016, 3). In light of this, an understanding of the way trauma impacts the individual, which has already been discussed at length in this literature review, along with realistic expectations of the survivor will promote the most meaningful life. Perhaps a meaningful definition of healing would include empowering the individual to recover, in whatever way recovery looks like for the individual.

Judith Herman states that recovery is based on the empowerment of the survivor and the creation of new connections (Herman 1997, 134). This involves the validation of experiences and supporting recovery. When the individual has

experienced trauma, power is lost. “The experience of a traumatic set of circumstances usually produces distress, disrupts one’s understanding of the world, makes salient one’s vulnerabilities and lack of power and control, and may make more salient one’s mortality” (Calhoun and Tedeschi 2014, 7). The victim has become aware that he or she is now more vulnerable than ever before. Empowerment comes through allowing the survivor to have a voice and form his or her own meaning from the experience, rather than having meaning ascribed to the individual (Ford 2011, 104).

Connection to others is also shown to be a protective factor and healing factor in relation to healing from trauma. Herman (1998) explains that part of the empowerment process for survivors is the creation of connections with others. Purvis, Cross, and Sunshine (2007) outline the important role parents can play in helping children heal from acute and chronic trauma. The first strategy they outline is the importance of creating “felt safety.” This includes providing an atmosphere where children feel and experience safety for themselves (Purvis, Cross, and Sunshine 2007, 48). Much of this comes from the ability to attune to and anticipate the child’s needs in order to develop a sense of trust. They offer simple tasks parents can do, such as visual and tangible reminders to children they will not go hungry, being aware of potentially frightening or alarming sounds and visuals in the environment, and showing consistent emotional warmth and affection to the child. Further, they outline play to help children heal. “Play is a safe route to the heart of a harmed child and a powerful vehicle for healing” (Purvis, Cross, and Sunshine 2007, 141). Play for children is strongly related to cognitive development and emotional well-being (Whitebread et al. 2012, 5). Playing with children creates lasting bonds (Anderson-McNamee and Bailey 2010, 1). Through building trust in consistent care and through

play, parents and caregivers can provide healing in children who have experienced trauma.

Connection with the community can also promote healing from trauma. Schultz et al. (2016) describe the role of community connection in trauma healing for Latino and Native American populations. They found that these communities create a sense of belonging, identity, solidarity, and hope. Within these communities is a common language and culture within which individuals are understood. Calhoun and Tedeschi add, "It would seem that when the individual is able to engage in disclosures that contain themes of growth, when growth themes are part of the narratives and idioms of the proximate culture's narratives and idioms related to posttraumatic response, and when disclosures are met with accepting or affirming responses from significant others, then growth is more likely to be experienced" (Tedeschi 2014, 7).

Recovery is also a physical and emotional process. Human beings are wired to recover from physical and emotional stress through self-regulation and affect regulation (Heller and LaPierre 2012, 6). Heller and LaPierre describe self-regulation simply as the body's way of recognizing needs, such as being tired, and responding appropriately (i.e., sleep). Affect regulation refers to the ability to manage our emotions. As infants, this is done for us by our primary caregivers. Ideally, as the infant grows and develops, the ability to regulate the self and emotions develops as well. Trauma, however, disrupts these abilities. Therefore, part of the healing process involves becoming aware of the self and how to redress the self. Phoenix (2007) indicates that understanding stress responses can make these responses more understandable and help the individual create coping strategies. For example, relaxation strategies and mobilization of social support can help the individual when he or she is experiencing physical or emotional distress (Phoenix 2007, 124).

Increasing the awareness of the individual's stress responses can increase the ability to cope with the stressor.

There are a number of evidence-based therapies and strategies to help assist in the healing process. One such method is Child Parent Psychotherapy. This method is for children from birth to six months with the goal to improve the parent-child relationship by enhancing the parent's capacity to provide safety and attachment, help the child's affect regulation, and improve the child's overall functioning (Lawson and Quinn 2013, 499). Another method is the Attachment, Self-Regulation, and Competency model, which is for children and adolescents and focuses on building caregiver attachment, child's self-regulation, executive functioning, and trauma experience integration (Lawson and Quinn 2013, 500). Lawson and Quinn also describe the Intergenerational Trauma Treatment Model, which helps the caregiver respond therapeutically to the child and function as the major change agent for the child (Lawson and Quinn 2013, 500). One of the most common forms of treatment is Trauma Focused Cognitive Behavioral Therapy (Cohen et al. 2012). It begins with an initial coping skills-building phase, followed by the narrative and trauma processing phase, and a final treatment consolidation and closure phase. This allows for skills to be developed to build resilience against stressors, formulate a narrative of the trauma that has occurred and then find closure to move forward. With all of these treatments, the overall goal is to reduce trauma symptoms and improve holistic function in survivors.

The Unique Role of the Church

The church has a unique role in supporting and facilitating healing for survivors of trauma. Since its inception, the church has served as a haven for the oppressed. The Book of Acts details the early church as a community where believers

broke bread together, fellowshipped together, and had all things in common, giving of themselves to those who had needs (Acts 2:42-45). This community then formed a sense of place, belonging, and shelter as they experienced the trauma of persecution. In the twenty-first century, the Church continues to have this ability to be both a shelter and a refuge for those who have experienced trauma.

One way the Church can do so is by becoming trauma-informed. Becoming trauma-informed refers to integrating an understanding of past and current experiences of violence into all aspects of service delivery and avoiding the re-traumatizing of individuals (Poole 2017). SAMSHA outlines four key assumptions in a trauma-informed approach. They are as follows (SAMSHA 2014, 9-10):

1. Realization about trauma and how trauma can impact individuals, families, groups, organizations, and communities.
2. Recognize the signs of trauma, which may be gender, age, or setting-specific.
3. Respond by applying the principles of a trauma-informed approach.
4. Resist re-traumatization of clients and staff by avoiding stressful or toxic environments that interfere with recovery or wellbeing.

There are various ways the Church can approach becoming trauma informed. Staff and leadership can familiarize themselves with the subject of trauma and how it manifests itself in the life of church members. There also must be a basic awareness of the reality that there will be members who have experienced trauma and different kinds of trauma. Further, those expressions of trauma will vary based on the individual.

While it is impossible to cater the church experience to each individual, there are ways the church can implement for the benefit of the congregation as a whole. This will include utilizing the six principles also outlined by Substance Abuse and

Mental Health Services Administration (2014). The first principle involves Safety. This includes felt safety, not just physical safety. One example of this can be the church staff releasing the order of the service or Scripture passages to be read in advance of the service so men and women can prepare. Trustworthiness and Transparency are the next principles and are vital to church health overall. Transparency through behavior, finances, decision-making, etc. can also serve a vital purpose in helping men and women who have experienced trauma. Peer support is the third principle. Peer support provides connection, and the Church is positioned to facilitate this support through groups and support systems such as Bible studies, recovery groups, life groups, etc.

The fourth principle involves collaboration and mutuality. This involves church leadership including survivors in the decision-making process and valuing their input. It also serves to empower survivors through a willingness to listen and promote change when the church is not meeting the needs of members adequately. This relates also to the fifth principle of empowerment, voice, and choice. SAMHSA states, "Individuals' strengths and experiences are recognized and built upon . . . fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma" (SAMSHA 2014, 11). The Church recognizes that survivors are valuable members of the church community with talents, gifts, and insights that serve to strengthen the Body of Christ. The final principle involves moving past cultural stereotypes and biases. This involves not abandoning the tenets of the faith, but being aware of the issues men and women will face as they heal from trauma, including issues involving race, sexual orientation, gender-identity, citizenship status, etc. An example of this would be providing services to women who have experienced

abortions. This includes not only an awareness of the shame and stigma surrounding abortions, but also an awareness of the trauma history and experiences leading to abortion decisions. The Church has the tools and resources to become trauma-informed, and a willingness to apply these principles will further enable men and women who are survivors of trauma to experience healing.

The Church is also uniquely designed to be a safe haven for the questions that arise in the survivor and the community in the aftermath of trauma. The Church as a whole must be willing to confront these questions with courage and a realistic understanding of the spiritual despair that can take place. “Although many persons report significant posttraumatic growth in their philosophies of life, it is also true that great loss and senseless tragedy can lead others to lose faith and experience significant existential despair” (Calhoun and Tedeschi 2014, 6). These questions can include “Why would God let this happen?” and “How can God be good when there is evil?” The Church does not need to have answers, because empowerment includes giving space to survivors to discover these answers for themselves. However, the Church can bear witness to the pain and validate the questions.

The Church also has the unique ability to mourn with the victim. Throughout the Old Testament, there are examples of collective mourning in the community over sin and trauma. Hunsinger states, “Mourning together reduces shame, opens our hearts to the sheer magnitude of our love for the world, and deepens our desire to act together in a responsive and responsible way” (Hunsinger 2021, 374). She adds, “Our relational capacities can unleash tremendous power when we entrust ourselves to the process of mutual listening, speaking and caring” (Hunsinger 2021, 368) For example, Numbers 20:29 tells us that the entire congregation of Israel mourned the death of Aaron for thirty days. After the death of Absolam, the author of Second Samuel

narrates, “So the victory that day was turned into mourning for all the people” (Numbers 19:2, NIV). In Judges 11, Jephthah’s vow before the Lord results in the decision to sacrifice his daughter. Before she dies, she requests to mourn for two months, “I am my companions” (Numbers 11:37, NIV). As a result, “It became a custom in Israel that the daughters of Israel went year by year to lament the daughter of Jephthah the Gileadite four days in the year” (Judges 11:40, NIV). The disciples carry on this theme of collective mourning. After Jesus’s resurrection, John tells us he appeared to them, indicating the disciples were mourning together after his death (John 20:19). There is healing when grief is done safely and in community.

Finally, the Church has the unique ability to provide hope, both in this life and in the one to come. First Peter 5:10 details, “And the God of grace, who called you to his eternal glory in Christ, after you have suffered a little while, will himself restore you and make you strong, firm and steadfast” (Peter 5:10, NIV). There is hope that suffering will be used for meaning and to make the survivor stronger. Further, the Church looks forward to the day when “He will wipe away every tear from their eyes, and death shall be no more, and neither shall there be mourning, nor crying, nor pain anymore” (Revelation 21:4, NIV). “God works out our salvation by bearing what cannot be borne, by transforming our mourning into longing, our longing into lament, our lament into hope, and through the redemption of the world, our hope into joy” (Hunsinger 2011, 25). The Church is able to provide hope to the survivor that God is able to transform, to create meaning, and even to bring joy in spite of suffering both in this time and for eternity.

Summary of Related Literature and Studies

This review of literature provides insight into the research and history surrounding pregnancy, attachment, trauma, and attitude. This review demonstrates

that while there is research involving these topics, there is a gap in literature involving childhood trauma and pregnancy, specifically involving the relationship between childhood trauma and its correlation with maternal attitude towards pregnancy and a woman's unborn child.

In the first section of this literature review, this researcher provided an overview of pregnancy. In order to conduct research and explore attitude and trauma regarding this pivotal time, there must be an understanding of the process involved. Pregnancy is argued to be a holistic act involving the mind, body, and emotions of a woman. The process of pregnancy involves the development of the fetus from an egg no larger than the tip of a pen to a baby capable of living and breathing on his own. While the baby must develop over the course of forty weeks, his mother is developing as well. Her own body stretches and grows as she begins to release her previous identity to embrace the new identity of herself as mother. After the birth of the baby, the Fourth Trimester, the weeks following the birth of the child, involve a delicate dance between mother and child in which the two are dependent individuals, yet also interdependent on each other. The primary tasks of the mother and child during this time involve organizing and discerning these new roles, as well as developing a secure bond with one another.

Attachment theory explains the process of bonding between infant and caregiver that goes beyond simply meeting needs or developing affection for one another. Section two of this literature review summarized the development of attachment theory by John Bowlby. Attachment theory posits the role of the mother as the secure base for her child, meaning his center of stability while he explores the world. Secure attachment is formed as the infant has a need and the caregiver anticipates or meets the need. The infant is able to trust his voice is heard, and he is

able to develop trust and curiosity in his environment. The literature demonstrates that the foundation for secure attachment could possibly begin during the prenatal period. A securely attached child, if all goes well, will continue through adolescence and into adulthood with secure attachment. Those adults will report satisfaction and trust in work and in life. If secure attachment is not able to develop, then the child will continue throughout life with a mistrust of himself or others. The research is still emerging as to how attachment plays out in adult life in regards to multiple relationships, such as romantic partnerships and parenting.

One key way attachment can be seriously affected is through trauma. The literature related to trauma was reviewed in the third section of this review. The literature demonstrates that trauma's impact is holistic and pervasive in nature. The age the trauma occurred, the frequency the trauma occurred, and the response of adults towards a child experiencing trauma will determine how significantly the trauma is experienced by the individual. If not addressed, the impact of the trauma can lead to physical and emotional impairment. Trauma can also impact attachment during pregnancy. Interpersonal trauma has been found to have the greatest influence in terms of long term and holistic impact.

Section four illustrated literature surrounding attitude and pregnancy. The literature reviewed concluded that attitude can make a difference in pregnancy. Attitude can influence the physical and emotional health of a child. A mother's negative attitude towards her child can increase her risk of delivering a child with a low birthweight. It can also increase the likelihood of abuse during the prenatal period and first year of life. A negative attitude could also lead to bonding failure between the mother and child.

Pregnancy and children are significant in the Bible. Throughout Scripture, God uses pregnant women to accomplish his purpose. Ultimately, it is through the pregnancy of Mary that the Savior enters the world. The womb is a place not of darkness but of blessing and purpose as nothing is hidden from the intentionality of a loving creator. From Scripture, it is understood that pregnant women are to be protected, and they are also given a place of prominence in God's story. Children are meant to be protected and treasured as well. Children are a symbol of God's blessing and redemption. They also are the fulfilment of desire. God treats the growth and development of children with care. Their protection is serious to Him. Pregnancy and the mother additionally are to be nurtured and regarded with dignity.

The Bible also speaks about trauma. Throughout Scripture, God weaves a narrative of men and women who are struggling with physical and emotional trauma, and God consistently rescues and restores his people through his presence and community. Jesus himself is able to empathize with his people as he endured trauma through suffering on the cross. He was despised, rejected, beaten, and betrayed. Jesus is able to heal and restore with compassion as he understands the holistic impact of trauma. This view of trauma is important to keep in mind as it gives hope towards the holistic nature of healing trauma. Yes, trauma is painful and can devastate. However, the hope of Scripture is the complete restoration and healing of men and women who have suffered trauma. Finally, there is evidence in the literature to support healing and recovery from trauma, and the Church plays a unique role in facilitating and providing space for this recovery.

CHAPTER III

RESEARCH METHODOLOGY AND PROCEDURES

Overview

The purpose of this research is to explore the relationship of childhood trauma to a mother's attitude towards pregnancy and her unborn child, specifically in Northwest and Northeast counties in Florida. This study relied on a framework of the holistic impact of childhood trauma and its relationship to attitude. This was done using a Mixed-Methods Design featuring both quantitative and qualitative methods. This chapter provides a description of this methodology, as well as the design of the research. The subjects and location of the study, ethical considerations, pilot testing, and methods of analysis will also be discussed.

Research Methodology

The following paragraphs will explore the methods employed in this research. I employed mixed-methods, using both quantitative and qualitative strategies. This increased my chances of achieving measurable data and answering the questions posed by this research.

Mixed-Methods Research

Research provides a valuable opportunity through the collecting and analyzing of data to study connections and relationships, and create opportunities to strengthen the bonds between a mother and her child. This research employed quantitative and qualitative methods for a mixed-methods study. Quantitative research is based on

collecting and analyzing data that is structured and can be represented numerically (Goertzen 2017, 12), while qualitative analysis focuses on understanding the meaning and experience dimensions of humans' lives and social worlds (Fossey et al. 2002, 717). For this study, both elements were important to measure the quantity of experiences, as well as understand the reasons behind the experiences in order to determine possible resulting behaviors.

The mixed methods approach affords the researcher multiple paradigms to consider a problem and understand it more completely (Migiro and Magangi 2011). Mixed methods are founded in a pragmatic philosophy, believing that both the qualitative and quantitative paradigms can be used, and that truth lies in what works best for a particular research problem. McKim states that the mixed-methods researcher must always ask the question, "Is using mixed methods going to add more value than using a single method" (McKim 2017, 202). Indeed, mixed methods are more time intensive and involve additional steps in planning, data collection, and analysis. Mixed methods also require the researcher to have additional knowledge in both areas. However, the benefits that a mixed methods study provide outweigh the cost of the added time. Using mixed methods adds value by increasing the validity of the findings, informing the collection of the second data source, and assisting with knowledge creation (Hurmerinta-Peltomaki and Nummela 2006). When seeking to gain a deeper understanding behind a particular research problem, the observation of human behavior and motivation, as well as measurable data proves invaluable in increasing the field of knowledge. Quantitative methods tell the researcher if an experience or event has occurred, while qualitative methods provide insight into the experience or event.

When determining how to implement a mixed methods study, the researcher must discern if the data will be collected concurrently or sequentially. According to Teddlie and Tashakkori (2006), in a concurrent design, the strands of a study occur in a parallel manner, while in a sequential design, the data occurs in chronological order with one strand emerging from the other. This research is sequential in nature. It allows for triangulation to occur by using different data collection methods to ensure that the researcher is correctly interpreting the data (Migiro and Magangi 2011). Triangulation increases the validity of constructs and inquiry results by counteracting or maximizing the heterogeneity of irrelevant sources of variance, and it will help corroborate the results from different methods (Greene, Caracelli, and Graham 1989, 259).

Teddie and Tashakkori (2006, 22) provide a sample framework for conducting a sequential mixed-methods study. The quantitative research is classified with a box frame and the qualitative research is classified by the oval frame. This is illustrated in the following figure (Teddie and Tashakkori 2006, 22):

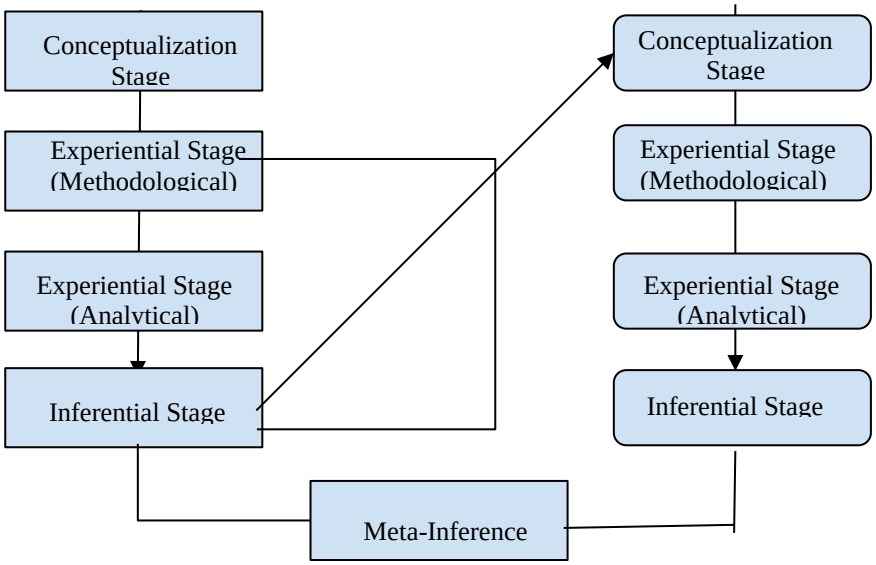


Figure 4. QUAL-QUAN Sequential Mixed Methods Design

This figure explains the beginning of the study with the conceptualization of the quantitative method. This research will use questionnaires to begin eliciting data from respondents. After analyzing the data, inferences will be made, which will influence the conceptualization of the qualitative method. Interviews from a sampling of respondents will take place using open ended questions. The data will be analyzed and then compared with the data retrieved from the quantitative data. Conclusions from the data will be drawn during the final meta-inference stage.

Research Design and Instruments

This study aimed to examine the relationship between childhood trauma and a woman's attitude regarding pregnancy and her unborn child. The research sought to answer the following questions:

1. What are the participant demographics in this study in terms of the following:
    a. Length of pregnancy (in weeks at the time of participation)
    b. Age Range
    c. Race
    d. Socioeconomic Status (Annual Household Income)
    e. Educational Background
    f. Marital Status
    g. County of Residence
2. What is the extent of childhood trauma experienced by pregnant women in Northwest and Northeast Florida?
3. What is the most common instance of childhood trauma experienced by pregnant women in Northwest and Northeast Florida?
4. Is there a relationship between Adverse Childhood Experiences (ACE) and reported participant demographics?

5. What insights can be gained from the Pregnancy Related Beliefs Questionnaire regarding the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves in Northwest and Northeast Florida?
6. Is there a relationship between the ACE scores and ACE types of the participants and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves in Northwest and Northeast Florida?

This research will consist of two phases. Phase One is the quantitative phase, in which data will be gathered using questionnaires. Phase Two is the qualitative phase where data will be gathered using participant interviews.

Phase I

During Phase I, the quantitative phase, data was collected to answer the first six research questions. The researcher elicited demographic information from the participants in order to have a better understanding of the women participating in the research and to enhance the data. According to SAMSHA, “Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, or sexual orientation. Trauma is a common experience for adults and children in American communities” (SAMSHA 2022). Keeping this in mind, this research asked for the approximate age of the participants, socioeconomic status as defined by annual household income, race, and educational background. These results could either confirm or deny that trauma is across all communities. Additional questions were asked such as the length of pregnancy in weeks, meaning how far a woman is into her pregnancy at the time of the study. The marital status was also asked to help provide a picture of the participant’s relationship with others. Finally, the county of residence was asked because this research took place in multiple locations.

In order to determine the extent of childhood trauma experienced and the most common instances of ACE (ACE type), the Adverse Childhood Experiences Questionnaire (ACE) was utilized. The ACE questionnaire is an instrument used to identify instances of childhood trauma in the life of an individual. Questions were asked based on exposure to the following: verbal abuse, physical abuse, sexual abuse, emotional abuse, neglect, parental separation or divorce, domestic violence, caregiver substance abuse, caregiver mental health hardships, and caregiver incarceration. The data elicited from this questionnaire determined the extent of childhood trauma exposure and the most common instances of childhood trauma experienced by participants.

Phase I also included collection methods to determine the attitudes of pregnant women towards their pregnancies and unborn children. This was done by utilizing the Pregnancy Related Beliefs Questionnaire (PRBQ). This questionnaire consists of fifty-four questions in a seven-point Likert scale, with rankings of Totally Agree, Agree Very Much, Agree Slightly, Neutral, Disagree Slightly, Disagree Very Much, and Totally Disagree. Because this questionnaire measures beliefs, thoughts, and feelings which are building blocks of attitude, the responses were classified as "Change-Resistant" versus "Change-Receptive."

A change-resistant attitude is a strong attitude, one that does not easily change, is relatively persistent over time, predictive of overt behavior, and is selective in the processing of information (Eagley and Chaiken 2014, 413). A change-resistant attitude can be understood as one that is cognitively rigid, meaning there is little willingness to change beliefs, attitudes, or personal habits (Greenberg, Reiner, and Meiran 2012). There is a close link between an object and its evaluation (Hill 2019). In contrast, a change-receptive attitude can be understood as a weak attitude, which

has a more open or separated link between object and evaluation (Hill 2019). A weak attitude can be understood as one that is uncertain (Sawicki and Wegener 2018) or cognitively flexible. Cognitive flexibility refers to the ability to adapt the cognitive processing strategies to face new and unexpected conditions in the environment (Canas et al. 2006). It is correlated with intellectual humility (Zmigrod et al. 2019), which means an individual is more open to the possibility of changing her beliefs, thoughts, and feelings, and thus, adjusts her attitude based on new information. On the other hand, an individual who has a change-resistant attitude means he or she is more prone to extreme thinking and is less open to the changing of thoughts and feelings (Zmigrod 2020). A resistance or receptiveness in changing one's attitude may influence the attitude of the individual towards herself, others, her pregnancy, her baby, and motherhood. Therefore, the categories change-resistant and change-receptive were used to help describe a participant's attitude. Responses were analyzed based on whether participants Agree, Disagree, or indicate a Neutral Response. If they tied with responses, then their attitude was not able to be determined.

Additionally, the researcher created twenty-seven questions to measure attitude using the same Likert scale. These researcher-created questions were utilized during the pilot testing of the instruments. The results will be discussed during the pilot testing discussion of this chapter. To make organizing the data easier, I have pre-categorized the research questions as follows:

Table 1. Researcher-developed categories for PRBQ data

Category and Question Numbers
Attitude Regarding Self 1, 2, 3, 5, 6, 7, 8, 9, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 26, 28, 30, 32, 34, 36, 41, 42, 44, 45, 46, 50, 51, 52, 53, 61, 68, 74, 76, 77, 80
Attitude Regarding Others 4, 10, 12, 18, 31, 33, 35, 37, 39, 48, 71, 72, 75, 81
Attitude Regarding Pregnancy 27, 43, 55, 56, 57, 58, 59, 60, 62, 67
Attitude Regarding Baby 11, 24, 49, 53, 64, 69, 70
Attitude Regarding Motherhood 25, 29, 38, 40. 47, 54, 65, 66, 78, 79

The first phase lasted an estimated one to two months per research location. As this research took place during a participant's regularly scheduled doctor visit or consultation with a pregnancy center, the amount of time varied based on location. During Phase One, I obtained fifty participants total from the various research locations. Fifty participants was the number selected for a variety of reasons. In the original PRBQ study conducted by Moorhead, Owens, and Scott (2003), forty-two participants were studied. Fifty surpassed the number conducted in the original study. Further, in 2019, there were 965 live births to residents of Jackson, Washington, and Holmes Counties (Florida Health 2019), which is the closest area to where I live. Based on this number, fifty participants is equivalent to five percent of the total number of live births. Not all residents of these counties utilize doctor's offices within these counties and may go elsewhere. This researcher hopes to have more participants, but fifty is the goal number in order to increase the likelihood of validity of the data. While I hoped to keep the research in Holmes, Washington, and Jackson

Counties, fifty could not be obtained in these counties alone. As a result, I looked to other counties in Northwest and Northeast Florida for participants.

Phase II

Seidman stated, "I interview because I am interested in people's stories" (Seidman 2006, 7). He goes on to say, "At the root of in-depth interviewing is an interest in understanding the lived experience of other people and the meaning they make of that experience" (Seidman 2006, 9). Phase II consists of the qualitative phase of research, which is the interview portion. The interview portion helps add to the data gained in questions one through six. The purpose of the interview is to expound on the experiences and stories of the participants in order to gain a better understanding of their attitudes towards pregnancy and motherhood, and how experiences of childhood trauma relate to those attitudes.

According to Dornyei (2007, 140), a good interview has two key features: 1) It flows naturally; and 2) It is rich in detail. The goal of the researcher is to provide a comfortable atmosphere in which the interviewer and interviewees are able to engage in conversations that will yield measurable data. Barber and Schostak (2005, 42-43) identify and explain the following key concepts to keep in mind when conducting interviews: power, social position, value, trust, meaning, interpretation, and uncertainty. The interviewer must consider the balance of power in place between the interviewer and interviewee. Social position also relates to power structures in place. I am aware of my status and privilege as an educated, heterosexual, white, middle-class woman in the Southern United States. Especially when interviewing participants of different races and social classes, there will be invisible power structures at play.

Barber and Schostak discuss value as the worth of the testimony or words of the participant. Trust is the ability of the researcher to gain the trust of the

interviewee, but also to present the data with accuracy and honesty. I remembered there are multiple meanings at play when interviews take place. A good interviewer must keep this in mind, as well as the possible various interpretations of the stories and experiences relayed. There can be uncertainty with multiple meanings and interpretations at play.

Furthermore, Seidman (2006, 9) states, “At the heart of interviewing research is an interest in other individuals’ stories because they are of worth” (Seidman 2006, 9). As an interviewer, it is my role and responsibility to demonstrate to the participant the worth and value of her story. This was done by respecting the cultural and social values of the interviewee and being aware of verbal and nonverbal cues indicating discomfort or relaxation. I tried to help the participants feel relaxed, as well as allow the participant to express herself within safe boundaries.

The interviews are semi-structured. I prepared questions ahead of time to give the interview guidance. However, because it is semi-structured, I am able to ask follow-up and clarifying questions to gain a better understanding of the interviewee’s experience and to gain a richer understanding of the data. During Phase I, the participant had the opportunity to indicate if she would like to be contacted for an interview. I hoped to interview at least ten participants, as this will be ten to twenty percent of respondents. I was able to interview twelve.

Selection of the Subjects

This study explored the relationship between childhood trauma history and the attitudes of pregnant women towards pregnancy and their unborn children. The population of interest was women who are currently pregnant and living in Northwest and Northeast Florida. Simple sampling scheme was utilized, in that participant all had an equal and independent chance of being utilized during the sampling frame. The

participants have common characteristics in that they were all pregnant women. However, I had participants of varying demographics in order to reflect the population of Northwest and Northeast Florida as best as possible. It was also based on convenience sampling, with participants who were willing to participate in the study (Migiro and Magangi 2011). Participants of this study met the following inclusion criteria to be considered. They were: 1) Within the first, second, or third trimester of pregnancy; 2) Natural born females; 3) Resident of counties in Northwest and Northeast Florida; 4) A minimum of eighteen years old.

Participants were recruited through local doctors' offices and pregnancy centers serving prenatal clients. Participants were given the option to complete the quantitative surveys during their appointments either in paper format or through a digital format called Qualtrics XM. Within the consent to complete the survey, participants were also given the option to give consent to be contacted for an interview conducted by the researcher. This was the selection criteria for both Phase I and Phase II. For Phase II, participants who indicated a willingness to be interviewed were eligible as long as they were still within the first, second, or third trimesters of pregnancy.

Counties within Northwest and Northeast Florida were chosen for multiple reasons, which included:

1. Proximity to the researcher. This researcher currently resides in Washington County, works in Holmes County, and frequently visits Suwannee County. The furthest county away is Columbia County, and it is a drivable distance from the researcher.

2. Relationships with doctors and pregnancy centers. This researcher can easily make contact with and be referred to other doctors' offices and pregnancy centers for research due to rapport already in place.
3. There has been little research of this nature conducted within Northwest and Northeast Florida.

World Atlas provides a state map with the Florida counties. The counties mentioned in this study are indicated below (World Atlas 2021).

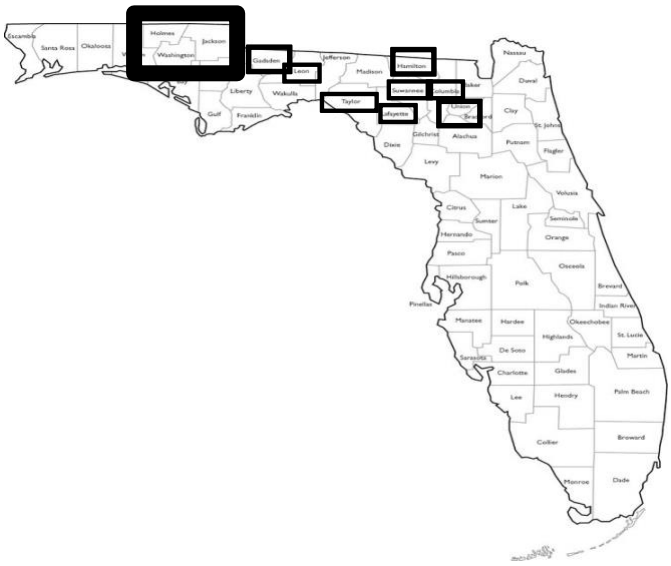


Figure 5. Map of the counties of Florida

According to the most recent demographic information provided by the 2020 U.S. Census, Leon County has a population of 292,198 people. Leon County holds Tallahassee, the capital city of Florida, as well as two major universities. Approximately 52.7% of the population is female. Of the total population, 61.5% identify as white, 32 % are black or African American, 6.7% are Hispanic or Latino, and 3.6% are Asian. Around 93.5% of the population over the age of 25 holds a high school diploma, and 46.2% hold a Bachelor's degree. According to this Census, 17.6% of the population is living in poverty (A description of the federal poverty level is found in Appendix A).

Columbia County has the next highest population of the counties listed with 69,698 people. Of this population, 48.2% are female. In terms of race and ethnicity, 77.7% are white, 18.7% are black or African American, 6.7% are Hispanic or Latino, and 1% are Asian. Approximately 86.1% of the population over the age of 25 has a high school diploma, and 14.9% have a Bachelor's degree. About 15.6% of the population live in poverty.

Jackson County has a population of approximately 46,414. Jackson County has a median age of 41.7 years. However, the proportion of people between the ages of 20 and 29 is 14.3% and more than 50% of the population are below the age of 50. Forty-six percent of the population are female. Of the total population, 69.6% are white, 26.3% are black or African American, 4.9% are Hispanic or Latino, and less than two percent are Asian or American Indian. Eighty percent of those over 25 years old hold a high school diploma, while 12.6% hold a Bachelor's degree or higher. Nineteen percent of the population is in poverty.

Following Columbia County in size is Gadsden County with a population of 43,714. Of the total population, 52.5% are female. The highest racial group is black or African American, who make up 55.5% of the population. The next highest is white with 41.9%. Hispanic follows with 10.9%. The percentage of persons holding a high school diploma over the age of 25 is 81.4%, and 18.2% hold a Bachelor's degree or higher. The total percentage living in poverty is 21.9%.

The next county in terms of population size is Suwannee County with a population of 43,474 people. Of these, 48.6% are female. Persons identifying as white comprise 84.2% of the population, while 12.6% are black or African American, and 9.9% are Hispanic or Latino. Of the total population over the age of 25, 82.3% have a

high school diploma, and 15.5% have a Bachelor's degree. The population below the poverty level is 15.6%.

Washington County has the next largest population of the three with 25,473. Of this total population, 45.8% are females. Eighty percent are white, 15.1% are black or African American, 3.8% are Hispanic or Latino, and around 2.3% are Asian or Native American. Eighty-one percent of the population have a high school diploma and 12.5% have a Bachelor's degree. In the workforce, 48.7% of women over the age of 16 are working. Twenty percent of the population is below the poverty level.

Taylor County has a population of 21,796 people. Of this population, 45.7% are female. Seventy-six percent are white, 19.9% are black or African American, and 4.2% are Hispanic or Latino. In terms of education, 78.8% have a high school diploma and 8.3% have a Bachelor's degree. Nineteen percent of the population lives below the poverty level.

Holmes County, Florida, has a population of 19,617 people living in the county. Forty-six percent of the population are female. Of this population, 88.9% are white, 6.7% are black or African American, 2.9% are Hispanic or Latino, and approximately 2% are Asian or Native American. In terms of education, 78.7% have a high school diploma and 10.7% have a Bachelor's degree. Forty-seven percent of females over the age of 16 are working, and 20% of the population is in poverty.

Following Holmes County is Union County with a population of 16,335 people. The female percentage of the population is 35.4%. This county consists of 74.5% persons who identify as white, 22.6% black or African American, and 5.6% Hispanic. Of the total population over the age of 25, 76.3% hold a high school diploma and 10.5% have a Bachelor's degree or higher. It is important to note that 20.7% of the population lives in poverty.

Hamilton County is next with a population of 14,004. Of this, 42.1% are female. This county has a white population of 62.8%, 33.2% are black or African American, and 9.8% are Hispanic or Latino. Of the total population, 73% have a high school diploma and 7.9% have a Bachelor's degree. There are 24.2% of the population currently living in poverty.

The smallest county is Lafayette County with a population of 8,226. Forty-four percent of the population is female. In terms of race and ethnicity, 84.5% are white and 12.7% are black or African American. Of the total population over the age of 25, 78.8% have a high school diploma and 8.3% have a Bachelor's degree. Finally, 19.3% live below the poverty level.

After completing the Pilot Testing, I began looking for other locations with which to expand the research base. Bailey Family Practice already agreed to continue the research, so this location was secured. I reached multiple hospitals and doctor offices located throughout Northwest Florida. However, the research proposal was rejected due to staffing shortages and Covid-19 restrictions.

At the encouragement of my dissertation advisor, I expanded my search to pregnancy resource centers. Pregnancy centers meet the physical and emotional needs of clients and offer support for women beyond what a doctor's office will provide. In addition to ultrasounds, pregnancy testing, and sexually transmitted disease testing, these centers provide parenting classes, support groups for expecting mothers and fathers, and meet physical needs by providing items for the baby. Pregnancy resource centers were included because they interact with prenatal clients and also get to know their clients on a more personal level through counseling and parenting classes. Pregnancy resource centers are also staffed with nurses, counselors, and support personnel who can assist with client's emotional and physical support needs.

Pregnancy resource centers also provide spiritual support and guidance if clients are receptive.

Due to a relational connection, I was able to contact the Lake City and Live Oak Pregnancy Care Centers, located in Columbia and Suwannee Counties. These locations agreed to participate in the research. The research process began at all three locations on January 3, 2022, and continued until April 11, 2022. A Woman's Pregnancy Center in Tallahassee, Florida (Leon County), agreed to participate in the research as well. This location began on March 14, 2022, and lasted until April 11, 2022.

Development of Instruments

In order to answer the research questions presented, the researcher looked for instruments to help illicit quantitative information that yielded workable data. This led to the identification of two instruments to measure childhood trauma history and prenatal attitude. The instruments selected have already been developed by previous researchers and measured for validity and reliability.

The first instrument to be administered in the current research is the Adverse Childhood Experiences (ACE) Survey. The ACE survey (Appendix A) was first developed by Vincent J. Felitti et al. (1998) to investigate the relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood trauma. It is a ten-item, self-report measure. Each yes to a question is assigned one point, for a total score ranging from zero to ten out of ten. This survey, discussed in detail in Chapter 2, has been used to understand the exposure of a child to traumatic events. The survey was developed using questions from published surveys, including the Conflicts Tactics Scale, the 1988 National Health Interview Survey, the Behavioral

Risk Factor Survey, the Third National Health and Nutrition Examination Survey, and the Diagnostic Interview Schedule of the National Institute of Mental Health.

This survey has been used in other studies, including The Prisoner ACE Survey (Ford et al. 2019). In this study, 468 adults were interviewed in a Welsh prison between February and June 2018. The research found that over eight in ten prisoners reported at least one ACE, with nearly half (46%) reporting four or more ACEs. They also found that prisoners with four or more ACEs were four times more likely to have served a sentence at a Young Offender Institution.

The second instrument to be administered in the current research is the Pregnancy Related Beliefs Questionnaire (PRBQ) (Appendix B). This questionnaire was developed by Stephen R. J. Moorhead, Julie Owens, and Jan Scott (2003). Permission was obtained from Stephen R. J. Moorhead to utilize the instrument for research purposes (Appendix C). The PRBQ was created to assess the risk of postnatal depression in pregnant women. Moorhead et al. developed the instrument through information from literature review, staff working with women with postnatal depression and interviews with recently ill patients. The PRBQ was piloted with 42 pregnant women and achieved a Cronbach alpha of 0.85. These scores significantly correlated with other measurements of postnatal depression, including the Beck Depression Inventory, the Dysfunctional Attitude Scale, and the Cognitive Adaptation to Stressful Events questionnaire. Thus, it was selected as a tool to help identify women who may be at risk for postnatal depression.

Leach, Terry, and Nikcevic (2018) utilized this instrument to measure risk factors leading to postnatal depression, including antenatal maternal attitudes. The aim of this study was to examine psychometric properties of the PRBQ to establish the utility of the instrument in predicting the symptoms of postnatal depression. These

researchers conducted two studies. In the first study, they utilized a cross-sectional sample of 344 participants, who were either pregnant or in the postnatal period, and completed the PRBQ, as well as questionnaires related to assessing background factors, general dysfunctional attitudes, and depression. In study two, a sample of 210 women completed questionnaires, including a measure of general dysfunctional attitudes, the PRBQ-8, and depression on two occasions: early in the second trimester and postnatally.

Their research found PRBQ-8 had good convergent, concurrent, and predictive validity and high internal and test-retest reliability. Hierarchical regression analysis revealed the antenatal PRBQ-8 scores predict the severity of postnatal depression symptoms. The researchers concluded the PRBQ-8 is a psychometrically sound measure of maternal attitudes that can be used antenatally to identify women at risk of postnatal depression.

The interview consisted of open-ended questions or prompts intended to illuminate the mother's experience growing up, as well as her current attitudes toward pregnancy and her unborn child. The questions were asked in a narrative style to help illicit full responses from the respondents. A full script of the interview and questions asked is located in Appendix D. These questions were used to help the researcher enhance the data from the ACE survey and the PRBQ by providing anecdotal support.

Pilot Testing

While Pilot Testing does not guarantee research methods will be without problems, it was conducted to measure the validity and feasibility of the research instruments and procedures. To the best of my knowledge, the ACE Survey and the PRBQ survey have not been used together in a research process. Pilot testing helped determine if the research instruments together would answer the research questions

guiding this study. Pilot testing allowed the researcher to improve the internal validity of the questionnaires by administering the pilot in the exact same way the study would be administered and by identifying ambiguities and difficult questions (Van Teijlingen and Hundley 2001). This was especially important as the quantitative research was conducted without the researcher present, and it was desirable for the participants to answer as many questions as possible.

I included additional questions to the end of the PRBQ survey developed by myself to be pilot tested. The researcher-developed questions are located in Appendix B. These questions were developed to provide additional information about the participant's attitude towards pregnancy, her unborn child, motherhood, others, and herself. When pilot testing data was measured, these questions were analyzed to determine validity. Validity is defined as the extent to which an instrument measures what it asserts to measure (Kimberlin and Winterstein 2008, 2278). In a mixed-methods research process, qualitative research is based on the fact that validity is a matter of trustworthiness, utility, and dependability (Zohrabi 2013, 258).

For the questions the researcher has developed, the researcher looked for both internal and external validity. During the pilot testing, content validity was important because the researcher was able to determine if questions were difficult for the participant or were unclear. This was demonstrated by questions being skipped over by the participant and by neutral responses. Questions that were consistently skipped over by participants, were removed after pilot testing. Internal validity means the study can be replicated (Mohajan 2017, 15). This is ensured by making the directions clear and concise for the participant. Zohrabi (2013, 258) also mentions internal validity can be measured through triangulation. Triangulation allows for multiple sources to be used to help explore a concept.

These questions to be pilot tested were scored using the Likert scale measure with rankings from one to seven. An additional column “Does Not Apply” was included. There were questions relating directly to the participant’s own life and experiences. For example, “My other children are supportive of this pregnancy” included a “Does Not Apply” column because the participant may not have other children. Whereas, the questions related to the participant’s own feelings, such as “I am overwhelmed” were not given a “Does Not Apply” option. Pilot testing enabled the researcher to determine if these questions were valuable and yielded results significant to the research.

Pilot testing began on Wednesday, September 8, 2021, and ended November 17, 2021. I met with the staff of Bailey Family Practice to explain the research procedures and distribute materials. During their lunch hour, I read the introductory information, as well as the receptionist instructions. I explained the survey and showed the staff the consent portion, the demographics, the ACE survey, the PRBQ, and the option to consent for an interview. I made sure to explain to the staff that because the ACE survey asks questions about trauma, patients are encouraged to stop the survey if they feel uncomfortable. The process for using the QR code was demonstrated to the staff as well.

Initially, the idea was for the receptionist to offer the survey. However, after receiving feedback from Dr. Bailey, the director and lead doctor, and her staff, it was determined that the survey would be offered by the nurse. There were several reasons for the change, which included the following: First, confidentiality. The survey could be offered when the patient was in a private room waiting to be seen by her doctor as opposed to sitting in a public waiting room. Second, rapport. The prenatal clients have rapport and familiarity with the nurses as they see the same nurses throughout their

pregnancy. Third, consistency because there is one primary nurse for obstetric patients, there would be fewer opportunities for the surveys to be lost or administration forgotten. The staff and I agreed that we would begin pilot testing the same day and it would conclude when there were ten responses. I also explained that even if the surveys were not complete, they would still be accepted because this is the pilot testing phase. I encouraged the staff to offer feedback and shared that I am available at any time for questions.

Ten women participated in the pilot study, and one participant was interviewed. As a result of the pilot testing, the following edits were made to the study: Firstly, the Researcher-Developed questions were removed from the study. One of the chief complaints during the pilot testing was the length of time required to complete the survey. The average time was about twenty minutes. The Researcher-Developed questions did not add significant data to the study, and they only increased the length of time, thus jeopardizing the possibility of more participants. Secondly, Question 20, "I should be able to bring on milk if I want to" was removed from the PRBQ. This is because all participants either skipped this question or answered "Neutral" to the question. This was the only question to yield this kind of a response across the board. One participant even wrote "?" in the survey, indicating she did not understand the phrasing. Finally, the demographic question "Number of pregnancies (including abortions and miscarriages)" was removed from the study at the request of the research locations.

No participants reported distress during the pilot testing phase while answering the ACE survey and PRBQ. The interview process also yielded workable data and provided insight into the trauma history and present attitude of the participant.

Field Procedures

In the following paragraphs, I outline the field procedures, meaning the considerations and methods to be undertaken throughout the duration of this research. This includes a discussion of ethics, followed by the study procedures.

Ethical Considerations

Research should always be guided by ethical principles to ensure the safety and well-being of research participants. Ketefian (2015) outlines key guiding principles that govern the researcher. The first is the respect for the person. Human beings have inherent worth and value, and they are to be regarded as such. Humans have the capacity for self-determination and must be able to state their opinions without fear of judgment or retribution. Further, Ketefian outlines the principle of beneficence, meaning doing good. The researcher should always seek to demonstrate good towards the participants and toward society as a whole. Finally, Ketefian describes the principle of justice. Justice, in the case of research, is considered fairness. I sought to regard participants with fairness, being careful not to demand unfairly from the participant.

Informed consent is also of critical consideration when conducting research. Informed consent means the participant engages in the study with full knowledge of what is involved and the potential consequences of participation (Piper and Simons 2005, 56). For the purposes of this study, informed consent was received from the doctors and directors who were managing the institutions in which the study will take place and included each individual participant. The informed consent process was two-fold for Phase I, in that the participants were offered the opportunity to participate by the nurse or counselor offering the surveys and through the informed

consent form. Phase II included the researcher explaining the interview process and obtaining consent, as well as allowing time for the participant to ask questions and to address concerns.

Ethical considerations were on my mind throughout the research process and during the writing and publication of the data. Confidentiality and anonymity are vital in order to ensure the safety and comfort of the participants. Confidentiality refers to the ability of the individual to talk in confidence, as well as refusing to allow confidential information to be shared in the final publication (Piper and Simons 2005, 57). Anonymity refers to protecting participant information and confidentiality (Piper and Simons 2005, 57). For the purposes of this research, Phase I did not include any specific demographics to be relayed in the writing and publication. During Phase II, I protected the identity of participants by using pseudonyms and eliminating as much identifying information as possible. The interview process also allowed me to explain the purpose of the data being gathered and to clarify with the participant what is allowed to be shared and what the participant wishes to withhold from publication.

Historically, there have been concerns about the participation of women of childbearing potential because of possible risks to the fetus (Schwenzer 2008, 1345). This researcher is aware that discussions of childhood trauma can evoke memories and feelings from the traumatic past, which may affect the mother and her unborn child. However, to exclude pregnant women as research subjects could lead to a lack of information regarding a vulnerable population and the need for access to care and intervention. Schwenzer (2008, 1346) recommends the following guidelines for consideration when conducting research with pregnant women in a clinical setting: 1) Pregnant women are presumed to be eligible for clinical studies; 2) Pregnant women are competent adults capable of making their own decisions about participating in

clinical studies; 3) Pregnant women are excluded if there is no potential for medical benefit to women, or if there are potential risks to the fetuses; 4) Pregnant women are given adequate information about the potential risks and benefits to themselves, their pregnancies, and their fetuses during the informed consent process.

These guidelines have served as an important compass for me. Other studies involving pregnant women were also explored for guidance and direction to perform research safely. Newman, Waler, and Gefland (1999) examined the frequency and correlates of adverse reactions and adequacy of informed consent among 1174 women in an HMO who completed a trauma-focused health survey, and a subset of 252 women who later completed a trauma-focused research interview. They found the majority of women participants deemed the overall experience to be positive and did not regret participating. The results suggested research on childhood victimization was well tolerated by women who participated.

Schwerdtferger and Goff (2008) sought to add to the research base on conducting trauma-focused research with pregnant women. In this study, 41 participants answered questions through paper and pencil or in an interview format. No participants chose to end the research protocol before completion. Researchers found that participants reported limited negative effects from participating in trauma focused research, and the majority indicated experiencing personal benefits, including insight and meaning. This supports the claim that pregnant women are at low risk for distress or harm in trauma-focused research.

I sought to ensure the participants of this study were treated with dignity, respect, and care. I took a number of steps to ensure the safety and care of each participant. During Phase I, participants were only given questionnaires if their consent was given, and they were allowed to end their participation at any time. The

participants were made aware of their rights to ask the doctor or nurse for help or guidance. Due to the safe location of the doctors' offices and easy access to care, the participants were not able to take the questionnaire and work on it from another location. Participants had immediate access to medical care, were they in any distress. Pregnancy centers were also considered safe due to the presence of trained counselors and medical staff on location. In the consent form, participants were encouraged to talk to their doctors or counselors if thoughts, feelings, or memories arose, and were asked to stop participating if they felt uncomfortable.

During Phase II, the interview process, I began by asking participants to rank their comfort level on a scale from one to five, with one being the most comfortable and five being in distress. Throughout the interview, I asked the interviewee to stop and check her comfort level. If the interviewee's discomfort or stress level rose, then I planned to stop the interview and encourage the interviewee to seek assistance. Fortunately, no situations arose where an interviewee experienced distress and needed to stop the interview. Because I did not know the interviewee's ACE score and survey response, I approached the interviewee with care and sensitivity and assumed there was trauma in the interviewee's past. This allowed me to be aware of signs and symptoms of stress during the interview.

Study Procedures

This mixed-methods study implemented a number of steps to seek the best results and provide a thorough explanation of the research problem. I developed the research questions, selected a research method, and then undertook steps to find participants. I sought and received permission from Leisa Bailey, M.D., to conduct research with patients through her office at Bailey Family Practice in Bonifay, which is located in Holmes County, Florida. Dr. Leisa Bailey is an obstetrician or

gynecologist who is the founder and director of Bailey Family Practice. She has been practicing medicine in Holmes County for over thirty years. Bailey Family Practice was chosen because of its ease of access for the researcher and its years spent serving Holmes County. Permission was obtained on March 18, 2021. The researcher then submitted the application for review of the research's methodology and risk factors through the Internal Review Board (IRB) of APNTS. The application was submitted on March 19, 2021, and approval was received May 10, 2021 (Appendix E).

After receiving approval from the researcher's dissertation panel, I began pilot testing Bailey Family Practice. The names of the ten participants who took part in the pilot testing were noted by the prenatal nurse so they will not be re-interviewed during the official data gathering phase.

After pilot testing concluded, I sought and obtained additional research locations across Northwest and Northeast Florida. The purpose of the research was explained to each doctor and director, and permission was obtained in writing (Appendix F and Appendix G). Once permission was obtained, the appointed staff of the location was instructed in the research gathering procedures and given a script to read to participants (Appendix H and I). Each location chose staff such as nurses and counselors to offer the research because of their familiarity with clients and rapport. Research was conducted during an agreed-upon time period between myself and the sight director. This was in keeping with the cross-sectional method of this study, as it is meant to take place during a moment in time, rather than over a longitudinal period.

The safety and security of the research participant remains of utmost importance to the researcher. Within the consent process for the survey, it was clear to the participant that filling out the survey was optional and could be halted at any time if she felt uncomfortable. The participant was given a Survey Consent Form

(Appendix J) and an Interview Consent Form (Appendix K). The participants were asked to fill out a form with general Demographic Information (Appendix L). Due to the personal nature of the questions and to reduce the risks to the participant, it was safest for her to complete the survey at the doctor's office or pregnancy center so she is in close proximity to help if she needed it. As a social worker, I have experience working with students ages five to eighteen who have adverse experiences. Therefore, I understand and appreciate the need to maintain the safety of participants.

The measures for safety extended to the interview process. From the data provided, I collected the names and contact information for participants who agreed to be interviewed. I hoped to interview at least ten participants, using questions relating to the data, and I was able to interview twelve. Each interviewee was given a Verbal or Written Consent Form (Appendix M) where the interview process was explained to her. I followed a prepared script with breaks and emotional check-ins built in for the participant (Appendix D). The interviews were transcribed and analyzed for themes. Data was analyzed as the research was obtained. This allowed me to maintain and organize the data while receiving input from multiple locations. I then formed conclusions and recommendations based upon the information gathered.

Data Collection and Recording

The process of data collection and recording took place in two phases, just as the research was conducted in two phases. The first phase was the quantitative phase, while the second was the qualitative phase. Data was obtained on location, and data was recorded on my computer at her home. Data was entered and recorded into an Excel spreadsheet so it could be organized.

During Phase 1, each research location was given a predetermined number of researcher packets. The time frame of research was agreed upon between the research

location and the researcher. The research occurred within the same time frame at multiple locations. Participants were given the opportunity to digitally fill out the survey through Qualtrics XM if she preferred. This was done by scanning a QR code provided by the researcher to the appointed staff (Appendix N). The participant could use her mobile device to scan the code and complete the survey during her appointment.

Each packet included the following: 1) Cover Page, 2) Participant Survey Consent Form, 3) Participant Demographic Information, 4) Participant Interview Consent Form, 5) ACE Survey, and 6) the PRBQ Survey. Each packet was assigned a number. For the pilot testing, the participant was assigned a number and the letter P to indicate "Pilot." If the participant chose the paper form of the surveys, it was returned to a convenient and secure location at the research location, such as the nurse's office. I collected these packets at an agreed upon time with the research location. As the data was collected, it was entered into Excel and the scores tallied. After each packet was entered into the computer, the consent forms and demographic information were separated from the responses to the surveys, and the identifying numbers were removed from the packets. Hard copies of the data will be kept in a secure location in the researcher's home for up to one year after publishing.

The second phase, the interview process, took place while the data for the first phase was being collected. This allowed me time to interview those who indicated a desire to participate before they delivered their babies. When I received forms from a location, I contacted participants who indicated an agreement to be interviewed. Because there were multiple locations participating and I did not want to miss the opportunity to interview before a participant gave birth, I did not wait until all surveys were collected before beginning interviews, but made contact as the forms were

collected. I scheduled time with each participant, and we met over the phone to conduct the interviews. Each participant was assigned a number to protect her identity. After reading through the consent process with the participant, I began the interview and audio recorded the interview using my computer. I explained to each participant I would not use her name while audio recording.

During the interview process, I began by asking participants to rank their comfort level on a scale from one to five, with one being the most comfortable and five being in distress. Throughout the interview, I asked the interviewee to stop to check her comfort level. If the interviewee's discomfort or stress level is rising, then I would have stopped the interview and encouraged the interviewee to seek assistance. No interviewee reported distress during the time of the interview. Once the interview was complete, I transcribed the interview word for word using Amberscript. The responses of all the participants were analyzed to create a narrative based on the different categories regarding attitude. Once the transcription and upload were complete, the audio recording was deleted.

Table 2. Timeline of research process

Week	Phase:	Location:	Data Analysis
1-9	Pilot Testing	Bailey Family Practice, Bonifay, Florida (Holmes)	Concurrent
10-15	Pilot Testing- Data/ Methodology Review	Researcher's Home	Concurrent
16-31	1- Quantitative- Surveys	Bailey Family Practice (Holmes), A Woman's Pregnancy Center (Leon), Pregnancy Centers of Live Oak and Lake City (Suwannee and Columbia)	Concurrent
16-31	2- Qualitative Interviews	Zoom or Research Location	Concurrent
32-35	Data Coding and Analysis Research Wrap-Up		

Data Processing and Analysis

The scores of both surveys were totaled, and the individual responses were examined. These themes are presented in a narrative format in Chapter Four. This helped produce descriptive and inferential data. The results were then analyzed with the intention of the qualitative data being used to expound the results of the quantitative data. The data was studied in both phases in order to determine if the research questions were being answered and how they were being answered. Each data instrument, the ACE Survey, the PRBQ Survey, and the Interview Responses, was examined.

Demographic information was used to categorize and compare the various participants to gain insights into the data. Demographic information included: number of weeks pregnant at the time of participation, age range, educational level, socioeconomic status, race, marital status, and county of residence. Responses were indicated with a check mark (✓) to reduce researcher-error when recording responses. The information was useful for drawing conclusions. For example, there is a correlation between _____ (ACE type) and length of pregnancy.

The results of the ACE Survey were recorded in the categories provided by the research instrument. The categories are as follows: 1) Verbal Abuse; 2) Physical Abuse; 3) Sexual Abuse; 4) Emotional Neglect; 5) Physical Neglect; 6) Parental Separation or Divorce; 7) Witness to Domestic Violence; 8) Substance Abuse Exposure; 9) Family Member Mental Illness or Suicide Attempt; and 10) Family Member Incarceration.

Every “Yes” response equals a point. The closer the score to 10, the more adverse childhood experiences the respondent has endured, and the more childhood

trauma the respondent has experienced. The data was analyzed for comparisons regarding demographic information and attitudes.

The PRBQ responses were categorized. The PBRQ contains a seven-point Likert scale (Appendix O). The original model of the PRBQ can yield results between 54-378. A higher score indicates higher levels of dysfunctional beliefs (Moorhead, Owens, and Scott 2003). Within the PRBQ survey, the responses range from "Totally Agree" to "Totally Disagree." I have been unable to find justification for ascribing a certain number value to the responses but I did have access to the scoring guide (Medical Data Models, 2020). A Strong or Weak Attitude Scoring Guide was created for the pilot study (Appendix P) and the final research study (Appendix Q). However, I do not have an explanation from this study's authors regarding the reasoning for scoring answers. For example, Question 1, "I should not have to ask for help with my baby" is scored as follows:

Totally Agree-7	Neutral- 4	Disagree Totally-1
Agree Very Much- 6	Disagree Slightly- 3	
Agree Slightly- 5	Disagree Very Much- 2	

Then, Question 2, "I am as enthusiastic as I should be about my future role as a mother," differs in scoring as follows:

Totally Agree-1	Neutral- 4	Disagree Totally-7
Agree Very Much- 2	Disagree Slightly- 5	
Agree Slightly- 3	Disagree Very Much- 6	

I assumed the data was scored as such to measure the strength of the dysfunctional belief. The first question asked the participant for her belief regarding the asking of help with her baby. A response of "Totally Agree" indicated either a

strong aversion to help, strong expectations of self-reliance, or an expectation of others stepping in to help without being asked. An answer of "Disagree Totally" could indicate the participant is not averse to receiving or asking for help. In Question 2, an answer of "Disagree Totally" could indicate the participant was not enthusiastic about being a mother. An answer of "Totally Agree" could indicate the participant was enthusiastic about being a mother.

The following methods were used to statistically analyze each research question:

1. What are the participant demographics in this study in terms of the following:

a. Length of pregnancy (in weeks at the time of participation)

b. Age Range

c. Race

d. Socioeconomic Status (Annual Household Income)

e. Educational Background

f. Marital Status

g. County of Residence

This was determined by calculating the frequency and percentages of each response based on the demographic information reported.

1. What is the extent of childhood trauma experienced by pregnant women in Northwest and Northeast Florida?

   This was determined by totaling the ACE scores of each participant. Frequency and percentage of responses was calculated to determine overall results.

2. What is the most common instance of childhood trauma experienced by pregnant women in Northwest and Northeast Florida?

This was determined by examining the ACE types experienced by each participant and calculating the frequency and percentage of each type for the overall results.

3. Is there a relationship between Adverse Childhood Experiences (ACE) and reported participant demographics?

Chi-Square testing was done to determine if there was a correlation between the Adverse Childhood Experiences and the reported participant demographics. ACE types and demographic information were utilized. A p-value of < 0.05 indicated a correlation between the ACE type and demographic information.

4. What insights can be gained from the Pregnancy Related Beliefs Questionnaire regarding the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves in Northwest and Northeast Florida?

This was determined by examining the individual responses and then scoring them. The individual responses were categorized into five groups: Attitude Regarding the Self, Attitude Regarding Others, Attitude Regarding Pregnancy, Attitude Regarding the Baby, and Attitude Regarding Motherhood. Based on the scoring guide, the individual responses were categorized as “Strong,” “Weak,” or “Neutral.” Frequency and percentage analysis was used to determine the overall results of the participants and determine the overall attitudes of the participants towards the five categories.

5. Is there a relationship between the ACE scores and ACE types of the participants and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves in Northwest and Northeast Florida?

This was conducted using Analysis of Variance (ANOVA) to determine the p-value of the different attitude categories and the ACE types, as well as the different attitude categories and ACE scores. A p-value of < 0.05 indicates a correlation. Based on the PRBQ scoring, a neutral response is always assigned a "4." Answers above a 4 indicate a rigid response and increase a likelihood of negative attitude.

The interview responses were used to enhance the data from questions one through six. I analyzed the responses of the participants, organized them based on themes, and distributed the data to create a narrative. Following the data analysis for Phase I, I used the semi-structured questions as the framework for the interview. The interview portion was transcribed using Amberscript. The participant responses were analyzed to determine insights towards the following: Attitude toward the Self, Attitude toward Others, Attitude toward Pregnancy, Attitude toward the Baby, and Attitude toward Motherhood. DeCuir-Gunby et al. (2013) outline the process of data-driven coding as first determining how to reduce raw information into smaller units using themes or categories. These results are discussed based on themes presented and integrated with the results of the research questions.

Summary

In this chapter, the methodology for conducting this study was outlined. I utilized a Mixed-Methods approach, which involved both qualitative and quantitative methods. A description of the Mixed-Methods approach, as well as a justification for its usage in this research was outlined. Mixed Methods allows the researcher the opportunity to achieve measurable results through quantitative data, and then expound on the numbers to form a narrative using qualitative data. The ACE Survey and PRBQ Survey were identified as research instruments, and their origins and

development were explained. Interviews were used to provide anecdotal evidence and support.

Because this research included a population indicated as vulnerable, ethical implications were discussed. Additionally, the selection and recruitment of subjects and research locations, as well as research methods was discussed. The process of pilot testing has been outlined as well as the research procedure. These methods were developed with the safety of research participants in mind. The process of data collection, recording, and analysis was discussed.

CHAPTER IV

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

The results of this study will be discussed in this chapter. This study found that the majority of participants had an ACE score of at least 1 or more, and as the ACE score increases, the more likely a participant is to have a change resistant or negative attitude towards herself, others, and pregnancy. Additional insights were gained through demographic information and participant interviews. Data was compiled utilizing frequency and percentage, as well as Chi-square and ANOVA testing. Participant interview responses are also included to expound on the data given.

Presentation of the Data

This study took place from January 2, 2022, until April 11, 2022. A total of 50 women completed the survey and 12 women were interviewed. The results of the study are discussed below based on the research questions.

Research Question 1: What are the Participant Demographics in this Study in Terms of the Following: Length of Pregnancy (in Weeks at time of participation), Age Range, Race, Socioeconomic Status (Annual Household Income), Educational Background, Marital Status, and County of Residence?

Each woman in the study was offered a Demographic Information sheet, which asked participants to identify her length of pregnancy in weeks, her age range, the race with which she identifies, her socioeconomic status, as based on her annual household income, the highest educational level she has obtained, her marital status,

and her county of residence. Forty nine of the fifty women who completed this survey also completed the Demographic Information survey. It is not known if the one participant who did not answer refused the sheet or if it was oversight by the person offering the survey. The results of this survey are described below.

described below.

Length of Pregnancy (in Weeks)

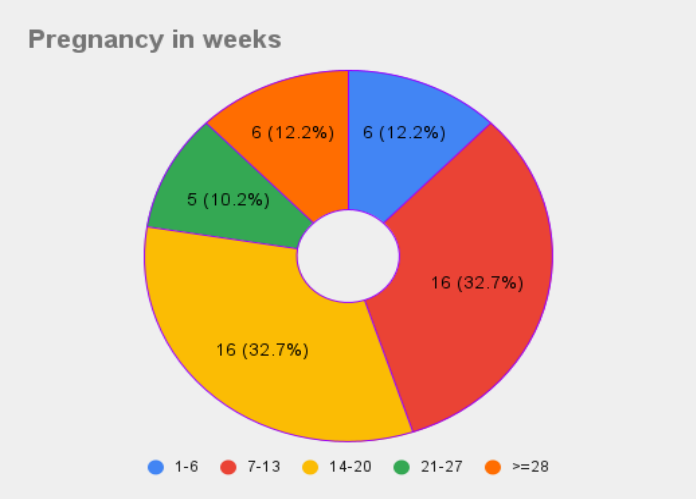


Figure 6. Results for length of pregnancy

This figure reflects the length of pregnancy expressed in weeks at the time of participating in the research. Based on Figure 6, six participants are 1-6 weeks pregnant (12.2%), sixteen participants are 7-13 weeks pregnant (32.7%), sixteen participants are 14-20 weeks pregnant (32.7%), five participants are 21-27 weeks pregnant (10.2%), and six participants are 28- 40 weeks pregnant (12.2%). The majority of participants, thirty-two (65%), are between 7-20 weeks pregnant, indicating they are in the first or second trimester of pregnancy. Twenty-two participants are in the first trimester of pregnancy (45%), twenty-one are in the second trimester of pregnancy (43%), and six (12%) are in the third trimester of pregnancy.

Age Range of Participants

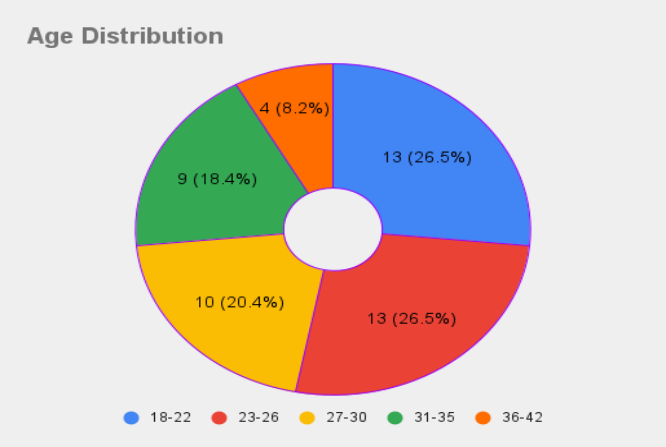


Figure 7. Results for age range

Based on Figure 7, thirteen participants are 18-22 years old (26.5%), thirteen participants are 23-26 years old (26.5%), ten participants are 27-30 years old (20.4%), nine participants are 31-35 years old (18.4%), and four participants are 36-42 years old (8.2%). Eighty percent (80%) of the participants are between 18 and 26 years old.

Race of Participants

Table 3. Results for race

Race	Frequency	Percentage
White	26	54.17%
Black	14	29.17%
Asian	1	2.08%
Hispanic	6	12.50%
Other	1	2.08%

Based on Table 3, the majority of participants identify as White with twenty-six respondents total (54.17%). Fourteen participants identify as Black (29.17%). Six participants identify as Hispanic (12.5%). One participant identifies as Asian (2.08%), and one participant identifies as Other (2.08%), but did not specify. The largest group of participants are those identifying as white, and the second highest are those

identifying as black. In the state of Florida, persons identifying as white form the highest percentage (77.3%), with Hispanic persons following at 26.4% and Black persons at 16.9%, while only 3% identify as Asian (U.S. Census 2020). This data reflects the distribution of race in Florida with white people as the majority. However, the demographics for Black and Hispanic women are reversed for this study.

Socioeconomic Status (Annual Household Income)

Table 4. Results for socioeconomic status (annual household income)

Average Annual Household Income	Frequency	Percentage
Less than $10,000	11	22.92%
$10,000-$30,000	19	39.58%
$31,000-$50,000	10	20.83%
$51,000-$70,000	2	4.17%
$71,000-$100,000	5	10.42%
More than $100,000	1	2.08%

Based on Table 4, eleven participants earn less than $10,000 annually (22.92%). Nineteen participants earn between $10-30,000 dollars annually (39.58%). According to the description of the Federal Poverty Level (Appendix R), a family of four people earning less than $30,000 is considered to be living below the poverty line. Based on these results, eleven participants (22.92%) of the participants are living below the poverty line. Nineteen of the participants (39.58%) can be considered below the poverty line, depending on the number of persons in their households. This is more than the overall population of Florida, which records about 12.4% of individuals living in poverty (U.S. Census 2020). One explanation for this large representation is that women near or below the poverty line could be more likely to utilize the resources of a pregnancy center or rural doctor’s office.

Ten participants earn $31-50,000 dollars annually (20.83%). Two participants earn $51-70,000 annually (4.17%). Five participants earn between $71-100,000 annually (10.42%), and one participant earns more than $100,000 (2.08%). The majority (39.58%) of participants earn between $10-30,000. Forty of the participants (83.33%) earn less than $50,000 annually.

Educational Background

Table 5. Results for educational background

Education	Frequency	Percentage
Did Not Finish High School	6	12.24%
Highschool Diploma/GED	21	42.86%
Associate/Vocational	13	26.53%
Bachelor's Degree	4	8.16%
Master's degree	4	8.16%
Doctoral Degree	1	2.04%

Based on Table 5, six participants did not finish high school (12.24%). Twenty-one of the participants earned a high school diploma or their General Education Diploma (GED) (42.86%). Thirteen participants hold an Associate's Degree or Vocational Certification (26.53%). Four participants hold a Bachelor's Degree (8.16%), and four hold a Master's Degree (8.16%). One participant holds a Doctoral degree (2.04%). Eighty-eight (87.75%) percent of participants hold at least a high school diploma. This matches the US Census data for 2020, which states 88.5% of persons over the age of 25 in Florida hold at least a high school diploma (U.S. Census 2020).

Marital Status

Table 6. Results for marital status

Marital Status	Frequency	Percentage
Single-Never Married	28	57.14%
Single-Divorced	4	8.16%
Single-Widowed	1	2.04%
Married	16	32.65%

Based on the results illustrated in Table 6, twenty-eight of the participants are currently single and have never been married (57.14%). As of February 2022, the Centers for Disease Control and Prevention placed the state average for births to unmarried mothers at 47.2% (CDC 2022). This percentage is roughly ten percent higher than the state average, especially when divorced and widowed participants were included. Four participants are currently single and have been divorced (8.16%). One participant is single and widowed (2.04%). Sixteen of the participants are currently married (32.65%). The high number of single participants could be due to the research locations and possibility indicate single women are more likely to utilize rural doctors' offices and pregnancy centers.

County of Residence

Table 7. Results for counties of residence

County of Residence	Frequency	Percentage
Jackson	2	4.08%
Holmes	7	14.29%
Columbia	11	22.45%
Washington	3	6.12%
Lafayette	2	4.08%
Suwannee	11	22.45%

County of Residence	Frequency	Percentage
Hamilton	1	2.04%
Taylor	1	2.04%
Leon	8	16.33%
Gadsden	1	2.04%
Union	1	2.04%
Other	1	2.04%

Based on Table 7, the participants all reside in the Florida counties listed. Two participants reside in Jackson County (4.35%). Seven participants reside in Holmes County (15.22%). Eleven participants live in Columbia County (23.91%). Three participants reside in Washington County (6.52%) and two reside in Lafayette County (4.35%). Eleven participants live in Suwannee County (23.91%). Eight participants live in Leon County (16.33%). Hamilton, Taylor, Gadsden, Union County, and one county listed as "Other" were each represented by one participant (2.04%). Columbia and Suwannee Counties were represented with almost half of the participants (47.82%). Leon County represented the third highest number of participants (17.39%). These are the counties where the pregnancy centers are located, which is the most likely explanation for these percentages. Holmes County is the location of Bailey Family Practice, which also can explain the higher number of Holmes County participants.

Research Question 2: What is the Extent of Childhood Trauma Experienced by Pregnant Women in Northwest and Northeast Florida?

Every participant was offered and answered the Adverse Childhood Experiences Survey, which consists of ten questions. Each participant responds with a "Yes" or "No" when asked if she experienced a certain experience. Each "Yes" earns one point, with a range of 0-10 points possible. The higher the score, the more adverse experiences the participant has endured. The results of the survey are outlined in

Appendix S which contains the ACE score and individual responses. For this section, the overall results of the ACE survey are described. First, the results will be described as how many participants received a certain ACE score.

Table 8. Results for the ACE scores of participants

ACE Scores	Frequency	Percentages
0	14	28%
1	14	28%
2	7	14%
3	2	4%
4	0	0%
5	3	6%
6	1	2%
7	1	2%
8	5	10%
9	2	4%
10	1	2%

Based on Table 8, fourteen participants received an ACE Score of 0, indicating they have not experienced any of the listed Adverse Childhood Experiences (28%). Fourteen participants received an ACE Score of 1 (28%). Seven participants scored with 2 (14%). Two participants scored 3 (4%). No participants received a score of 4 (0%). Three participants received a score of 5 (6%). One participant scored a 6 (2%). One participant scored a 7 (2%). Five participants scored an 8 (10%). Two participants scored a 9 (4%). One participant scored a 10 (2%). The most common scores were a tie between 0 and 1. Of the fifty participants, thirty-six (72%) had at least one ACE. Thirteen of the participants (26%) had a score of roughly five or more ACEs. Based on these results, it can be assumed that roughly three out of four pregnant women in this survey have experienced at least one ACE, while one in four have experienced five or more.

Felitti et al. (1998) in their original ACE study found the probability of someone having at least one ACE was between 65%-93%. With this study, 72% of participants scored 1 or higher, which is in keeping with the results of the original ACE study. In the original study, the likelihood of participants scoring a 2 or higher was between 40-74%. In this study, 44% of participants scored 2 or more ACEs, also in keeping with the results of the original study. Their study also found that individuals with four or more ACEs had an increased likelihood for poor health outcomes such as diabetes and emphysema, cancer, heart disease, chronic lung disease, and poor self-rated health outcomes (Felitti et al. 1998, 251). Based on these findings, 26% of participants are at an increased likelihood for negative health outcomes, compared with those who have less than 4 adverse childhood experiences.

Research Question 3: What is the Most Common Instance of Childhood Trauma Experienced by Pregnant Women in Northwest and Northeast Florida?

Each of the fifty participants were offered the ACE Survey. Table 9 illustrates the number of participants who responded "Yes" to each question. Each "Yes" represents the ACE the participant lived through before turning 18 years old.

Table 9. Results for the ACE types of participants

ACE Types	Frequency	Percentages
Verbal Abuse	14	28%
Physical Abuse	14	28%
Sexual Abuse	13	26%
Emotional Neglect	13	26%
Physical Neglect	6	12%
Divorced/Separation	26	52%
Domestic Violence	9	18%
Substance Abuse	16	32%
Mental Illness	10	20%
Incarceration	9	18%

Based on these results of Table 9, the most common ACE experienced is parental separation or divorce. More than half (52%) of the participants responded "Yes." This is slightly up from the national average that 45% of marriages will end in divorce (Pelley 2022). The next highest ACE with sixteen of the fifty participants (32%) is Question 8 regarding substance abuse. The original ACE study did not include parental separation or divorce. In the original study, the highest ACE type of all participants was substance abuse exposure with 25.6% (Felitti et al. 1998, 248). It is interesting to note that at least one in four participants in this study has experienced physical, verbal, or sexual abuse. This is higher than the CDC average, which states 1 in 7 children have experienced some form of abuse (CDC 2022). Below is a list of the ACE types participants have endured ranked by most common to least common:

1. Parental Separation or divorce (52%)
2. Household member substance abuse (32%)
3. Physical Abuse and Verbal Abuse (tie) (28%)
4. Sexual Abuse and Emotional Abuse (tie) (26%)
5. Household member with mental illness (22%)
6. Witness to domestic violence or Household member in prison (tie) (18%)
7. Neglect (12%)

Research Question 4: What is the Relationship Between Adverse Child Experiences and Participant Demographic Information?

The table in Appendix S illustrates the ACE Score, the questions answered, and the demographics for each participant. The data was analyzed using Chi-square test. A p-value less than 0.05 suggests correlation in the incidence of ACE type and the demographic information. The ACE types were compared with the participant demographic information.

Length of Pregnancy (in weeks at the time of participation)

Table 10. Length of pregnancy and incidence of ACE

Charac-teristics	Verbal Abuse (n=14)	Phy. Abuse (n=14)	Sexual Abuse (n=13)	Emo. Neglect (n=13)	Phy. Neglect (n=6)	Divorce/ Sepa-ration (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarce-ration (n=9)
Length of Pregnancy										
1-6	2 (14.%)	2 (14.%)	0 (0%)	1 (8%)	0 (0%)	4 (15%)	1 (11%)	3 (19%)	1 (10%)	1 (11%)
7-13	5 (36%)	5 (36%)	5 (38%)	5 (38%)	2 (33%)	8 (31%)	3 (33%)	4 (25%)	2 (20%)	2 (22%)
14-20	2 (14.%)	1 (7%)	2 (15%)	2 (15%)	1 (17%)	6 (23%)	2 (22%)	3 (19%)	1 (10%)	3 (33%)
21-27	1 (7%)	2 (14.%)	1 (8%)	3 (23%)	1 (17%)	2 (8%)	0 (0%)	2 (13%)	3 (30%)	1 (11%)
28-35	3 (21%)	3 (21%)	4 (31%)	2 (15%)	2 (33%)	5 (19%)	3 (33%)	3 (19%)	3 (30%)	1 (11%)
36-41	1 (7%)	1 (7%)	1 (8%)	0 (0%)	0 (0%)	1 (4%)	0 (0%)	1 (6%)	0 (0%)	1 (11%)
p-value	*0.291*	*0.054*	*0.031*	*0.249*	*0.297*	*0.287*	*0.814*	*0.168*	*0.012*	*0.558*

Regarding length of pregnancy and ACE Type, there appears to be a relationship between the length of pregnancy and sexual abuse (p-value 0.031). Five (38%) of the participants who responded “Yes” to experiencing sexual abuse were between 7-13 weeks pregnant. Five participants who were 28-40 weeks pregnant (39%) indicated they had experienced sexual abuse. One possible explanation is that experiencing childhood sexual abuse can result in “hypervigilance” and increased awareness of bodily sensations and changes occurring in the body (Leeners et al. 2006). Therefore, these participants might be aware of the changes occurring in their bodies and could experience increased anxiety as they really begin to experience the symptoms of pregnancy such as nausea. There also is a relationship between length of pregnancy and participants who have experienced mental illness (p-value 0.012). Six (60%) of the participants who indicated “Yes” for caregiver mental illness are 21-35 weeks pregnant. To the best of my knowledge, there are no studies related to the experience of adult women who had parents with mental illness and are pregnant for comparison with this study. It is possible that as women advance in their pregnancies,

they become more aware of the possible psychiatric disorders that are common, such as depression, especially if they have experienced a parent with mental illness (Satyanarayana et al. 2011).

Age Range of Participants

Table 11. Age range and incidents of ACE

Characteristics	Verbal Abuse (n=14)	Phy. Abuse (n=14)	Sexual Abuse (n=13)	Emo. Neglect (n=13)	Phy. Neglect (n=6)	Divorce/ Separation (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarceration (n=9)
Age Range										
18-22	3 (21%)	2 (14.%)	3 (23%)	4 (31%)	2 (33%)	10 (38%)	3 (33%)	5 (31%)	3 (30%)	2 (22%)
23-26	6 (43%)	6 (43%)	5 (38%)	4 (31%)	4 (67%)	7 (27%)	3 (33%)	5 (31%)	5 (50%)	4 (44%)
27-30	3 (21%)	2 (14.%)	1 (8%)	3 (23%)	0 (0%)	3 (12%)	1 (11%)	2 (13%)	0 (0%)	1 (11%)
31-35	1 (7%)	3 (21%)	3 (23%)	1 (8%)	0 (0%)	3 (12%)	1 (11%)	3 (19%)	2 (20%)	0 (0%)
36-42	1 (7%)	1 (7%)	1 (8%)	1 (8%)	0 (0%)	3 (12%)	1 (11%)	1 (6%)	0 (0%)	2 (22%)

There was no statistical relationship between participant age range and ACE type, and it can be concluded age does not impact ACE Type. All age ranges and ACE types had a p-value of greater than 0.05.

Race

Table 12. Race and incidence of ACE

Characteristics	Verbal Abuse (n=14)	Phy. Abuse (n=14)	Sexual Abuse (n=13)	Emo. Neglect (n=13)	Phy. Neglect (n=6)	Divorce/ Separation (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarceration (n=9)
Race										
White	11 (79%)	9 (64%)	8 (62%)	8 (62%)	5 (83%)	15 (58.%)	6 (67%)	11 (69%)	7 (70%)	5 (56.%)
Black	2 (14.%)	2 (14.%)	1 (8%)	3 (23%)	1 (17%)	6 (23%)	2 (22%)	2 (13%)	2 (20%)	3 (33%)
Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Hispanic	1 (7%)	1 (7%)	2 (15%)	1 (8%)	0 (0%)	3 (12%)	1 (11%)	2 (13%)	1 (10%)	1 (11%)
Other	0 (0%)	2 (14.%)	2 (15%)	1 (8%)	0 (0%)	2 (8%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)
p-value	0.026	0.381	0.824	0.25	0.018	0.362	0.281	0.216	0.036	0.391

Based on the results given, there does appear to be a relationship between the race of participants and those who have experienced verbal abuse (p-value 0.026), physical neglect (0.018) and caregiver mental illness (0.036). Eleven white participants (79%) have experienced verbal abuse, five white participants (83%) have experienced physical neglect, and seven white participants (70%) have experienced caregiver mental illness. Mersky and Janczewski (2018) found that whites were more likely than other racial groups to report abuse, neglect, and household dysfunction. This could also explain differences in this study based on ACE types and race. The statistical relationship in this study can only be described for white participants, as they were the highest racial group represented in the study (n=26). While Black, Hispanic, and Asian women were represented, more participants of these racial groups are needed to draw any conclusions.

Socioeconomic Status (Annual Household Income)

Table 13. Socioeconomic status and incidence of ACE

Characteristics	Verbal Abuse (n=14)	Phy. Abuse (n=14)	Sexual Abuse (n=13)	Emo. Neglect (n=13)	Phy. Neglect (n=6)	Divorce/ Separation (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarceration (n=9)
Ave. Ann. Household Income										
Less than $10,000	4 (29.%)	4 (29.%)	3 (23%)	3 (23%)	2 (33%)	7 (27%)	3 (33%)	4 (25%)	2 (20%)	2 (22%)
$10,000-$30,000	4 (29.%)	4 (29.%)	6 (46%)	5 (38%)	2 (33%)	10 (38%)	3 (33%)	6 (38%)	4 (40%)	4 (44%)
$31,000-$50,000	3 (21%)	3 (21%)	3 (23%)	2 (15%)	0 (0%)	4 (15%)	2 (22%)	2 (13%)	1 (10%)	2 (22%)
$51,000-$70,000	1 (7%)	1 (7%)	0 (0%)	1 (8%)	0 (0%)	1 (4%)	0 (0%)	2 (13%)	1 (10%)	0 (0%)
$71,000-$100,000	2 (14.%)	2 (14.%)	1 (8%)	2 (15%)	2 (33%)	2 (8%)	1 (11%)	2 (13%)	2 (20%)	1 (11%)

There was no statistical relationship observed between the socioeconomic status and the type of ACEs indicated by the participants. All ACE types resulted in a p-value of greater than 0.05. Table 14 below shows the respondents' educational status and incidence of ACE.

Educational Status

Table 14. Educational status and incidence of ACE

Characteristics	Verbal Abuse (n=14)	Physical Abuse (n=14)	Sexual Abuse (n=13)	Emotional Neglect (n=13)	Physical Neglect (n=6)	Divorce/ Separation (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarce-ration (n=9)
Did Not Finish Highschool	1 (7%)	1 (7%)	1 (8%)	0 (0%)	0 (0%)	3 (12%)	0 (0%)	2 (13%)	0 (0%)	1 (11%)
Highschool Diploma/ GED	7 (50%)	6 (43%)	7 (54%)	7 (54%)	3 (50%)	11 (42%)	5 (56.%)	7 (44%)	5 (50%)	5 (56.%)
Associate/ Vocational	4 (29.%)	5 (36%)	4 (31%)	4 (31%)	2 (33%)	8 (31%)	3 (33%)	5 (31%)	4 (40%)	3 (33%)
Bachelor's Degree	1 (7%)	1 (7%)	0 (0%)	1 (8%)	0 (0%)	1 (4%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)
Master's Degree	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	(0%)
Doctoral Degree	1 (7%)	1 (7%)	1 (8%)	1 (8%)	1 (17%)	2 (8%)	1 (11%)	1 (6%)	1 (10%)	0 (0%)
p-value	*0.853*	*0.837*	*0.562*	*0.412*	*0.789*	*0.883*	*0.361*	*0.824*	*0.325*	*0.942*

There was no statistical relationship observed between the educational attainment of participants and the type of ACE indicated. All of the ACE types resulted in a p-value of greater than 0.05. Table 15 below shows the respondents' marital status and incidence of ACE.

Marital Status

Table 15. Marital status and incidence of ACE

Characteristics	Verbal Abuse (n=14)	Physical Abuse (n=14)	Sexual Abuse (n=13)	Emotional Neglect (n=13)	Physical Neglect (n=6)	Divorce/ Separation (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarceration (n=9)
Marital Status										
Single-Never Married	7 (50%)	7 (50%)	6 (46%)	6 (46%)	3 (50%)	15 (58.%)	5 (56.%)	8 (50%)	5 (50%)	5 (56.%)
Single-Divorced	1 (7%)	2 (14.%)	2 (15%)	1 (8%)	0 (0%)	3 (12%)	1 (11%)	2 (13%)	1 (10%)	1 (11%)
Single-Widowed	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Married	6 (43%)	5 (36%)	5 (38%)	6 (46%)	3 (50%)	8 (31%)	3 (33%)	6 (38%)	4 (40%)	3 (33%)
p-value	0.281	0.382	0.268	0.871	0.685	0.027	0.044	0.381	0.268	0.027

Based on Chi-square test, there does appear to be a relationship between marital status and ACE type. These types are Parental Separation or Divorce (0.027), witnessing Domestic Violence (0.044), and Caregiver Incarceration (0.027). Fifteen participants who are single and never married indicated they experienced parental separation and divorce (58%). Five single-never married participants (56%) witnessed domestic violence, and five (56%) of those single-never married experienced caregiver incarceration. Dietz et al. (1999) found there may be a relationship between unintended pregnancy and experiencing abuse or household dysfunction such as domestic violence and mental illness. While this dissertation did not ask participants if their pregnancies were intended, it might account for the association between women who are single and never married and the ACE types experienced.

County of Residence

Table 16. County of residence and incidence of ACE

Characteristics	Verbal Abuse (n=14)	Physical Abuse (n=14)	Sexual Abuse (n=13)	Emotional Neglect (n=13)	Physical Neglect (n=6)	Divorce/ Separation (n=26)	Domestic Violence (n=9)	Sub. Abuse (n=16)	Mental Illness (n=10)	Incarceration (n=9)
County of Residence										
Jackson	1 (7%)	1 (7%)	1 (8%)	1 (8%)	0 (0%)	1 (4%)	1 (11%)	1 (6%)	0 (0%)	1 (11%)
Holmes	1 (7%)	1 (7%)	1 (8%)	1 (8%)	1 (17%)	4 (15%)	1 (11%)	2 (13%)	2 (20%)	0 (0%)
Colombia	5 (36%)	5 (36%)	5 (38%)	4 (31%)	1 (17%)	8 (31%)	4 (44%)	6 (38%)	3 (30%)	4 (44%)
Washing-ton	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (11%)
Lafayette	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Suwannee	4 (29.%)	3 (21%)	4 (31%)	4 (31%)	2 (33%)	5 (19%)	2 (22%)	2 (13%)	2 (20%)	2 (22%)
Hamilton	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (4%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)
Taylor	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Leon	1 (7%)	1 (7%)	1 (8%)	1 (8%)	1 (17%)	4 (15%)	1 (11%)	2 (13%)	2 (20%)	0 (0%)
Gadsden	0 (0%)	1 (7%)	1 (8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Union	1 (7%)	1 (7%)	0 (0%)	1 (8%)	0 (0%)	1 (4%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)
Other	1 (7%)	1 (7%)	0 (0%)	1 (8%)	1 (17%)	1 (4%)	0 (0%)	1 (6%)	1 (10%)	1 (11%)
p-value	0.817	0.265	0.287	0.715	0.689	0.334	0.821	0.545	0.841	0.288

Based on the statistical analysis completed, there did not appear to be a relationship between the ACE types indicated by participants and the counties of residence. All resulted in a p-value of greater than 0.05.

The first null hypothesis “There will be no relationship between the participant's adverse childhood experiences and the following demographics: number of weeks pregnant, age range, educational background, socioeconomic status, race, marital status, and county of residence,” was accepted for certain demographics.

There was no relationship found regarding the type of ACE indicated and the ages of participants, educational attainment, socioeconomic status, and county of residence. A relationship was found for length of pregnancy, marital status, and race; thus, the first null hypothesis was rejected for these demographic factors.

Research Question 5: What Insights Can be Gained from the Pregnancy Related Beliefs Questionnaire Regarding the Attitudes of Pregnant Women Regarding Pregnancy, Motherhood, their Unborn Children, and Themselves in Northwest and Northeast Florida?

The results of the Pregnancy Related Beliefs Questionnaire (PRBQ) will be discussed. The survey statements are divided into the following categories: Attitude Regarding the Self, Attitude Regarding Others, Attitude Regarding Pregnancy, Attitude Regarding the Baby, and Attitude Regarding Motherhood. Within each category are the corresponding statements and the frequency and percentage of each response. In order to derive more data, all statements and responses were analyzed for Change-Resistant and Change-Receptive Attitudes to provide more insight into the inferred attitudes of participants. The statements are lumped together with their responses. Neutral responses are not assigned a "Change-Resistant" or "Change-Receptive" label because it is assumed the participant is undecided in her feelings or thoughts regarding the category presented and ultimately, her attitude will not be determined if she scores higher with Neutral responses than all others. A higher instance of Change-Resistant thoughts and feelings was interpreted as a negative attitude. A higher instance of Change-Receptive thoughts and feelings was interpreted as a positive attitude. The overall PRBQ scores, along with a breakdown of positive, negative, and neutral attitudes towards each category, are located in Appendix T.

Table 17. Attitude regarding the Self Frequency and Percentage

Attitude Regarding the Self	**Change-Resistant**	**Neutral**	**Change-Receptive**
I should not have to ask for help with my baby.	20 (40%)	13 (26%)	17 (34%)
I can cope with my baby on my own.	29 (58%)	8 (16%)	13 (26%)
If I do not keep up my appearance, people will reject me.	14 (28%)	5 (10%)	31 (62%)
If people criticize my baby, it is not a criticism of me.	40 (80%)	4 (8%)	6 (12%)
If my home does not look absolutely right, I feel like a failure.	16 (32%)	9 (18%)	25 (50%)
My independence is very important to me.	38 (76%)	6 (12%)	6 (12%)
If people only see me as a mother or wife I would feel diminished as a person.	8 (16%)	13 (26%)	29 (58%)
I should be able to control how I feel.	32 (64%)	12 (24%)	6 (12%)
I can't keep my baby safe from all sources of infection.	11 (22%)	10 (20%)	29 (58%)
It is important for me to get back to my normal activities as soon as possible after the birth.	26 (52%)	10 (20%)	14 (28%)
I have to do all it takes to make my baby completely happy.	39 (78%)	6 (12%)	5 (10%)
People who cry for no reason are just being hysterical.	1 (2%)	9 (18%)	40 (80%)
I feel frustrated if I am prevented from doing the things I want to do.	22 (44%)	8 (16%)	20 (40%)
My wishes are no less important than those of other people in my life.	24 (48%)	3 (6%)	23 (46%)
I should try hard to keep my figure during pregnancy.	28 (56%)	8 (16%)	14 (28%)
I have to be able to plan my day.	28 (56%)	12 (24%)	10 (20%)
Sometimes it is necessary to put my own needs before those of my baby.	15 (30%)	8 (16%)	27 (54%)
It is selfish to get upset in front of my family.	9 (18%)	6 (12%)	35 (70%)
I should be able to just cope like everyone else does.	10 (20%)	12 (24%)	28 (56%)
It is important for me to make sure I look my best.	22 (44%)	13 (26%)	15 (30%)
I have got to do regular exercise after the birth to get my figure back.	21 (42%)	7 (14%)	22 (44%)
If I do not have lots of interesting news it shows I am a dull person.	19 (38%)	7 (14%)	24 (48%)
My sense of worth entirely depends on my achievement at work	16 (32%)	11 (22%)	23 (46%)
Feeling continually tired is an unpleasant experience I could not bear.	10 (20%)	11 (22%)	29 (58%)
If I can't look after my baby properly it shows I am useless.	6 (12%)	3 (6%)	41 (82%)

For this category, there were no statements that resulted in more neutral responses. Participants indicated mostly Change-Resistant and Change-Receptive responses, which can be interpreted as their attitudes towards themselves have been formed. Twelve of the twenty-five statements resulted in higher change-resistant responses. These responses indicate strong expectations for themselves and the way they are perceived by others. The resistant statements include "I should not have to ask for help with my baby," "I can cope with a baby on my own," and "My independence is very important to me." The highest statement, "If people criticize my baby is not a criticism of me" must be explained. As indicated by the scoring guide, participants who disagree with this statement receive a "Change-Resistant" score because it means they interpret criticism of their baby to reflect upon them as well. Therefore, this statement should be understood as 80% of participants believe criticism of their babies is criticism of themselves.

During the interviews, participants were asked to describe their childhood experiences, which can provide insight into their high expectations for themselves. Feeling less than or like an outsider could have led to an attitude where participants believe they must rely on themselves or portray a certain image. Five of the twelve participants described themselves as "outcasts" during their childhood or believed they did not fit in with others. Participant One stated, "We grew up Jehovah's Witnesses. We did not do lots of things other families did. We were outcasts in social settings with some individuals because they did not have the kind of views we did." Her feeling as an outcast resulted from having different religious beliefs. Participant Two believed she was an "oddball" due to personality differences between herself and her peers. She stated, "Everyone was outgoing, and I wanted to stay home and read." Participant Five stated she felt her whole life she did not fit in, and then she learned

when she was a teenager that she was adopted. This continued her feelings of not fitting in or "feeling like I was a part of something." This participant did not believe she fit in even with her own family, and discovering she was adopted confirmed this.

Thirteen of the twenty-five statements resulted in change-receptive thoughts and feelings, and it can be concluded the participants overall have a positive attitude regarding themselves. The statements receiving a change-receptive response included statements such as "If I do not keep up my appearance, people will reject me." Based on the scoring guide, a "Disagree" response would indicate flexible thoughts and feelings. This question should be understood as 62% of participants do not believe they must maintain their appearance to be accepted by others. Forty-one participants (82%) disagree that not being able to look after their baby means they are useless. This indicates these respondents are able to look at themselves with grace and adjust if they cannot meet their own expectations. Finally, forty participants (80%) disagree with the statement "People who cry for no reason are just being hysterical." This statement demonstrates participants overall have a more gracious outlook towards crying and tears.

The interviews also provided insight as to activities and events happening in childhood that led participants to indicate a positive attitude towards the self. At least five of the twelve participants were able to name good things about their childhood, and activities remained a happy memory. Several participants recalled playing with dolls and playing "house" as they grew older. They also mentioned sports such as swimming, cheerleading, volleyball, gymnastics, and basketball. These activities gave them a sense of confidence and happiness. Participant Three even described it as a way to be away from home and was the source of good memories when home was not her place.

Fahami et al. (2018) found that pregnant women who have a positive body image increase their self-confidence, and increase their positive relations with others, self-acceptance, environmental mastery, and purposefulness, which results in increased psychological well-being. Because these participants have an overall more positive attitude regarding themselves, it can be concluded the majority will experience psychological well-being.

Table 18. Attitude regarding others, frequency and percentage

Attitude Regarding Others	**Change-Resistant**	**Neutral**	**Change-Receptive**
My immediate family should be the only ones I need.	40 (80%)	6 (12%)	4 (8%)
I expect to just be able to see more people as a result of this pregnancy.	17 (34%)	8 (16%)	25 (50%)
I expect my relationship with my partner might become very different after this pregnancy.	7 (14%)	16 (32%)	27 (54%)
People know what kind of person I am by the activities I do.	16 (32%)	14 (28%)	20 (40%)
If someone important pays me less attention after the birth it is because the baby is more important to them than I am.	27 (54%)	10 (20%)	13 (26%)
I should be cheerful and entertaining for people when they come to visit.	14 (28%)	7 (14%)	29 (58%)
Even if I really let myself go my partner would not leave me or have an affair.	13 (26%)	14 (28%)	23 (46%)
During the time following childbirth my partner has as much responsibility as I have to make our relationship work.	33 (66%)	9 (18%)	8 (16%)

There were eight questions regarding participants' attitudes towards others. There were no responses where Neutral held the majority. Three of the statements were majority Change-Resistant, and five were majority Change-Receptive, indicating that overall, participants have a more positive attitude towards others. These results are confirmed by the study done by Fahami et al. (2018), that indicates when pregnant

women have a more positive attitude towards themselves, they will have a more positive attitude towards others.

The three questions where participants were majority Change-Resistant can be interpreted as follows: Eighty percent of participants agree their immediate family members should be the only ones they need; Fifty-four percent agree someone paying more attention to their baby means they are less important; Sixty-six percent agree their partner has responsibility to make the relationship work. These three statements reflect the needs of participants for attention and support. They expect to have support from their immediate families. They also interpret the baby receiving more attention to mean they are less important, which can be problematic if the baby is viewed as competition for attention. Finally, they expect their partners to devote attention to them even after the baby is born. These results can also indicate potential for problems if the participant interprets the baby receiving more attention from the partner or family as competition, instead of understanding the baby may require more attention. Belsky (1985) found that unmet expectations regarding pregnancy and parenthood can lead to negative changes in relationships between partners. While overall these participants have a more positive attitude towards others, it is important to be aware of the potential for unmet expectations that can lead to a negative attitude.

During interviews, participants recalled moments during their childhoods that included positive shared experiences with others. At least five of the twelve recalled their happiest moments from childhood involving family time. Participants spoke fondly of their siblings across all interviews. Participant Four recalled watching her brother's birth, and Participant Two named her happiest moments in childhood as the arrival of her siblings. Being the youngest of seven children was a happy memory for another participant because she was treated as the baby of the family, and she enjoyed

having so many playmates. Holidays were also a common theme of enjoyable memories. Participant Six described birthdays like Christmas, where she would "get everything I wanted." Participant Eight detailed her family's Christmas traditions stating, "Christmas was my favorite. We always get together, watch movies, open presents, and sing Christmas carols." Several participants wanted to continue these traditions with their own families and even create new ones.

During childhood, these participants shared the various ways they related to their mothers. Four out of twelve stated they had a good relationship with their mothers. Participant Twelve stated she was very close with her mother, and she still is to this day. Participant Nine was able to state she had a good relationship with her mother, even though her mother struggled with addiction. She believed her mother was still someone she could talk to who was supportive of her. Even though her parents were not together, Participant One stated her parents still did a good job raising her and "did what they were supposed to do without messing up." She was appreciative of the effort her parents placed on trying to make sure their children were well and safe, even though their own relationship was not.

Grandparents also played an important role in the lives of participants. Dunifon and Bajracharya (2012), outline that grandparent provide a means of reducing stress in the family and can provide academic and emotional support to grandchildren. Participant Ten recalled how her grandfather was a steady presence in her life who "never wavered" even when she was struggling or not making good decisions. Participant Eleven was raised by her grandparents because of her own parents' addiction issues. She spoke respectfully of grandparents who worked hard to provide for her and her siblings in spite of their own financial hardships and medical hardships. Participant Nine recalled being spoiled and loved by her grandparents who

raised her until her mother could bring her to the United States. For all of these participants, grandparents provided an extra source of support and buffered what could have been additional stress and trauma as they were growing up.

Table 19. Attitude regarding the Baby, Frequency and Percentage

Attitude Regarding the Baby	**Change-Resistant**	**Neutral**	**Change-Receptive**
If someone else's baby is happier than mine it is probably because I am an inadequate mother.	41 (82%)	4 (8%)	5 (10%)
If I am unable to satisfy my baby I am a bad mother.	46 (92%)	3 (6%)	1 (2%)
If my baby is unhappy I will feel that it is my fault.	20 (40%)	9 (18%)	21 (42%)
If my baby was unhappy it would be because of something I had not done.	22 (44%)	11 (22%)	17 (34%)
I have a very clear picture in my mind of what it will be like to have a newborn baby.	27 (54%)	8 (16%)	15 (30%)
If I do not feel completely emotionally attached to my baby I should worry about what this means.	4 (8%)	7 (14%)	39 (78%)
If my baby loves me back (s)he will play with me better than anyone else.	7 (14%)	2 (4%)	41 (82%)
If my baby is able to rule my activities it is because I am too weak.	20 (40%)	13 (26%)	17 (34%)
After my baby is born, I will never be lonely in my life again.	22 (44%)	10 (20%)	18 (36%)
I expect my baby will be happy if I am around a lot.	7 (14%)	9 (18%)	34 (68%)
I should appreciate every single moment of the early part of my baby's life.	18 (36%)	10 (20%)	22 (44%)

There were eleven statements related to the participants' attitudes regarding their babies. Six of the eleven responses were Change-Resistant, and five of the responses were majority Change-Receptive. Overall, participants had more Change-Resistant thoughts and feelings, which could be interpreted as a more negative attitude towards their babies due to rigidity. These statements directly reflect on their

ability to care for their children with words and phrases like “bad mother,” “inadequate mother,” and “too weak.” They also indicate high expectations, such as having a clear picture of life with a newborn and life with the baby meaning an end to loneliness.

Harwood et al. (2007) found that when expectations developed during the prenatal period were not met, it resulted in poorer psychological adjustment in the postnatal period. These change-resistant beliefs and resulting overall negative attitude can lead to negative experiences and maladjustment after the baby is born. Being aware of the high expectations of the baby could lead to a more positive attitude, especially once the baby arrives. At least three of the twelve participants interviewed disclosed they felt nervous and were overwhelmed about the impending births of their babies. However, one participant demonstrates viewing her baby with a change-receptive attitude. Participant Two realistically anticipates, “At first, lots of stress, but I think it will work itself out… a lot of taking a breath and trying again.” This indicates she understands adjusting to her baby will be difficult, but she can also give herself room to try again.

Table 20. Attitude regarding motherhood, frequency and percentage

Attitude Regarding Motherhood	**Change-Resistant**	**Neutral**	**Change-Receptive**
Motherhood is a time when I should be calm and serene.	44 (88%)	3 (6%)	3 (6%)
Being a mother will be the most fulfilling experience I can ever have.	7 (14%)	10 (20%)	33 (66%)
If I ask for help with mothering my baby it is not a sign that I am failing.	14 (28%)	7 (14%)	29 (58%)
I am as enthusiastic as I should be about my future role as a mother.	7 (14%)	3 (6%)	40 (80%)
I do not have to be a perfect mother	35 (70%)	5 (10%)	10 (20%)
If I do not feel maternal, it means I am bad.	30 (60%)	6 (12%)	14 (28%)
Motherhood is an instinctive and natural state for a woman.	18 (36%)	14 (28%)	18 (36%)

There were eight statements that measured participants' attitudes towards motherhood. These participants tied with four majority Change-resistant responses and four majority Change-receptive responses. This indicates the overall attitude cannot be determined regarding how participants feel as a whole towards motherhood. These participants with majority Change-resistant thoughts and feelings expect themselves to be calm and serene as mothers and they expect to feel maternal. Seventy percent also expect to be perfect mothers. Their Change-receptive responses, however, indicate there is a balance to these expectations, or perhaps even a conflict in thoughts and feelings. They do not expect motherhood to be the most fulfilling experience, they believe they can ask for help with mothering, and they do not have strong expectations towards their level of enthusiasm. There is a tie between change-resistant and change-receptive thoughts and feelings (18 which is 36%) regarding whether or not motherhood is instinctive and natural.

Deave (2005) states that a pregnant woman's capacity to visualize herself as a mother is central to maternal psychological preparation for parenting. Because this study did not ask if women had been pregnant before, there is no way of knowing whether or not these expectations differ based on previous experience. However, it is known that unmet expectations can lead to maladjustment and negative outcomes as pregnant women transition to becoming mothers (Eastwood et al. 2012). Henderson et al. (2016) found that internalizing guilt and the pressure to be perfect is detrimental to mothers and can lead to poorer mental health outcomes. It is possible the inability to provide a firm attitude regarding motherhood is because these participants as pregnant women have yet to interact with their babies outside of the womb and do not have a firm decision as to what motherhood will mean for them.

While the PRBQ results reflected a tie in Change-Resistant and Change-Receptive attitudes, the interviews reflected more positive and Change-Receptive attitudes towards motherhood. When asked how participants hope their children describe them as mothers, most stated they want their children to describe them as loving, supportive, and someone they can talk with about anything. Participant Four stated she wants her child to say about her, "I took care of him good and was a supporter of him." Participant Five said, "I want them to know I always gave my best effort and took time to spend with them." No participants expressed a desire to let their children run their lives or refuse to provide discipline. Instead, these participants all stated they wanted to provide stability and structure. One expressed a desire to "Be authoritarian, but someone he can talk to." These participants also expressed a desire not to repeat the trauma of their past. They want to provide for the needs of their children and "Be able to cope with life different from what I had to." Furthering this point, Participant Eight also stated she desires to "shelter her child from the adult things she was exposed to." Participant Twelve hoped her child would describe her as "Warm, a safe place. Like a big hug."

Table 21. Attitude regarding pregnancy, frequency and percentage

Attitude Regarding Pregnancy	**Change-Resistant**	**Neutral**	**Change-Receptive**
I expect that my life will be generally improved as a result of this pregnancy.	15 (30%)	9 (18%)	26 (52%)
I welcome the changes in my body, even those like odors (not including any illnesses).	11 (22%)	16 (32%)	23 (46%)

Two questions measured the participants' attitudes towards pregnancy. Both questions resulted in majority Change-Receptive thoughts and feelings and thus, an overall positive attitude towards pregnancy. These participants expect their lives will be improved as a result of their pregnancies, and they welcome the changes in their

bodies. This confirms the findings of Clark et al. (2009) who found that pregnancy resulted overall in a new sense of meaning and purpose in life for the pregnant women they studied. It also resulted in a transition in life priorities as their bodies became vessels responsible for the creation of offspring and consequently, they attached meaning and purpose to the changes their bodies were experiencing. From the responses provided in this study, it can be concluded these participants overall believe the changes in themselves as a result of pregnancy are viewed positively.

The interview responses also reflected a majority Change-Receptive attitude towards pregnancy and a more positive attitude. All participants spoke of enjoying feeling their babies move and grow. They also imagined meeting their babies and were excited about the moment the baby arrived. Anxiety about labor and delivery was not mentioned. However, participants did state whether or not they could have their support person of choice with them was a concern, and this appeared to be more of a concern than the actual labor itself. Participant Ten disclosed she was experiencing this pregnancy differently than her first pregnancy because she was now sober and doing what she felt like she was supposed to be doing to stay healthy. She shared that she was nervous about life with a newborn, but she was looking forward to the time with her child, which she did not get to experience with her first child. Several participants, such as Participants Nine and Ten, stated that although their pregnancies were not expected, they looked forward to meeting their babies, and they were excited about being pregnant.

Overall, the majority attitudes of participants were positive towards themselves, others and pregnancy. The attitudes of participants towards the baby were majority negative. This can indicate the participants place a high expectation on how they treat their babies and how their babies respond, thus leading to a negative attitude

because the expectations are so high (i.e., not meeting the baby's needs could mean she is a "bad mother"). Finally, the overall attitude of the participants towards motherhood could not be determined due to a tie between Rigid and Flexible thoughts and feelings. A possible explanation for this is because while all the participants have interacted with themselves, others, pregnancy, and to an extent their babies already, they have not experienced parenting this particular child, and they may not have a firm attitude developed yet due to a lack of interaction. Another possible explanation is that participants may have higher expectations of themselves and put more pressure on themselves regarding the care of their babies and their bonding with them. For example, one of the questions states, "If my baby is unhappy then I will feel it is my fault." Agreeing with this statement indicates pressure on the mother to make sure her baby is happy, and she could internalize the baby's unhappiness as failure on her part. However, based on the data provided, a positive attitude towards the baby and others could indicate she does not have those high expectations to keep herself or others happy.

Research Question 6: Is there a Correlation between the ACE Type of the Participant and the Attitudes of Pregnant Women Regarding Pregnancy, Motherhood, their Unborn Children, and Themselves in Northwest and Northeast Florida?

In order to determine if there is a correlation between the ACE type of the participant and the attitudes of pregnant women, mean and standard deviation were used as part of the statistical analysis. Analysis of variance (ANOVA) was used to obtain the p-value. A p-value <0.05 indicates a correlation. Each category of attitude was compared to the type of ACE examined within the ACE survey. In the PRBQ, questions range from "Totally Agree" to "Totally Disagree," and they are scored from 1 to 7 depending on the answer. A Neutral response always receives a score of "4." A

result of greater than 4 indicated a significant rigid response, resulting in a negative attitude.

Table 22. ACE type and attitude

ACE Type	Self	Others	Baby	Motherhood	Pregnancy
None	3.12 ± 0.56	3.2 ± 0.94	3.1 ± 0.96	3.17 ± 0.93	2.89 ± 1.56
Verbal Abuse	3.83 ± 0.69	3.88 ± 0.73	3.62 ± 0.85	3.64 ± 1.2	3.79 ± 1.66
Physical Abuse	4.88 ± 0.62	4.02 ± 0.7	3.81 ± 0.81	3.77 ± 1.25	4 ± 1.51
Sexual Abuse	4.98 ± 0.54	4 ± 0.73	3.87 ± 0.9	3.86 ± 1.13	3.73 ± 1.45
Emotional Neglect	3.9 ± 0.67	3.77 ± 0.64	3.64 ± 0.9	3.59 ± 1.14	3.92 ± 1.48
Physical Neglect	4.21 ± 0.86	3.83 ± 0.86	3.89 ± 1.22	3.6 ± 1.55	4.17 ± 1.86
Divorced/ Separation	4.1 ± 0.7	4.06 ± 0.69	4.14 ± 0.82	3.97 ± 1.07	3.56 ± 1.53
Domestic Violence	4.65 ± 0.59	4.75 ± 0.66	3.72 ± 1.03	3.6 ± 1.07	3.89 ± 1.58
Substance Abuse	4.91 ± 0.69	4.98 ± 0.77	3.85 ± 0.95	3.9 ± 1.24	4.09 ± 1.53
Mental Illness	4.21 ± 0.67	4.11 ± 0.81	3.95 ± 0.96	3.77 ± 1.23	4.1 ± 1.45
Incarcera-tion	5.06 ± 0.74	4.07 ± 0.79	3.65 ± 0.73	3.59 ± 1.21	4.33 ± 1.41
p-value	*<0.001*	*<0.001*	*0.1077*	*0.182*	*0.0182*

These results verify that not all ACEs are equal in their impact on the individual (Negriff 2020; Atzl et al. 2019). Based on this analysis, a correlation (<0.001) was found between the Category Attitude Regarding the Self and Physical Abuse (4.88), Sexual Abuse (4.98), Physical Neglect (4.21), Divorce/Separation (4.1), Domestic Violence (4.65), Substance Abuse (4.91), Mental Illness (4.21), and Incarceration (5.06). Negriff (2020) found that different types of ACEs resulted in different mental health outcomes. For example, she found that sexual and physical

abuse resulted in higher instances of depression, trauma, and externalizing symptoms, while emotional abuse and neglect resulted in depressive, trauma, and anxiety symptoms. Experiencing childhood physical abuse is correlated with lower self-esteem (Celik and Odaci 2020), so it can be assumed these participants may be struggling with self-esteem as well, as indicated by their negative attitudes towards themselves. Sexual abuse can also result in negative attitude towards the self. In their discussion of childhood sexual abuse's effects on adults, Lamoreaux et al. (2012) discuss self-esteem (sense of self-worth) and self-efficacy (belief in one's abilities) as important factors in mediating the impact of the negative consequences of childhood sexual abuse, such as psychological distress. If self-esteem and self-efficacy are not there, then it can be concluded there is a higher likelihood of experiencing negative consequences. All ACEs were found to be positively associated with suicide attempt into adulthood, and all ACEs expect for an incarcerated family member resulted in a higher likelihood of depressed affect as an adult (Merrick et al. 2017).

A correlation was also found between Attitude Regarding Others and ACE Type (p-value <0.001). The correlation was found with Physical Abuse (4.02), Sexual Abuse (4), Divorced/Separation (4.06), Domestic Violence (4.75), Substance Abuse (4.98), Mental Illness (4.11), and Incarceration (4.07). These responses indicate more rigid thoughts and feelings, and thus, negative attitudes can be concluded. Experiencing these ACEs can lead to poor outcomes in interpersonal relationships when these children become adults. Labella et al. (2018) state that adult women with history of maltreatment report less warm and supportive romantic relationships and were more likely to have engaged in infidelity. Young and Widom (2014) indicate that child maltreatment can lead to deficits and dysfunction in emotional processing, such as identifying and recognizing emotional expressions. Emotional processing is

important for understanding the thoughts and feelings of others and being able to respond appropriately. Huurre et al. (2006) found that adult females who experienced parental divorce before the age of 16 reported more psychological problems and more problems in their interpersonal relationships. Regarding domestic violence, it must be noted that whether or not children grow up in a home where they witness domestic violence is the best predictor of whether or not they will become victims or perpetrators themselves, and witnessing domestic violence can lead to a higher likelihood of becoming perpetrators (Harrison 2021, 64). With substance abuse, children who have been exposed to substances have an increased likelihood of using substances themselves, and this will impact their relationships with others in a negative way (Merrick et al. 2017). There is also increased family dysfunction in families where parents have mental illness (Weigand-Grefe et al. 2019). Children of mentally ill parents have an increased likelihood of developing mental illness themselves (Lauritzen et al. 2014). Lee, Fang, and Luo (2013) report that parental incarceration history is linked to poor outcomes such as lack of safe, stable, nurturing relationships and exposure to violence.

The interview responses demonstrated that while trauma can negatively relate to attitude, social support could play a role in alleviating the effects of trauma. For some participants, their families were a source of encouragement and helped them mediate the effects of trauma and difficulties. Bath (2008) reminds us that connection to others is important for the healing of trauma. Participant Twelve recalled struggling with dyslexia, a learning disability, that could have made schooling very difficult. However, she recalled having supporting parents and siblings who encouraged her. Participant One, who is a Jehovah's Witness, recalled being close with her family, and this helped lessen the feeling of being an outcast. She stated that she would not

change her parents or change how she was raised because of the closeness of her family.

Pregnant women with low social support systems have increased negative outcomes for pregnancy and postnatal health (Elsenbruch et al. 2006). At least seven of the twelve participants named their husband, boyfriend, or the father of their child as a source of support. They mentioned that they had not wanted to have children until they found the right partner, and they expressed relief at having found someone with whom they could have a family. For the other five, a significant other was not mentioned. However, parents were mentioned as a source of support. Some of the ways their families demonstrated support were by calling, making sure they were okay, accompanying them to appointments, and providing emotional support. One participant stated, "When I found out I was pregnant, no one was mad or made me feel any kind of way." This support helped to alleviate the stress she has felt during her pregnancy. In addition to parents, participants spoke of their siblings, friends, aunts and uncles, as additional sources of support. Also encouraging to hear, several participants spoke highly of the encouragement they had received through their local pregnancy resource centers. This included counseling and classes that helped to bring peace and alleviate questions. The government program Healthy Start was also mentioned by participants as a source of support.

Participants looked to members of their families as role models for being mothers, as well as examples of what they would not do as parents. Participant Four stated the women in her family were wonderful mothers; however, she noticed things they allowed when she was a child, and she is determined not to repeat those same mistakes with her own child. Participant One stated she wanted to stay with her partner, unlike her parents who did not stay together. Participant Two does not want

to repeat the mistakes of her mother, and instead, she looks to her partner's mother as someone she wanted to model herself after. In spite of her mother's struggles, Participant Nine still looks to her mother as a role model because of what she was able to overcome. She looks to her grandfather as well because of his constant presence and care for her throughout her life. Participant Five, who was adopted, does not want to be like her biological mother because she was never there for her children, and she wants to be a good mother instead. Grandmothers were also named as role models for participants because they created welcoming homes and gave love and support to everyone. Finally, two of the participants named their best friends who "made motherhood look easy" and inspired them to have families of their own.

A correlation was found between Attitude Regarding Pregnancy and ACE Type (p-value 0.0182). A correlation was found with Physical Abuse (4), Physical Neglect (4.17), Substance Abuse (4.09), Mental Illness (4.1), and Incarceration (4.33). Chung et al. (2010) found that overall, there was a higher likelihood of risky behaviors during pregnancy such as smoking and substance use among women who had a history of adverse childhood experiences over women who did not. Osofsky et al. (2021) confirmed pregnant women who were exposed to child maltreatment reported more anxiety, depression, posttraumatic stress symptoms, and substance usage, while those exposed to household dysfunction reported more posttraumatic stress and also increased risk for substance use during pregnancy.

No correlation was found between ACE Type and Attitude Regarding the Baby (p-value 0.1077) or Attitude Regarding Motherhood (p-value 0.182). For Attitude Regarding the Baby, one ACE Type (divorce/separation) resulted in more Change-Resistant thoughts and feelings (4.14), but there was not a statistical correlation found over all.

The interviews reflect these results. Regardless of the trauma or hardships these participants experienced in their own lives, they all overwhelmingly spoke of excitement and joy when they discussed their babies. It is important to note that while these responses reflect joy and excitement, they also provide an example of high expectations for themselves and their babies in terms of bonding and feeling love. When asked what they anticipate feeling or thinking when the baby arrives, participants spoke of love and joy. Participant Two stated, "I am ready to meet him and having that bonding moment." Participant Three said, "I am gonna fall in love. I am already in love and will fall in love even more. I know it will be overwhelming, and I am going to be happy." Participant Eight disclosed, "I am looking forward to loving her, spoiling her, being the number one protector and making sure she is safe." Loving her child unconditionally and expecting to receive it in return was another thought expressed by Participant Eleven.

Relief was also a common emotion felt by the participants. Participant Nine described it best when she stated, "I expect to be so excited, so in love and so relieved. The relief of knowing she is here and everything is ok, and she is here in my arms." These participants all looked forward to meeting their babies, holding them in their arms, and welcoming the feeling of being in love with their babies. These findings agree with a previous study conducted by Darvill et al. (2008) who found women began the bonding process with their infants long before the babies were born and expressed positive feelings on discovering the pregnancy and meeting their infants.

Interview responses also reflected strong expectations on themselves as mothers. When asked how they want their children to describe their childhoods, all participants again placed high expectations on themselves to be able to provide warm,

loving, and stable environments. Participant Six hopes her child describes his life as "Awesome" with parents who allowed him to pursue his dreams. Participant Seven desires that her child is able to say his life was fulfilling and that he was able to do what other children his age may not have done. Two of the participants expressed a desire to experience nature and being outside with their children, as well as raising them away from televisions. All participants spoke of creating fun-loving environments with no fussing or screaming at one another. Those fun-loving environments included making their own memories, traveling, and creating their own traditions as a family. Stability and providing a good family home was another desire expressed by participants for their children. While these are all positive aspirations, they require effort on behalf of their mothers to provide stable and loving environments where children can explore and grow in healthy ways. These desires will require a lot of work and could potentially be a struggle or source of discouragement if these expectations are not met. Eastwood et al. (2012) found that maternal unmet expectations play a significant role in postpartum depression and subsequent child development. While it is premature to state these women are all at risk for developing postpartum depression, unmet expectations are a risk factor for negative maternal health outcomes.

Finally, these participants were asked what their hopes and dreams were for their children. All of these mothers have dreams, with the most common dream that their children will be successful. Success does mean different things to different mothers. Participant Eight hopes success will come in the form of caring for herself and navigating through life on her own, going to school, and having a career. For Participant Three, success means her child will be able to do what he loves to do, regardless of what others might say. Success for Participant Two means not having to

worry about having physical needs met. To Participant Six, success means having a good supportive family who pushes you to be better, helps you remain disciplined, and cares about what you do. Success also means a lack of trauma for all of these participants.

Additional hopes and dreams include that their children are born healthy and intelligent, and when facing hardships, they can still accomplish their own dreams. These participants expressed the hope their children would have families of their own and love them, care for them, and treat them well. Participant Three hopes her child will grow physically, mentally, and emotionally strong as he journeys through life. All of these participants also affirmed they would be there for their children and support them in all their endeavors. They hope to always be someone "in their corner" and able to be trusted by their children.

The second null hypothesis, "There will not be a correlation between the ACE type of the participants and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves," was partially accepted for attitudes regarding the baby and motherhood. However, a correlation was demonstrated for ACE type and attitudes regarding the self, others, and pregnancy, and the null hypothesis was partially rejected for these attitude categories.

For the categories Attitude Regarding the Self, Attitude Regarding Others, and Attitude Regarding the Baby, it was found that as the ACE score increases, the rigidity in responses also increases. Thus, it can be concluded for these three categories that as the ACE score increases, so does the likelihood of a negative attitude towards each category.

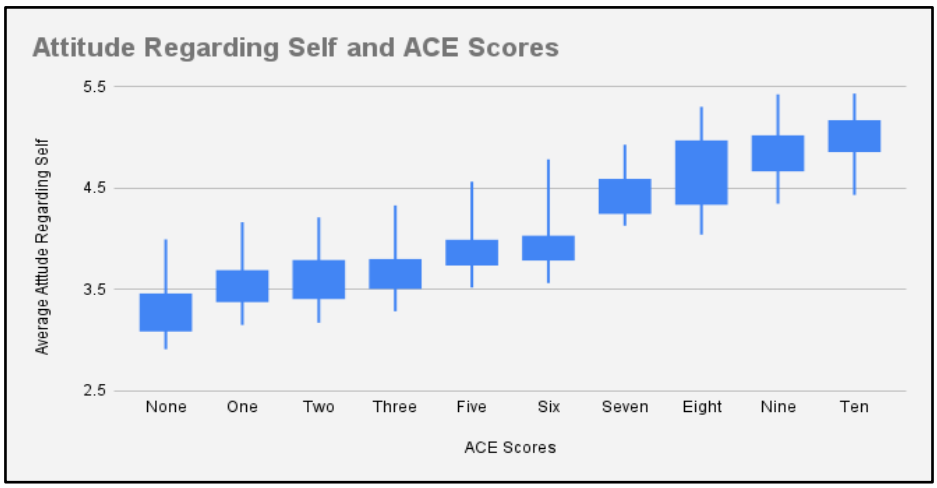


Figure 8. Attitude regarding self and ACE scores

Based on Figure 8, it can also be noted that as ACE score increases, so does the likelihood of an individual having a negative attitude towards herself. Once the ACE score reaches five, the average attitude is greater than 4 (Neutral value), and the likelihood of a negative response increases. This is supported by other research regarding Adverse Childhood Experiences that as ACE score increased, the odds of experiencing drug and alcohol use, suicide attempts, and depressed affect in adulthood also increased (Merrick et al. 2017). It makes sense that as the instances of adverse childhood experiences increases, so does the likelihood of a negative attitude towards the self.

It is interesting to note that in the interviews with participants there were adverse experiences mentioned that were not mentioned with the ACE survey. There were several participants who described a challenge they experienced as moving around a lot. For Participant Twelve, this was due to parents being in the military. However, for other participants, this was a result of parental choices, such as moving for a parent's paramour or an unstable living situation due to financial stress. Participant Three was in multiple foster homes, and this created another source of instability. Participants Five and Seven disclosed they were adopted. Participant

Seven stated that she felt “less than” because she was the adopted child in her family and not a biological child. Participant Nine recalled not fitting in because she moved to the United States as an elementary-aged child, and she did not speak English. Going to a school where there were few children like her reminded her that she was an outsider. Understanding how these adverse experiences such as immigration, foster care, adoption, and multiple moves relate to attitude would be topics recommended for further study.

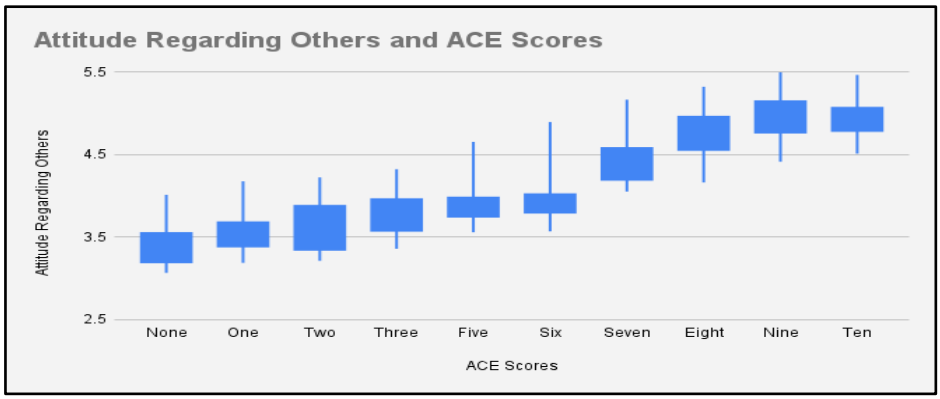


Figure 9. Attitude regarding others and ACE scores

Based on Figure 9, it can be concluded that as the ACE scores of participants increase, so does the likelihood of a negative attitude towards others. As the ACE score approaches five and six, the attitude surpasses the median of 4 (Neutral) and becomes more rigid. Balistreri and Alvira Hammond (2015) demonstrated that higher ACE scores resulted in worse reported physical and emotional well-being than those with fewer ACEs. However, family functioning could moderate the negative impact of cumulative ACEs. A possible explanation for the trend in this research is that these participants may not have had positive family relationships or dynamics that would mediate a negative attitude as the score increases.

The responses from interviewees reflected negative attitudes towards others due to strained relationships. Strained relationships were also noted between

participants and their mothers. Participant Six stated she was close to her mother, but her mother gave birth to her as a young teenager and struggled with addiction as she got older. Even now, she considers her mother to be her best friend, although her mother now lives far away. Participants Five and Seven, who were adopted, did not believe they had good relationships with their mothers. One participant stated her adoption was "not as good as it should have been." Participant Seven was told by her adoptive parents that she did not fit. She stated, "They made me feel like this because they were lighter and I was darker and that me and my skin wasn't right." For these participants, their families did not mediate or lessen the trauma they experienced as a result of being adopted. These statements affirm the findings of Brodzinsky et al. (2021, 7), which state that when respectful, affirming, and supportive messages are received by the adopted child from the family, healthy internalization and integration of the adoptive identity occurs. The disclosures from Participants Five and Seven demonstrate they were not affirmed and supported as adopted children.

For nine of the twelve participants, their fathers were more commonly absent or a source of stress. Participant Twelve stated her father had "mental conditions" and this led to "ups and downs" in the relationship. Other participants did not have a relationship with their fathers. This was either due to the father's complete absence, having never met their fathers, or their fathers' incarceration. Participant Eleven, who outlined the substance addiction of her parents, mentioned her mother's desire to have a relationship with her; however, she did not mention her father and did not name him as a supporter in her childhood or adult years. Participant Four stated that she was always "on edge" around her father when she was growing up, and as an adult, she has now realized that her father was abusive. The absence of a relationship with her father led Participant 9 to desire this even more for her own children. She stated,

"With my dad, at first, I got upset that he was not a part of my life. Now I don't feel as sad that he was not a part of my life. It makes me feel stronger now that I want my kids to have a good relationship with their father and me." This participant has been able to reframe the loss she experienced in the lack of a relationship with her father as a motivator to change her own family.

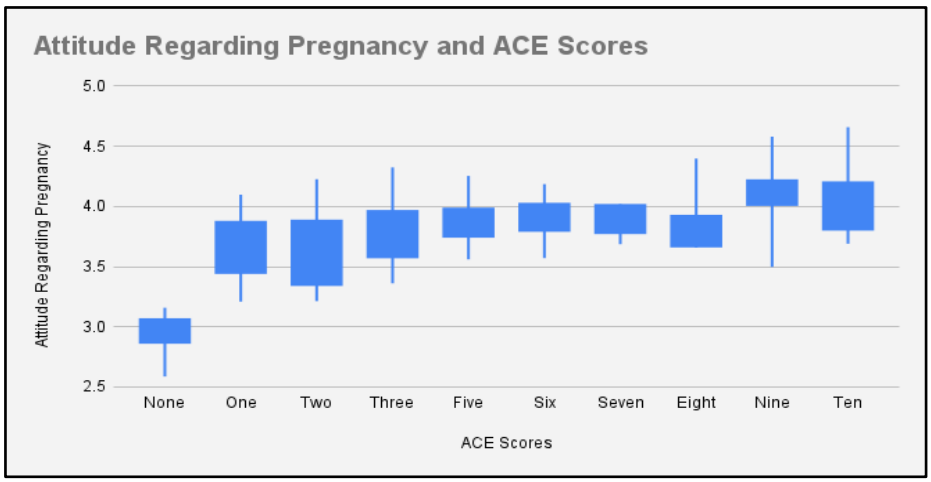


Figure 10. Attitude regarding pregnancy and ACE scores

While not as pronounced as Figures 8 and 9, Figure 10 demonstrates that as the ACE score of participants increases, so does the likelihood of change-resistant thoughts and feelings, and as a result, a negative attitude towards pregnancy increases as well. However, it was only once participants reached an ACE score of at least 9 that results were significantly over the 4 (Neutral) line. This could be as a result of only two questions in the study regarding pregnancy. This could also indicate it requires a higher number of ACEs to make a significant impact on the attitudes of women regarding pregnancy. Brigitte et al. (2014) noted that women who have experienced ACEs have an increased risk of obstetrical risk factors and an increased risk for premature delivery. Smith et al. (2016) also found that each additional ACE decreased birth weight by 16.33 grams and decreased gestational age by 0.063. The findings of this study demonstrate that an increase in ACE score can lead to an

increase in negative attitude towards pregnancy, which could relate to the negative health outcomes demonstrated by the literature.

The interview responses demonstrated the experiences of these women during their pregnancies have not been easy. “Pain” and “morning sickness” were common struggles. Participant Eight explained she was not able to “drink water in the morning without throwing up.” Medical hardships made pregnancy difficult for others. Participant Ten disclosed she had recently suffered a stroke due to a blood clot. While she and the baby were okay, she was now taking medication and being monitored weekly. Covid-19 was an additional source of physical stress for several participants. For participants who worked in the healthcare system, additional restrictions, the threat of becoming sick, and having to wear masks while suffering from asthma. Two participants had recently recovered from Covid and were not allowed medication while they were sick.

Additional hardships included previous miscarriages. One participant suffered a miscarriage before her current pregnancy. However, she described her current pregnancy as “Enlightening” because the doctors were able to figure out what was going on and she is more hopeful about her current pregnancy being a success. Participant Ten, who also suffered a miscarriage before her current pregnancy, became increasingly fearful when she experienced bleeding and spotting. However, these fears have alleviated as the pregnancy has progressed and the baby continues to grow.

Other hardships mentioned by participants included emotional and financial hardships. Emotionally, participants recalled dealing with the lack of support from a partner or not having family members close by to help. Participant Four mentioned the stress of working while being pregnant, especially while being more tired than

usual and being sick. Financial strain has been a challenge for participants who are trying to navigate work, childcare, and prepare material items to prepare for the baby. When the pregnancy was unexpected, the stress and anxiety experienced by participants was even higher. However, participants who reported this, such as Participants Ten and Eleven, also stated having a support system lessened their anxiety and that these anxieties got better as the pregnancies have progressed.

Regarding the third null hypothesis "There will be no correlation between the ACE score and the attitudes of participants," this was accepted for the attitudes of pregnant women regarding motherhood and the baby. However, there was a correlation found between ACE scores and attitudes regarding the self, others, and pregnancy and the null hypothesis was rejected for these attitude categories.

These interviews provided additional insights into the attitudes of the participants. At least seven of the twelve experiences of abuse, neglect, and living with family members who were incarcerated, abused substances, or had mental health issues. Four of the twelve disclosed hardships that while they are not questions on the ACE survey are definitely considered trauma, such as parental abandonment and separation, experiencing foster care and adoption, racism, and immigration. These experiences impacted their attitudes towards themselves, as well as their attitudes towards others. Their attitudes towards themselves varied as at least four classified themselves as outsiders. Six of the twelve were able to recall positive moments from childhood, three were not able to recall memories at all.

It appears that having a good support system serves as a buffer from the difficult experiences they had as children and might be currently experiencing as expecting mothers. Liang, Williams, and Siegal (2006) found that a secure maternal relationship helped to buffer against marital problems as an adult in survivors of

childhood abuse. Herman (2002) also affirms supportive connections are essential for buffering and healing from trauma. For these participants, having a supportive person in their life, such as a parent, grandparent, sibling, partner, or even friend helped ease the discomfort and loneliness they might have experienced. Even when a caregiver was the source of stress and trauma, having a supportive person helped them look forward to having their babies and becoming mothers. Above all, while these participants have high expectations for themselves as mothers, they look forward to meeting their babies and experiencing joy and love when they hold their children. They also hope they can provide a life where their children are loved, supported, successful, and able to achieve their hopes and dreams. Every participant, no matter her circumstances or experiences, hopes to provide a better life for her child than what she experienced herself.

Summary of the Chapter

This chapter contains the presentation and analysis of the data resulting from the research which sought to answer the overall question, "What is the impact of childhood trauma history on a pregnant woman's attitude toward motherhood and her unborn child in Northwest and Northeast Florida?" This study was a mixed-methods study utilizing both qualitative and quantitative methods to answer the research questions. The demographic results, the Adverse Childhood Experiences Scores and Type were discussed. The results of the Pregnancy Related Beliefs Questionnaire were addressed as well. Various statistical methods were used to derive data. Frequency and percentage were utilized for the demographic information, ACE scores, ACE types, and PRBQ results. Chi-Square was used to determine the correlation between demographic information and ACE Scores/Types. ANOVA testing was used to determine the p-value and correlation between ACE Scores/Types

and participant attitudes. A narrative of the participants' interview responses was developed based on the attitudes of the participants regarding themselves, others, pregnancy, the baby, and motherhood.

Pilot testing was undertaken with ten participants from Holmes, Jackson, and Washington counties in Northwest Florida. The actual study was undertaken with fifty participants from counties in Northwest and Northeast Florida. Twelve individuals participated in interviews. The majority of the fifty participants are between the ages of 18 and 26 (53%), while most participants are in the first or second trimester of pregnancy (65.4%). The ACE scores of the participants ranged from 0 to 10, with the most common ACE score to be 0 (28%) or 1 (28%). Twenty-six percent (26%) of participants had 4 or more ACEs. The most common ACE Type was Parental Divorce/Separation (52%) followed by Substance Abuse (32%). Using Chi-Square test, a correlation was found between length of pregnancy, sexual abuse, and mental illness. A correlation was also found between race, in particular white women, and verbal abuse, physical neglect, and mental illness. Marital status correlated with parental separation and divorce, domestic violence, and incarceration.

Based on frequency and percentage, when PRBQ results were examined, the overall responses of all participants indicated a positive attitude towards the Self (13 of 25), Others (5 of 8) and Pregnancy (2 of 2). The overall responses of all participants indicated a negative attitude towards the Baby (6 of 11). The overall attitude towards Motherhood could not be determined because there was a tie between rigid and flexible responses (4 and 4). Analysis of Variance (ANOVA) was used to determine the p-value (<0.05) when evaluating the correlation between ACE Type and Attitude. A correlation was found between Attitude Regarding the Self and physical abuse, sexual abuse, physical neglect, parental divorce and separation,

domestic violence, substance abuse, mental illness, and incarceration. For Attitude Regarding Others, there was a correlation with physical abuse, sexual abuse, divorce and separation, domestic violence, substance abuse, mental illness and incarceration. For Attitude Regarding Pregnancy, a correlation was found with physical abuse, physical neglect, substance abuse, mental illness, and incarceration. For ACE score and attitude, it was found that as the score of the participant increased, the attitudes regarding the self, others, and pregnancy became more negative.

Further insights were gained when the individual responses and attitudes were compared. The interviews provided further insight in that although participants might have experienced childhood trauma, they all indicated a desire to create a good life for their children, and they had high expectations of themselves to be good mothers and provide a life different from their own.

This chapter contained an overview of the research process. The participants' demographic information, ACE score results, and PRBQ results were included, as well as the interview responses. These were provided in response to the research questions posed. The summary of findings, conclusions, and recommendations will be provided in the following chapter.

CHAPTER V

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter discusses the summary of findings, conclusions, and recommendations. Within this chapter, the most important elements of the study will be discussed. Conclusions of the study will be included, along with recommendations based upon the research for further study as well as practical application for the results of the study.

Summary of Findings

This present study is entitled "Examining the Impact of Childhood Trauma on the Attitudes of Pregnant Women Towards Motherhood and Their Unborn Children in Northwest and Northeast Florida." Understanding that trauma is pervasive and can impact the next generation, this research sought to understand connections between a pregnant woman's childhood trauma history and her attitude regarding herself, others, pregnancy, her child, and motherhood.

This research is based upon the framework that trauma impacts all areas of an individual's life. Trauma impacts the cognitive, social, emotional, physical, and spiritual development of the individual. When a child experiences trauma, her development is affected, and then she becomes a mother. Trauma has the potential to mediate the various ways trauma affects her development as she is pregnant and then raises a child herself. Trauma impacts the attitude of the individual, which is formed by the thoughts and feelings of an individual towards a particular subject. Attitude then mediates behavior. When a woman becomes pregnant, her attitude towards

herself, others, her pregnancy, her baby, and motherhood will influence her behavior. She can either utilize behaviors that will allow her to create a life in which her child grows holistically in all areas of development, or she can utilize behaviors that will perpetuate the cycle of trauma she has experienced.

This research was a mixed methods study conducted with three locations in Northwest and Northeast Florida. These locations were selected because of their proximity to the researcher and their willingness to participate in the study. All three locations directly serve pregnant women in a medical or supportive capacity. Participants were given the opportunity to participate through the Adverse Childhood Experiences survey and the Pregnancy Related Beliefs Questionnaire. Participants also answered demographic questions.

After a consenting participant completed the survey, her results were collected and given to the researcher. The responses to the ACE survey were added together. Every "Yes" answer was given one point, with the range of scores available to be 0-10. The PRBQ questionnaire contained 53 questions (one question was excluded after pilot testing) with a 7-point Likert scale. The questions were analyzed based on categories: self, others, pregnancy, baby, and motherhood. The data was analyzed for themes and results were compared between the ACE scores and the PRBQ responses. I took the data analysis a step further to determine which responses to the PRBQ indicated rigid, flexible or neutral thoughts and feelings. Change-Resistant thoughts and feelings are interpreted as a negative attitude. Change-Receptive thoughts and feelings are interpreted as a positive attitude, and neutral thoughts and feelings are interpreted as an undetermined or undecided attitude.

Once participants completed the survey, they were offered the opportunity to be interviewed. If they stated "Yes," then they were contacted by the researcher. The

questions were structured to provide coherence and to be able to establish themes across the various responses. Each response was recorded and transcribed using Amerscript software. The interview responses were examined based on the attitude categories in order to gain further insights into how participants view their childhoods and anticipate becoming mothers in light of what they have experienced.

This research sought to understand the impact of childhood trauma on a pregnant woman's attitude towards herself, others, pregnancy, her unborn child, and motherhood. This research was conducted with fifty women who are over the age of eighteen, pregnant during the time of the research study, and residents of Northwest and Northeast Florida. The overall results of the study are reviewed in the following paragraphs.

Question One, which measured the demographic information of participants, was determined using frequency and percentage. Thirty-two (65.7%) of the women who participated were between 7-20 weeks pregnant, meaning the majority were in the first and second trimesters of pregnancy. Thirty-nine (53%) of the participants are between 18-26 years old. Twenty-six participants (54.17%) identify as white, while fourteen (29.17%) identify as black, one (2.08%) is Asian, six (12.50%) are Hispanic, and one (2.08%) participant identified her race as "Other." Thirty (62.5%) of the participants earn less than $30,000 annually and could be considered below the Federal Poverty Level, depending on the number of individuals in their households. Forty (83.33%) participants earn less than $50,000 annually. In terms of education, twenty-one (42.86%) earned at least a high school diploma or their GED, and thirteen (26.53%) have an Associate's or Vocational Degree. Twenty-eight (57.14%), or more than half of the participants, are single and have never been married, while sixteen (32.65%) are married, four (8.16%) are divorced, and one (2.04%) is widowed.

Columbia and Suwannee Counties both held the highest number of participants with eleven each (22.45%). Leon County was the next-highest with eight participants (16.33%) and seven came from Holmes County (14.29%). This can be explained by the fact that the pregnancy centers and doctor offices are located in these counties. Participants from surrounding counties travel to these locations to receive prenatal care.

Question Two asked the extent of trauma experienced by pregnant women in Northwest and Northeast Florida. This was determined by examining the ACE scores of participants. The individual scores were totaled, and frequency and percentage were used to draw overall conclusions. Regarding the ACE scores of the participants, fourteen (28%) had an ACE score of 0, meaning they had no adverse childhood experiences based upon the survey. Fourteen (28%) had an ACE score of 1, which means they experienced at least one adverse childhood experience. Seventy-two percent of the participants had an ACE score of at least 1. The next highest number of ACE scores was seven participants with a score of 2 (14%). Twenty-six percent, or one in four participants, had an ACE score of four or more, which indicates these participants are at an increased risk for negative health outcomes such as mental illness and sickness (Felitti et al. 1998). Three out of four participants had at least one ACE. It can be concluded pregnant women in Northwest and Northeast Florida are likely to have endured at least one Adverse Childhood Experience, with one in four experiencing four or more.

Question Three asked for the most common incidence of ACEs among pregnant women in Northwest and Northeast Florida. This was determined by examining each participant's "Yes" response. The frequency and percentage of the "Yes" responses for each ACE type were calculated to obtain the overall results. The

most common Adverse Childhood Experience marked by participants was regarding the separation and divorce of parents. Twenty-six participants (52%) experienced either parental separation or divorce. Following this, sixteen participants (32%) experienced substance abuse by members of their families. Fourteen experienced physical abuse and fourteen experienced verbal abuse (28% each). The least common ACE was physical neglect (12%). It can be concluded that approximately half of the pregnant women in Northwest and Northeast Florida have experienced parental separation and divorce, and at least one in four have experienced substance abuse by a caregiver.

Question Four examined the relationship between the ACE types indicated by the participants and the demographic information presented. To determine this, Chi-Square testing was conducted. A p-value of <0.05 suggests a correlation. A correlation was found regarding length of pregnancy and sexual abuse (0.031) and mental illness (0.012). A correlation was found regarding race, particularly for white women, and verbal abuse (0.026), physical neglect (0.018), and mental illness (0.036). Because of the smaller sample sizes for Black, Hispanic, and Asian pregnant women, conclusions cannot be drawn regarding their results. A correlation was also found between marital status and separation/divorce (0.027), domestic violence (0.044), and incarceration (0.027). No correlation was found between ACE type and the age range, socioeconomic status, educational status, and counties of residence.

Question Five looked for insights regarding attitude, as measured by the Pregnancy Related Beliefs Questionnaire. When the responses of the PRBQ survey were analyzed, there was no single question with which all fifty participants were neutral, agreed, or disagreed. However, there were questions with which a majority of participants responded similarly, and these lead to further insights regarding the

attitudes of participants. The individual results were scored and the responses were determined to be “Change-Resistant,” “Change-Receptive,” or “Neutral.” A higher instance of change-resistant thoughts and feelings was interpreted as leading to a negative attitude, while a higher instance of change-receptive thoughts and feelings was interpreted as leading to a positive attitude. The questions from the survey were divided into five categories: Attitude Regarding the Self, Attitude Regarding Others, Attitude Regarding Pregnancy, Attitude Regarding the Baby, and Attitude Regarding Motherhood. The results were totaled and analyzed using frequency and percentage. Overall, it was found that based on the results of the PRBQ, participants were more likely to have a positive attitude regarding themselves (13 of 25 majority change-receptive responses), others (5 of 8 majority change-receptive responses), and pregnancy (2 of 2 majority change-receptive responses). However, participants were more likely overall to have a negative attitude towards the baby (6 of 11 majority change-resistant responses). There was a tie between change-resistant and change-receptive thoughts and feelings regarding motherhood (4 and 4 out of 8). As a result, the overall attitude towards motherhood was not able to be determined. It can be concluded that based on PRBQ results alone, pregnant women in Northwest and Northeast Florida are more likely to have a positive attitude towards themselves, others, and pregnancy, a negative attitude towards their babies, and an undetermined attitude towards motherhood.

Question Six looked for a correlation between ACE Type and participant attitude and ACE score and participant attitude. Analysis of Variance (ANOVA) was used to determine the p-value. A p-value of <0.05 indicated a correlation. For the PRBQ, a Neutral response always received a score of “4.” A score higher than 4 indicates a change-resistant response. A correlation was found for Attitude Regarding

the Self (<0.001) and the following ACE types: physical abuse (4.88), sexual abuse (4.98), physical neglect (4.21), divorce and separation (4.1), domestic violence (4.65), substance abuse (4.91), mental illness (4.21), and incarceration (5.06). A correlation was found for Attitude Regarding Others (<0.001) and the following ACE types: physical abuse (4.02), sexual abuse (4), divorce and separation (4.06), domestic violence (4.75), substance abuse (4.98), mental illness (4.11), and incarceration (4.07). A correlation was also found for Attitude Regarding Pregnancy (0.0182) and the following ACE types: physical abuse (4), physical neglect (4.17), substance abuse (4.09), mental illness (4.1), and incarceration (4.33). Based on these results, it can be concluded that physical abuse, substance abuse, mental illness, and incarceration all impacted the attitudes of pregnant women regarding themselves, others, and pregnancy. There was no correlation found between ACE Type and Attitude Regarding the Baby or Motherhood.

Question Six also looked for possible correlation between the ACE score and participant attitude. It was determined that as the ACE score increased, the likelihood of a negative attitude increased for attitudes towards the self, others, and pregnancy. No correlation was found with the baby and motherhood. For the self and pregnancy, an ACE score of five or six indicated an increase in more change-resistant thoughts and feelings (with responses measuring over 4, neutral). For pregnancy, an ACE score of 9 or 10 indicated an increase in more rigid thoughts and feelings and a likelihood of a negative attitude. It can be concluded that as the ACE score of a pregnant woman in Northwest and Northeast Florida approaches 10, her likelihood of having a negative attitude towards herself, others, and pregnancy increases as well.

The following are the Null Hypotheses for this study:

1. There will be no relationship between participant ACEs and the following demographics: number of weeks pregnant, age range, educational background, socioeconomic status, race, marital status, and county of residence.
2. There will not be a correlation between the ACE type of the participants and the attitudes of pregnant women regarding pregnancy, motherhood, their unborn children, and themselves.
3. There will be no correlation between the ACE score and the attitudes of participants.

For statement one, a correlation was found between ACE type and the number of weeks pregnant, race, and marital status of participants. However, the null hypothesis was accepted for age range, educational background, socioeconomic status, and county of residence.

For statement two, there was a correlation found with the ACE type of participants and attitudes regarding the self, others, and pregnancy. This hypothesis was accepted for ACE Type and attitudes regarding the baby and motherhood.

For the third statement, there was a correlation found with the ACE score of participants and their attitudes regarding the self, others, and pregnancy. As the score increased, so did the likelihood of a negative attitude regarding these categories. This hypothesis was accepted for ACE score and attitude regarding the baby and motherhood as there was no proven correlation.

This research benefited from additional insights gained through participant interviews. These interviews were conducted with twelve pregnant women. They were transcribed using Amberscript and organized by theme and category to create a narrative. From the interviews, additional insights have been gained. While

participants disclosed experiences of divorce, abuse, substance use, and neglect, they also disclosed additional experiences of trauma not included in the ACE survey, such as abandonment, foster care, adoption, racism, and immigration. In spite of these experiences, it appears strong support systems provide a buffer against the negative effects of the trauma or at least lessens them. Participants overall reported thoughts and feelings that lead to a positive attitude towards pregnancy and their babies. All expressed a desire to be good mothers and high expectations for themselves to provide a wonderful life for their children, better than what they experienced. It appears that trauma does not diminish the desire to be a good mother or to love a child completely. Instead, trauma might be a motivator to be a good parent and provide a good life for a child, as well as develop a stable and happy family.

Conclusions

Based on the data analysis presented, the conclusions of this study will be presented here and will be addressed by the research questions. The overall conclusion of this research is that trauma impacts the attitudes of pregnant women in Northwest and Northeast Florida regarding themselves, others, pregnancy, their babies, and motherhood, and the extent to which this impact occurs is based on a variety of factors, such as the extent of trauma experienced, the type of trauma experienced, and certain demographic factors. In spite of their trauma, pregnant women want to be good mothers to their children, and they desire a life better for their children than what they have experienced.

1) Regarding the demographic information of participants, it was found the majority of participants are 7-20 weeks pregnant (64.5%). Fifty-three percent of the participants are between 18-26 years old. The majority of participants are white (54.17%). The majority of participants (62.5%) earn less than

$30,000 annually. In terms of educational status, the largest group has earned a high school diploma (42.86%). The majority of participants are single (57.14%). The majority of participants live in Columbia and Suwannee Counties (11 which is 22.45%).

While this research was conducted with fifty women and large generalizations cannot be made, this demographic information does provide a picture of a pregnant woman in Florida. She is likely to be white, between 18-26 years old, with a high school diploma, earning less than $30,000 annually, and single. These insights can provide indications as to services and interventions she may need. For example, if the majority of pregnant women are single, then an understanding of her support system will be important as this research has already demonstrated the importance of support for alleviating the symptoms of trauma. Further, she may need financial assistance to care for her child if she is only earning around $30,000 annually.

2) The extent of trauma experienced by the pregnant women in this study was determined based on their self-reported ACE scores. Twenty-eight percent of the participants have not experienced any of the ACEs surveyed and received a score of 0. However, about three out of four participants (72%) have at least one ACE. One in four participants (26%) has experienced 4 or more ACEs.

The interviews of this study demonstrated there were women who participated who experienced adverse experiences not included on the ACE survey such as foster care and immigration. Therefore, while these results show that twenty-eight percent of respondents have an ACE score of 0, these conclusions must bear in mind the possibility of adverse experiences or traumas not included. It is significant also that one in four participants (26%), have experienced at least four or more ACEs, which, as previously discussed, can lead to an increased likelihood for negative health

outcomes (Felitti et al. 1998). It can be concluded that more women have experienced trauma than women who have not, as at least three out of four women in this research reflect this.

3) The most common experiences of trauma was determined by analyzing the individual "Yes" response of each participant on the ACE survey. The most common instance of ACE was parental divorce/separation at 52%. Substance abuse was the second highest with 32% of participants indicating "Yes." It can be concluded that at least one in two pregnant women in this survey has experienced parental divorce/separation and one in four have experienced caregiver substance abuse.

These results are not surprising to me as a researcher. A common anecdote I have heard repeatedly throughout my life is that fifty percent of marriages end in divorce. This is slightly up from the national average that forty-five percent of marriages will end in divorce (Pelley 2022). Kleinsorge and Covitz (2012) found that high levels of exposure to parental conflict can lead to negative emotional adjustment in children. These women have experienced parental conflict, and could be experiencing the consequences of poor emotional adjustment. More research is needed. It is also important to consider that one in three women in this research have been exposed to substance abuse. It would be interesting to consider how substance abuse exposure in childhood related to the attitude of the participants in this research towards substance abuse as adults and if they have continued the example of their caregivers. This will be discussed further under implications for further study.

4) When the adverse childhood experiences of the participants was compared with the demographic information of the participants, a correlation was found with the following:

a. Length of pregnancy and sexual abuse

b. Length of pregnancy and mental illness

c. Race and verbal abuse

d. Race and physical neglect

e. Race and mental illness

f. Marital Status and parental divorce/separation

g. Marital Status and domestic violence

h. Marital Status and Incarceration

There was no correlation between age range, socioeconomic status, educational status, and county of residence. This partially accepts the null hypothesis, which states there will not be a correlation between demographic information and adverse childhood experiences. The null hypothesis was rejected for length of pregnancy, race, and marital status.

These relationships again are not surprising. As has been discussed earlier, women who have experienced sexual abuse or the mental illness of a caregiver can be hypervigilant regarding their bodies and the changes they are experiencing. A relationship was found with race and verbal abuse, physical abuse, and mental illness. As stated earlier, white women are more likely to report abuse than minority women. This will be discussed further under recommendations. The relationship between marital status and divorce, domestic violence, and incarceration is understandable. The majority of women in this research are single and these experiences in childhood could have negatively influenced their attitude towards marriage. This will also be discussed under recommendations.

5) The Pregnancy Related Beliefs Questionnaire provided insight into the attitudes of participants regarding the self, others, pregnancy, the baby, and

motherhood. When the overall results from all participants were analyzed, it was concluded that the majority of pregnant women in Northwest and Northeast Florida have a positive attitude regarding the self, others, and pregnancy. The majority of women have a negative attitude regarding the baby. Their attitudes towards motherhood cannot be concluded at this time.

There are assumptions that can be made based on these results. Attitudes are object-evaluation assumptions (Overwalle and Siebler 2005). Because these women have interacted with themselves, others, and pregnancy, they have formed their attitudes. They have not yet interacted with their babies outside of the womb, so they are forming their attitudes based on information and experiences not related to their children. They understandably have high expectations for themselves as mothers and how they relate to their babies. Their attitudes regarding motherhood are also not fully solidified because they have not yet experienced themselves as mothers to their babies.

6) The adverse childhood experiences were compared with the attitudes of participants. This was done by comparing the incidence of ACEs with the participant attitudes and the ACE scores with the participant attitudes. A correlation was found between the ACE incidence (type) and the following attitudes: Attitude Regarding the Self and physical abuse, sexual abuse, physical neglect, divorce and separation, domestic violence, substance abuse, mental illness, and incarceration; Attitude Regarding Others and physical abuse, sexual abuse, divorce and separation, domestic violence, substance abuse, mental illness, and incarceration; Attitude Regarding Pregnancy and physical abuse, physical neglect, substance abuse, mental illness, and incarceration.

There was no correlation found between the ACE type and attitudes regarding the baby and motherhood. This partially accepts the null hypothesis, which stated there would not be a correlation between adverse childhood experiences and participant attitudes. The null hypothesis was rejected regarding attitudes towards the self, others, and pregnancy.

The attitudes of the participants were also compared with the ACE scores of participants. It was found that the higher the ACE score, the more likely a participant's attitude towards herself, others, and pregnancy would be negative. There was no correlation found between the ACE score and the attitudes regarding the baby and motherhood. This partially accepts the null hypothesis, which stated there would not be a correlation between the ACE score and participant attitude because there was no correlation found between the ACE score and attitude towards the baby and motherhood.

It can be concluded that adverse childhood experiences negatively impact attitudes towards the self, others, and pregnancy, but they do not significantly impact the attitude towards the baby and motherhood. One possible reason for this is that the attitudes towards the baby and motherhood were negative or undetermined, so introducing childhood trauma as a variable did not alter their attitudes significantly; whereas, introducing adverse childhood experiences does impact attitudes in such a way that a previously positive can become increasingly negative.

The interviews in this study provided additional insight regarding the attitudes of pregnant women and their experiences of childhood trauma. These participants provided additional experiences of trauma not measured on the ACE survey, such as experiencing racism, foster care and adoption, and immigration. Relational support could provide a buffer for women against the impact of trauma. Participants wanted to

be good mothers to their children and be a system of support for them, as well as provide a great life.

Recommendations

This research led to insights regarding pregnancy, attitude, and trauma. Based on the conclusions, recommendations will be made regarding implications for study replication, further study, recommendations for interventions and services, and recommendations for the church.

Recommendations for Study Replication

This research was conducted with fifty participants from multiple counties around Northwest and Northeast Florida. There were multiple successes and complications which arose while conducting this study. These will be discussed and taken into consideration so the study can be replicated.

One recommendation would be to really examine an instrument more thoroughly before determining it will be used. The PRBQ survey, while it did yield a lot of data, was complicated to analyze. In order to really glean insight from the data, the individual responses to each question posed must be examined. The overall score is helpful, but it does not provide insights into participant attitudes. Therefore, I had to create categories and determine a scale for what were rigid and flexible responses. The original survey included a guide for scoring, but did not provide details on how to interpret the data. This was left to the researcher, and it makes it more complicated to recommend the instrument for use in a clinical setting.

There were numerous complications with this study. The most pressing complication arose from conducting this study in the midst of the Covid 19 pandemic. While Florida did have fewer restrictions than most states in the U.S., there were still

restrictions and mandates which made conducting the study difficult, especially in a medical setting. As a result, I was able to conduct the research in a small medical clinic, but I was not able to conduct the research with larger medical clinics due to staffing shortages. This led me to the pregnancy resource centers located in several counties. Fortunately, three pregnancy centers agreed to the study, and this allowed me to reach the number of required participants.

Another recommendation that can be made when replicating the study is to obtain a research contract from each location before establishing the details of the study. When I first began this study, I had verbal agreements with different locations; however, after the pilot testing was completed, some locations were not able to honor those verbal agreements for various reasons. This left me in a scramble to find other research locations to meet the required number of participants. Having written agreements would have reduced the stress of the study significantly.

Further, the researcher must anticipate challenges and blockades, such as complications from Covid-19. Covid-19 resulted in restrictions to medical facilities that led to staff shortages, reduced hours, and limited ability to interact with potential participants. Expecting these challenges and making contingency plans would also reduce stress and increase the likelihood of successful research. Had I anticipated these challenges, I might have selected a different method to study the research problem.

There were successes with this study as well. I was reminded of the value of relationships and having good relationships within the community. This led to openings at research locations such as the pregnancy centers when other doors had closed. In spite of the research relating to trauma, no participants reported distress at any point while taking their surveys or being interviewed. There was minimal risk to

the participants, and I believe the relationships participants had with their nurses and counselors also mediated possible distress.

Recommendations for Further Study

While insights were gained, further questions emerged as a result of this study. The data yielded questions where additional knowledge would be helpful. While the participants were diverse across racial backgrounds, more research needs to be done with Black, Hispanic, and Asian women particularly. Comparisons could not be made and firm conclusions could not be drawn regarding whether race, other than white, influenced or mediated trauma and attitude during pregnancy. These groups of women are underrepresented in research, so further study would provide gains in understanding their unique needs and creating interventions. While this question was not asked, it would provide additional insight to learn whether or not unintended pregnancy resulted in a positive or negative attitude for participants. This would be an interesting comparison for participants who are single as well as participants who are married.

Another area of interest for further study would be to examine the impact of each ACE on attitude specifically. For example, the majority of participants were single and fifty-two percent have experienced parental divorce/separation. It would be insightful to investigate how the experience of parental divorce has shaped their attitudes now towards marriage, especially given their pregnancies and impending births. Another way this could be approached is by examining the attitudes of pregnant women towards substance abuse. One in three women in this research have been exposed to caregiver substance abuse, and understanding their attitudes towards their own usage or what they will tolerate from others (i.e., their partners) would

provide valuable insight towards caring for these women and implementing intervention or support services.

During the interview portion, participants disclosed additional traumas such as being placed for adoption, experiencing racism, and immigration. These traumas are not tested in the ACE survey provided. It would be interesting to note what additional traumas are present in the lives of participants. Other traumas such as being involved in a car accident, hospitalization, and witnessing a violent incident were not tested for either. It would be insightful to learn if these traumas impact attitude as well, especially for participants who scored a 0 on the ACE survey. Expanding the survey to include other traumas could be helpful in further understanding how attitudes are shaped and developed.

An additional further study could follow up with participants after their babies are born to determine if their attitudes were maintained or if they changed. This could provide direction into areas where intervention and services are truly needed. For example, if all participants believed before their children were born that they could not ask for help, and then they changed their minds after their children were born, then this would not be an area where interventions or corrective services were needed. However, if before the birth all participants believed they are bad if they do not feel maternal and these beliefs were not changed after birth, then this is an area where intervention should be concentrated. It would also be interesting to implement the Adverse Babyhood Experiences survey to participants after their babies have been born or are at least a year old to determine if trauma has already been perpetuated in the next generation.

While the participants indicated they had experienced childhood trauma, there was nowhere to disclose the age when the trauma occurred or how often. For

example, a child who began experiencing sexual abuse at the age of three and it continued throughout her childhood might have a different attitude or trauma reaction than a child who experiences physical abuse only once at the age of sixteen. Research including these factors would be beneficial to help explain participant attitudes and provide additional insight for interventions.

Other areas for studying the impact of trauma and pregnancy could include spirituality and self-efficacy. Because trauma impacts all areas of development, spiritual development would be an area affected. It would be interesting to know if spirituality provides an additional supportive factor or buffer for women who have experienced trauma, or if spirituality suffers as a result of trauma. Spirituality was not discussed with participants in this research due to the diversity of research locations. While pregnancy centers offer spiritual support if clients are open to it, medical clinics are less likely to do so and possibly would not be open to spiritual questions being asked of the participants. I did not want to risk losing a research location due to possible controversial questions; therefore, spirituality was not discussed. However, spirituality is important and would yield insight into its relationship with trauma history.

Self-efficacy is how people feel, think, behave, and motivate themselves (Zulkosky 2006), and utilizing the Childbirth Self Efficacy Inventory (Lowe 1993) compared with the ACE Questionnaire might yield valuable insight. Because pregnancy and mothering require the development of new skills and reacting to new circumstances, self-efficacy is important in order to be successful. Trauma's impact on the self-efficacy of pregnant women would be useful to understand and is of particular interest to this researcher.

Recommendations for Interventions and Services

Based on the data recorded in this research, it is important to provide recommendations to service providers in order to increase the likelihood of positive outcomes in pregnancy and parenting. One specific intervention that can be used is the administering of the ACE survey to all clients when they are initiating services. This can lead to identifying areas where interventions can be applied to prevent negative outcomes. For example, if a client has a family history of mental illness and has grown up with a family member with a mental illness or who attempted suicide, she could be at an increased risk to develop mental illness as well, especially during a stressful time such as pregnancy (Nestler et al. 2006). Knowledge of this will allow providers to help make sure supports are in place, including counseling, connection to community resources, education about the symptoms of mental illness, and lifestyle factors such as diet and exercise that can alleviate symptoms.

Further, it is known that the more ACEs experienced, the more the individual is at risk for risky behavior, chronic disease, and mental disorders in adulthood (Cheng et al. 2019). Knowledge of this could encourage medical professionals to administer a holistic work up or physical for these participants to help determine the health of the client and increase her likelihood of carrying her pregnancy to term and surviving her pregnancy and childbirth.

While the PRBQ is a long survey and may not be practical, providers can use portions of the survey to create a script and identify possible areas where interventions can be applied. For example, the question, “I welcome the changes in my body” can be used to determine how participants are feeling about themselves and their pregnancy. If participants do not welcome changes in their bodies, this could be an indication of body dysmorphia, a lack of understanding regarding the changes that

will occur and what changes are natural (i.e. weight gain), and could provide additional understanding about hardships a client may be experiencing. In another example, the question, “I expect my life will be improved as a result of this pregnancy,” can be used to discern what challenges a client may be experiencing and how her needs can be met. Maybe the client’s partner has left her or she is faced with the additional burden of childcare, or maybe the pregnancy was unplanned. These insights can help providers fill in gaps of care and connect clients to services that will increase their likelihood of success.

Recommendations for the Church

This research has made it clear there are areas where the church can be involved in the lives of pregnant women and their families. The church should be in the business of caring for the vulnerable and providing community and support. The church has a vested interest in the health of the next generation. By not only taking pregnancy seriously as the start of new life, but also understanding it can come with a host of complications will allow the church to provide a tremendous amount of support and care for women.

One recommendation that the research made abundantly clear is that more and more women are having children outside of wedlock. More than half of the participants of the study were single and had never been married, and others were single and divorced or widowed. This indicates that the church must be willing to provide community and support for women who are not married. While having a child outside of wedlock may not be ideal or might be against a church’s values, rejecting these women means rejecting their children as well and refutes the church’s vision of being pro-life. The church cannot claim to value children while rejecting their unwed mothers at the same time.

It must also be remembered that every woman's experience of trauma is different. Similarly, trauma does not have a distinct appearance, and simply looking at a woman or her circumstances will not provide insight into her trauma history. For example, a married white woman with a Master's degree could have a more extensive trauma history than a single white woman with only a high school diploma. Therefore, stereotyping and bringing in perceived bias will not provide the services needed. It is also important to remember that based on this data, pregnant women are more likely than not to have experienced childhood trauma. It would not be beneficial to assume everyone in the congregation had a great childhood. It is also not a good idea to assume every pregnant woman is receiving the support she needs or has a positive attitude towards herself, others, her pregnancy, her baby and motherhood. It is also important to remember that symptoms of childhood trauma will look different for each woman, and women should be given safe spaces to process their trauma and seek help.

Rather than make assumptions or wait for women to reach out, the church can provide opportunities for women to experience community and support while they are pregnant. This could include offering classes or small groups for pregnant women. Pastors can take the opportunity to speak about motherhood and pregnancy as it appears in the Bible. Pastors can also take the opportunity to point out when trauma occurs in the Bible and use it as an opportunity to encourage members to seek help for trauma experienced. The church can partner with local ministries and organizations to connect women to additional support and invite those local partners to speak or provide information and resources. Some churches of size have low cost counseling resources available within the church, but ladies must be aware of these and encouraged to use them.

The church can play a vital role in promoting the healing and welfare of the pregnant mother. One example that comes to mind is the participant who disclosed during her interview that she was celebrating three years of sobriety. She also shared that closest supporters (her mother and family) did not live geographically close to her. This is where the church and its members can step in by helping to meet physical, emotional, and spiritual needs. These areas include helping her with groceries, accompanying her to doctor appointments, encouraging and cheering for her when she attends her counseling sessions, and being there for her when she is tempted to relapse. The church can also remind her of how much she is loved by God and affirm her potential to be a wonderful mother.

Finally, one important point made by this research is that regardless of trauma history, women want to be good mothers to their children. They place high expectations on themselves, which can result in a negative attitude towards themselves or other aspects of mothering. However, at no point did a woman ever state that she wants to repeat the cycle of trauma with her own children. Instead, these women expressed a strong desire to provide a different life for their children. It is also important to remember that trauma does not automatically lead to poverty, abuse, and laziness– stigmas that have arisen in society. The woman may not have the tools and resources needed to provide a better life for her child or the support she needs. This presents a wonderful challenge and opportunity for the church to extend itself as the hands and feet of Jesus and meet the needs of women and their families. The health of the church and future generations depends on the church's willingness to rise to the occasion.

APPENDIX A

ADVERSE CHILDHOOD EXPERIENCE (ACE) QUESTIONNAIRE

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically, the first 18 years of your life. Please answer by placing a check (✓) by YES if it did happen and NO if it did not.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   □ Yes □ No

2. Did a parent or other adult in the household often:
   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   □ Yes □ No

3. Did an adult or person at least 5 years older than you ever:
   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   □ Yes □ No

4. Did you often feel that:
   No one in your family loved you or thought you were important or special?

   Or

   Your family didn't look out for each other, feel close to each other, or support each other?

   □ Yes □ No

5. Did you <u>often</u> feel that:

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

□ Yes □ No

6. Were your parents <u>ever</u> separated or divorced?

□ Yes □ No

7. Were any of our parents or other adult caregivers:

<u>Often</u> pushed, grabbed, slapped, or had something thrown at them?

Or

<u>Sometimes or often</u> kicked, bitten, hit with a fist, or hit with something hard?

Or

<u>Ever</u> repeatedly hit over at least a few minutes or threatened with a gun or knife?

□ Yes □ No

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

□ Yes □ No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

□ Yes □ No

10. Did a household member go to prison?

□ Yes □ No

APPENDIX B

PREGNANCY RELATED BELIEFS QUESTIONNAIRE

Please read each question carefully and place a check under which statement you feel best describes you now.

Belief: Answer each statement according to the way you think most of the time.	Totally agree	Agree Very much	Agree Slightly	Neutral	Disagree Slightly	Disagree very much	Totally disagree
1. I should not have to ask for help with my baby.							
2. I am as enthusiastic as I should be about my future role as a mother.							
3. I can cope with my baby on my own.							
4. If I do not keep up my appearance, people will reject me.							
5. If people criticize my baby, it is not a criticism of me.							
6. If my home does not look absolutely right, I feel like a failure.							
7. If I do not feel maternal, it means I am bad.							
8. I do not have to be a perfect mother							
9. My independence is very important to me.							
10. During the time following childbirth my partner has as							

much responsibility as I have to make our relationship work.							
11. I expect my baby will be happy if I am around a lot.							
12. If people only see me as a mother or wife I would feel diminished as a person.							
13. I should be able to control how I feel.							
14. I can't keep my baby safe from all sources of infection.							
15. I should appreciate every single moment of the early part of my baby's life.							
16. It is important for me to get back to my normal activities as soon as possible after the birth.							
17. I have to do all it takes to make my baby completely happy.							
18. People who cry for no reason are just being hysterical.							
19. I feel frustrated if I am prevented from doing the things I want to do.							
20. I should be able to bring on milk if I want to.							
21. My wishes are no							

less important than those of other people in my life.							
22. If I ask for help with mothering my baby it is **not** a sign that I am failing.							
23. I should try hard to keep my figure during pregnancy.							
24. I have a very clear picture in my mind of what it will be like to have a newborn baby.							
25. Motherhood is an instinctive and natural state for a woman.							
26. I have to be able to plan my day.							
27. I expect that my life will be generally improved as a result of this pregnancy.							
28. If my baby was unhappy it would be because of something I had not done.							
29. Being a mother will be the most fulfilling experience I can ever have.							
30. Sometimes it is necessary to put my own needs before those of my baby.							
31. My immediate family should be the only ones I need.							

32. It is selfish to get upset in front of my family.							
33. I expect to just be able to see more people as a result of this pregnancy.							
34. I should be able to just cope like everyone else does.							
35. I expect my relationship with my partner might become very different after this pregnancy.							
36. It is important for me to make sure I look my best.							
37. People know what kind of person I am by the activities I do.							
38. If my baby is unhappy I will feel that it is my fault.							
39. If someone important pays me less attention after the birth it is because the baby is more important to them than I am.							
40. If someone else's baby is happier than mine it is probably because I am an inadequate mother.							
41. If I am unable to satisfy my baby I am a bad mother.							
42. I have got to do regular exercise after the birth to							

get my figure back.							
43. I welcome the changes in my body, even those like odors (not including any illnesses).							
44. If I do not have lots of interesting news it shows I am a dull person.							
45. I should be cheerful and entertaining for people when they come to visit.							
46. My sense of worth entirely depends on my achievement at work.							
47. If I do not feel completely emotionally attached to my baby I should worry about what this means.							
48. Even if I really let myself go my partner would not leave me or have an affair.							
49. If my baby loves me back (s)he will play with me better than anyone else.							
50. Feeling continually tired is an unpleasant experience I could not bear.							
51. If my baby is able to rule my activities it is because I am too weak.							

52. If I can't look after my baby properly it shows I am useless.							
53. After my baby is born I will never be lonely in my life again.							
54. Motherhood is a time when I should be calm and serene.							

Researcher-Developed Questions

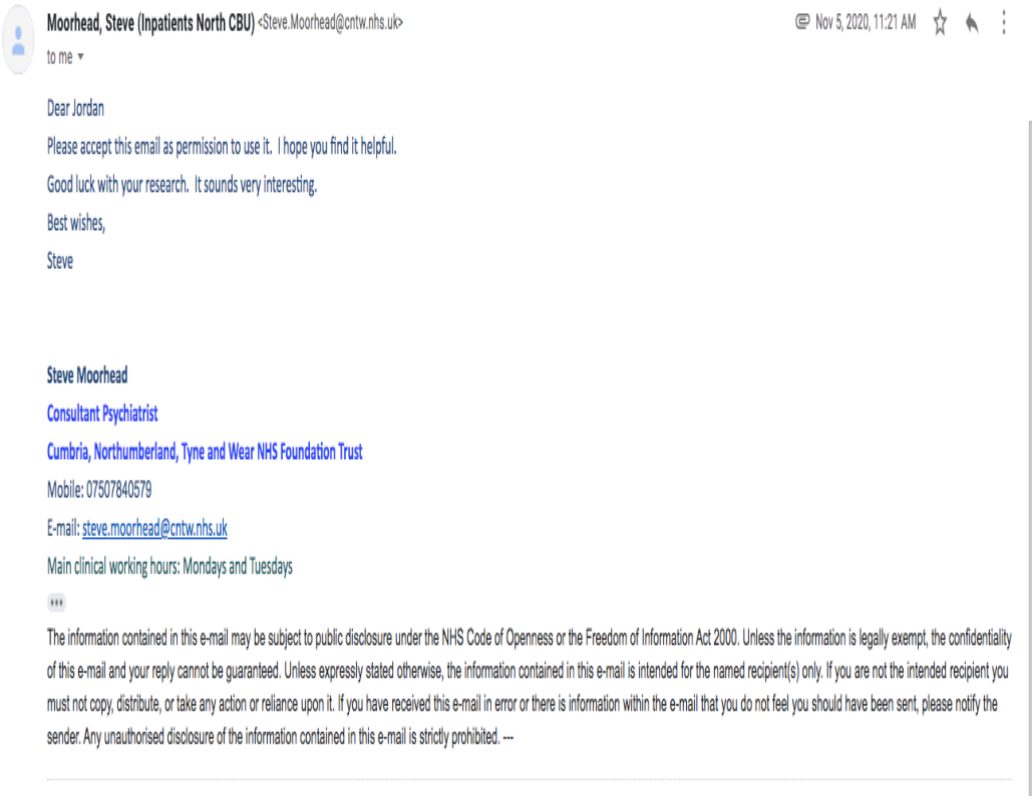
Belief: Answer each statement according to the way you think most of the time.	Totally Agree	Agree Very Much	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much	Totally Disagree	Does Not Apply
55. I often think about what will go wrong during pregnancy.								
56. I often worry I will lose this pregnancy.								
57. I was surprised to find out I was pregnant.								
58. It was difficult for me to conceive.								
59. I often think about the other baby(ies) I miscarried.								
60. I often think about the other baby(ies) I aborted.								
61. I feel guilty for not enjoying this pregnancy.								
62. I am ashamed to be pregnant.								
63. I frequently talk to my unborn baby.								

64. I often imagine what (s)he will look like.								
65. I feel prepared to be a mother.								
66. I feel I will be a good mother.								
67. I often think about losses I experienced.								
68. I remember more bad times than good times from my childhood.								
69. I enjoy feeling my baby move and kick in my stomach.								
70. I enjoy buying things and planning for my baby's birth.								
71. I am proud that I was adopted.								
72. I had/have a good relationship with my mother.								
73. My partner is supportive of this pregnancy.								
74. My family is supportive of this pregnancy.								
75. I feel alone.								
76. No one understands how I feel.								
77. I am overwhelmed.								
78. I am concerned about how I will manage life with a baby.								

79. I am planning to surrender this child for adoption.								
80. I considered terminating this pregnancy.								
81. My worth is determined by how good of a mother I am to my child.								
82. My other children are supportive of this pregnancy.								

APPENDIX C

PERMISSION TO USE THE PREGNANCY RELATED BELIEFS QUESTIONNAIRE



Moorhead, Steve (Inpatients North CBU) <Steve.Moorhead@cntw.nhs.uk> Nov 5, 2020, 11:21 AM

to me

Dear Jordan

Please accept this email as permission to use it. I hope you find it helpful.

Good luck with your research. It sounds very interesting.

Best wishes,

Steve

Steve Moorhead

Consultant Psychiatrist

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Mobile: 07507840579

E-mail: steve.moorhead@cntw.nhs.uk

Main clinical working hours: Mondays and Tuesdays

APPENDIX D

INTERVIEWER SCRIPT

Beginning of the Interview:
Thank you so much for giving your consent. If, during this process, you have any questions or concerns, please feel free to let me know immediately.

I will first begin by asking you to rate your current feelings on a scale from 1 to 5, with 1 being very calm to 5 being in distress. On a scale from 1 to 5, how are you feeling right now? (Do not proceed if the client is a 4 or 5)

During this interview, I periodically stop and ask you to check how you are feeling. If you feel uncomfortable or in distress (a 4 or 5), then we will stop the interview immediately. We will also take breaks so you can remain calm and check in with yourself.

Do you have any questions or concerns? (Wait for questions and answer them).
I will begin with question 1. Let's go!

1. Think about your childhood. What are some of your earliest memories?
2. If you were to watch your childhood like you were watching a movie, what memories would make the highlight reel?
3. What memories do you enjoy looking back on?
4. What are some of the challenges or difficulties you faced while growing up? (Check to see if the interviewee needs a break; Rate herself 1-5)
5. How would you describe your relationship with your parents as you grew up?
6. Thinking back to when you were a teenager, what were your thoughts about being pregnant and becoming a mother?
7. What has been your experience with your current pregnancy?
8. What are some of the challenges or difficulties you have experienced during this pregnancy? (Check to see if the interviewee needs a break; Rate herself 1-5)
9. What or who has influenced your thoughts or feelings about being a mother?
10. How would you describe your support system?
11. Let's look forward to your baby's arrival. What do you anticipate thinking or feeling when your baby arrives?
12. When your baby is your age, how do you want him or her to describe you as a mother? How do you want him or her to describe childhood?
13. What are your hopes and dreams for your child?
    (Ask interviewee to rate herself 1-5; Finish with deep breathing and relaxation exercise)

End of the Interview:
Thank you so much for participating in this research. I cannot express how grateful I am for your time and your input. I have prepared a list of resources you can find in our local community to better serve you if you need any support. Please feel free to contact me at any time with your questions or concerns.

APPENDIX E

APNTS-IRB APPROVAL FORM

Asia-Pacific Nazarene Theological Seminary
Ortigas Avenue Extension, Kaytikling
Taytay 1920, Rizal, Philippines

NOTIFICATION OF REVIEW APPROVAL

May 10, 2021

Jordan Horvath
jordanrachelh@gmail.com

Protocol Title: EXAMINING THE IMPACT OF TRAUMA HISTORY ON MATERNAL ATTITUDES BETWEEN A PREGNANT MOTHER AND HER UNBORN CHILD
Protocol#: AR-011
IRB Review Date: May 10, 2021
Effective Date: May 10, 2021
Expiration Date: May 10, 2022
Review Type: Expedited Review
Review Action: Approved

The IRB made the following determinations:

- Waivers: Waiver of informed consent documentation
- Other Documentations: All necessary attachments submitted
- Risk Determination: No greater than minimal risk

Please contact me at nehemiah.bathula@apnts.edu.ph if you have any questions.

Sincerely,

Dr. Nehemiah Bathula
Administrative Assistant to the Academic Dean
Asia-Pacific Nazarene Theological Seminary

APPENDIX F

DOCTOR/DIRECTOR INTRODUCTION LETTER

Dear Sir/Madam,

My name is Jordan Rachel Horvath, and I am a student at Asia Pacific Nazarene Theological Seminary in Manila, Philippines, pursuing a PhD in Holistic Child Development. I am currently working as a school social worker for the Holmes District School Board, and I am a Registered Clinical Social Work Intern with license number 14223. I am a PhD candidate conducting a study entitled "EXAMINING THE IMPACT OF CHILDHOOD TRAUMA ON THE ATTITUDES OF PREGNANT WOMEN TOWARDS MOTHERHOOD AND THEIR UNBORN CHILDREN IN NORTHWEST AND NORTHEAST FLORIDA." The purpose of this study is to understand and identify the relationship between a mother's own history of childhood trauma and whether this impacts her attitude toward her pregnancy and unborn child. I seek to explore if a significant relationship exists.

I believe this study is important in helping healthcare providers, clinicians, and those offering services to mothers understand the effects of childhood trauma in order to provide holistic services and interventions. This study will contribute to the growing knowledge surrounding pregnancy, prenatal care, and addressing needs in our communities. I am hopeful the findings of this study will be a tool to promote the health and well-being of families. The findings of this study are primarily for academic purposes and in no way meant to be used to victimize or incriminate your patients, your practice, or your community. I will share the findings with you, and I hope to publish the work in an academic journal. Any information in this data that is sensitive and private will be held confidential and all the participants will be well protected. Additionally, your involvement as a practice will also be confidential.

This study will consist of two parts: Participants will be administered the Adverse Childhood Experiences Survey and the Pregnancy Related Beliefs Questionnaire. Participants who indicate consent will be contacted for a follow-up interview. Participants will not be asked to participate in the interview unless they give consent. The process of recruitment for participants will be explained in the consent form below.

If you agree to allow your patients to participate in this study, please read and sign the consent form attached to this letter. Your support is greatly appreciated.

Sincerely, Jordan Horvath

APPENDIX G

DOCTOR/DIRECTOR INFORMED CONSENT FORM

STUDY TITLE: "EXAMINING THE IMPACT OF CHILDHOOD TRAUMA ON THE ATTITUDES OF PREGNANT WOMEN TOWARDS MOTHERHOOD AND THEIR UNBORN CHILDREN IN NORTHWEST AND NORTHEAST FLORIDA"

STUDY LOCATION: (Name of Doctor's Office/ Pregnancy Center)

PURPOSE OF THE STUDY: The purpose of this study is to understand the connection between childhood trauma history and a pregnant woman's attitude towards her pregnancy and unborn child.

DESCRIPTION OF THE RESEARCH STUDY: When participants arrive for their appointments at the doctor's office, they will be offered the opportunity to complete the survey by the receptionist of the doctor. If they agree, the participants will be given two questionnaires to fill out during their regular doctor's appointment. The participants will be asked for basic demographic information, but will not be asked to provide anything specific to be identifiable. The participants will also be assigned a number for distinguishing purposes by the researcher. When the participant is finished, she will return the survey to a locked box provided by the researcher to the doctor's location. Participants will be given the chance to consent to be contacted for a follow-up interview. Participants will only provide their name and phone number if they wish to be contacted for the interview, but will not be identified in the research. The data collected will be secured in an online platform and computer systems are protected with passwords.

Participation in this study is voluntary. Participants can choose not to answer questions or not complete the study at any time.

RISK/BENEFITS: There is minimal risk involved in participating in this study. When answering questions about trauma history, there is a possibility of emotional stress. Participants are encouraged to stop participating and talk to their doctor if they are feeling stressed. The benefits are the results of this study being used to provide further interventions and ideas to meet the needs of expectant mothers in the community.

CONFIDENTIALITY: No personal identifiers of participants and healthcare providers will be shared. Signatures will be collected as part of the informed consent process. Should a participant agree to be interviewed, the name and phone number will be collected for contact purposes only.

CONTACT INFORMATION: If you have any questions regarding this study, please contact Jordan Horvath at 850-326-0284. You are also welcome to contact my dissertation chair, Dr. Karen Garber-Miller. She may be reached at kgarbermiller@gmail.com.

DECLARATION OF CONSENT: I understand the contents of this consent form, the purpose of the study, and the role of the participants. I understand the participants are free to choose to be part of the study and can withdraw participation at any time. I have therefore agreed to offer this study to my clients without coercion.

Doctor/Director Name and Signature: _____
Date: _____

Study Time Frame: _____to _____

APPENDIX H

NURSE/COUNSELOR INSTRUCTIONS

To Whom It May Concern:

Thank you so much for your willing participation in my Doctoral Dissertation entitled: "EXAMINING THE IMPACT OF CHILDHOOD TRAUMA ON THE ATTITUDES OF PREGNANT WOMEN TOWARDS MOTHERHOOD AND THEIR UNBORN CHILDREN IN NORTHWEST AND NORTHEAST FLORIDA"

During the research period _____ to _____, you will be asked to provide a copy of this survey to your prenatal patients when they come in for an appointment. Please read the recruitment script to the patient and provide her with a copy to complete if she agrees. She may also take a copy to look over before deciding if she would like to participate. You will also be provided with a QR code. If the patient wishes to complete the survey electronically, she can scan the QR code with her phone's camera. Please do not pressure patients to participate. Patient safety is of the utmost importance. If a patient is feeling stressed or uncomfortable, she is encouraged to stop immediately and discuss this with her doctor. When the patient is finished, she can place the survey in the locked box provided to you.

Please keep the following in mind:

- In order to make sure paper based surveys are accounted for and data is not lost, please do not allow patients to leave with the survey. She may think about the survey and then return at a later date to complete it if she would like.
- When the patient is finished with the survey, please place it in the locked box given to you by the researcher for surveys.
- Please offer this survey to all prenatal patients 18 and older.
- If the patient has an iphone8 or higher, she may need to download the free QR code app in order to scan the QR code.

Again, thank you so much for your help. Please call or text me at any time if you have questions or concerns about this research or process.

Sincerely,
Jordan Horvath
850-326-0284

APPENDIX I

RECRUITMENT SCRIPT FOR THE NURSE/COUNSELOR

Jordan, a lady working on her doctorate in holistic child development, is conducting research with women who are pregnant. Here is some information about the study along with the surveys. If you are interested, please fill it out, along with the consent form and return them to the box (point to the box) when you are finished. You can fill this out at any time during your appointment.

You may also take this survey electronically. Just scan this QR code with your phone's camera and the link will appear (Provide QR code). If something in the survey makes you feel discomfort or distress, just stop taking it and share this with your doctor. Your participation and information will be kept confidential. If you do not want to fill it out, that is fine, too. Either place the blank survey in the box or you are welcome to throw it away. There is contact information included in the survey if you have any questions. Thank you!

APPENDIX J

PARTICIPANT SURVEY CONSENT FORM

Greetings!

My name is Jordan. The following surveys are part of a research project for my doctoral dissertation at Asia Pacific Nazarene Theological Seminary. The purpose of this project is to better understand childhood trauma and the attitudes of mothers regarding their pregnancies. The research will be used to better understand how the needs of participants and their families can be served in Washington, Holmes, and Jackson Counties.

If you choose to participate in my study, please fill out the attached two surveys. It should only take you about 20 minutes to complete both. Your responses to the survey questions are confidential. They will be added to the responses of other women to get an overall picture. Of course, you are not obligated to participate at all.

As part of the research is exploring childhood trauma, you will be asked some questions about your childhood, such as: *Did a parent or other adult in your home often swear at you?* If any question makes you uncomfortable or causes some distress, please discontinue taking the survey and talk with your doctor during your appointment. You are under no obligation to complete the survey.

If you would like to complete the surveys, please read through the following statements and check the appropriate box below.
*I understand the researcher is a PhD candidate and not a medical professional.
*I understand that I will be asked things like my age, educational level and county of residence, but that information will be used to gather a complete picture of all the women participating in the study. It will not be used in the research to identify me.
*I understand that others, including the staff and other patients, may see me completing the survey, but my responses will be confidential.
*I understand that reading about and discussing things from my childhood can bring up unpleasant reminders or flashbacks. If I experience these, I should inform my doctor.
*I understand that I can talk to my doctor about any concerns I might have.
*I understand that I can talk to my doctor about my trauma history and explore my options.

If you have any questions, you are free to contact me directly. I can be reached at jordanrachelh@gmail.com. You are also welcome to contact my dissertation chair, Dr. Karen Garber-Miller. She may be reached at kgarbermiller@gmail.com.

After reading this consent form, I would like to participate in this study by completing the two surveys. □ Yes □ No

APPENDIX K

PARTICIPANT INTERVIEW CONSENT FORM

I am willing to be contacted by the researcher for an interview □ Yes □ No
Contact Number: _____
Best time to call: _____
**Please expect to be contacted by Jordan, the researcher, within two weeks from today.

I completed the survey □ Yes □ No

APPENDIX L

PARTICIPANT DEMOGRAPHIC INFORMATION

Please select all of the following that apply:

I am ___ weeks pregnant:

□1-6 □7-13 □14-20 □21-27 □28-35 □36-41

Age Range:

□18-22 □23-26 □27-30 □31-35 □36-42 □43-50

Educational Background:

□Did not finish high school □High School Diploma/GED
□Associate's Degree/Vocational Certification
□Bachelor's Degree □ Master's Degree □Doctoral Degree

Socioeconomic Status (Average Annual Household Income):

□Less than $10,000 □$10,000-$30,000 □$31,000-$50,000

□$51,000-$70,000 □$71,000- $100,000 □More than $100,000

Race:

□White □Black □Asian □ Pacific Islander □Hispanic □Other

Marital Status:

□Single-Never Married □Single-Divorced □Single-Widowed □Married

County of Residence: _____

Time started this survey: **Time ended this survey:**

APPENDIX M

VERBAL/WRITTEN CONSENT SCRIPT FOR INTERVIEWS

Thank you so much for taking the time to participate in this research study for my doctoral dissertation. Your input and voice is incredibly important to this research, and I am honored that you would like to participate. Before we begin, I would like to obtain verbal consent from you regarding the following. After I read each statement, please reply with a verbal yes and then a check mark:

_____ I understand that my participation is voluntary, and I am not being forced or coerced into participating in this interview.
_____ I understand that I can stop the interview at any time and withdraw my participation.
_____ I understand that I will be recorded to ensure my responses will be saved. I understand this audio recording will not be distributed or shared without my consent.
_____ I understand that my safety and the safety of my unborn child is of utmost importance, and I will stop at any point if I feel uncomfortable or distressed.
_____ I understand that my personal information will be protected and my identifying information will be kept confidential.
_____ I understand that I should talk to my doctor if I am feeling distressed, uncomfortable, or need additional resources such as counseling.
_____ I understand that the researcher is a mandatory reporter according to the state of Florida. If I share that I am in danger, someone is hurting me, or if I am or planning to hurt others, the researcher is obligated by law to report this information and break confidentiality.
_____ I understand that my words and experiences are important, and the researcher will seek to treat me with utmost respect and dignity during this interview process.

APPENDIX N

QR CODE FOR SURVEY RESPONSES

Participants will be given the option to scan this QR code to complete their surveys through their mobile device.

APPENDIX O

PREGNANCY RELATED BELIEFS QUESTIONNAIRE
LIKERT-SCALE SCORING GUIDE

Belief: answer each statement according to the way you think most of the time	Totally agree	Agree very much	Agree slightly	Neu-tral	Dis-agree slightly	Dis-agree very much	To-tally disagree
1. I should not have to ask for help with my baby	7						
2. I am as enthusiastic as I should be about my future role as a mother	1						7
3. I can cope with my baby on my own.	1						7
4. If I do not keep up my appearance people will reject me	7						
5. If people criticise my baby it is not a criticism of me	1						7
6. If my home does not look absolutely right I feel a failure	7						
7. If I do not feel maternal it means I am bad	7						
8. I do not have to be a perfect mother	1						
9. My independence is very important to me	7						
10. During the time following childbirth my partner has as much responsibility as I have to make our relationship work	1						
11. I expect my baby will be happy if I am around a lot	7						
12. If people only see me as a mother or wife I would feel diminished as a person	7						
13. I should be able to control how I feel	7						
14. I can’t keep my baby safe from all sources of infection	1						

15. I should appreciate every single moment of the early part of my baby's life	7						
16. It is important for me to get back to my normal activities as soon as possible after the birth	7						
17. I have to do all it takes to make my baby completely happy	7						
18. People who cry for no reason are just being hysterical	7						
19. I feel frustrated if I am prevented from doing the things I want to do	7						
20. I should be able to bring on milk if I want to	7						
21. My wishes are no less important than those of other people in my life	1						
22. If I ask for help with mothering my baby it is **not** a sign that I am failing	1						
23. I should try hard to keep my figure during pregnancy	7						
24. I have a very clear picture in my mind of what it will be like to have a newborn baby	1						
25. Motherhood is an instinctive and natural state for a woman	7						
26. I have to be able to plan my day	7						
27. I expect that my life will be generally improved as a result of this pregnancy	7						
28. If my baby was unhappy it would be because of something I had not done	7						

29. Being a mother will be the most fulfilling experience I can ever have	7						
30. Sometimes it is necessary to put my own needs before those of my baby	1						
31. My immediate family should be the only ones I need	7						
32. It is selfish to get upset in front of my family	7						
33. I expect to just be able to see more of people as a result of this pregnancy	7						
34. I should be able to just cope like everyone else does	7						
35. I expect my relationship with my partner might become very different after this pregnancy	1						
36. It is important for me to make sure I look my best	7						
37. People know what kind of person I am by the activities I do	7						
38. If my baby is unhappy I will feel that it is my fault	7						
39. If someone important pays me less attention after the birth it is because the baby is more important to them than I	7						
40. If someone else's baby is happier than mine it is probably because I am an inadequate mother	7						
41. If I am unable to satisfy my baby I am a bad mother	7						
42. I have got to do regular exercise after the birth to get my	7						

figure back							
43. I welcome the changes in my body, even those like odours (not including any illnesses)	1						
44. If I do not have lots of interesting news it shows I am a dull perso	7						
45. I should be cheerful and entertaining for people when they come to visit	7						
46. My sense of worth entirely depends on my achievement at work	7						
47. If I do not feel completely emotionally attached to my baby I should worry about what this means	7						
48. Even if I really let myself go my partner would not leave me or have an affair	1						
49. If my baby loves me back (s)he will play with me better than anyone else	7						
50. Feeling continually tired is an unpleasant experience I could not bear.	7						
51. If my baby is able to rule my activities it is because I am too weak	7						

APPENDIX P

CHANGE-RESISTANT/ CHANGE-RECEPTIVE SCORING GUIDE FOR THE RESEARCHER DEVELOPED QUESTIONS FOR PILOT TESTING

Researcher-Developed Questions

Belief: Answer each statement according to the way you think most of the time.	**Agree Response**	**Disagree/ Does Not Apply Response**
I often think about what will go wrong during pregnancy.	C-RES	C-REC
I often worry I will lose this pregnancy.	C-RES	C-REC
I was surprised to find out I was pregnant.	C-RES	C-REC
It was difficult for me to conceive.	C-RES	C-REC
I often think about the other baby(ies) I miscarried.	C-RES	C-REC
I often think about the other baby(ies) I aborted.	C-RES	C-REC
I feel guilty for not enjoying this pregnancy.	C-RES	C-REC
I am ashamed to be pregnant.	C-RES	C-REC
I frequently talk to my unborn baby.	C-REC	C-RES
I often imagine what (s)he will look like.	C-REC	C-RES
I feel prepared to be a mother.	C-REC	C-RES
I feel I will be a good mother.	C-REC	C-RES
I often think about losses I experienced.	C-RES	C-REC
I remember more bad times than good times from my childhood.	C-RES	C-REC
I enjoy feeling my baby move and kick in my stomach.	C-REC	C-RES

I enjoy buying things and planning for my baby's birth.	C-REC	C-RES
I am proud that I was adopted.	C-REC	—---------- -
I had/have a good relationship with my mother.	C-REC	C-RES
My partner is supportive of this pregnancy.	C-REC	C-RES
My family is supportive of this pregnancy.	C-REC	C-RES
I feel alone.	C-RES	C-REC
No one understands how I feel.	C-RES	C-REC
I am overwhelmed.	C-RES	C-REC
I am concerned about how I will manage life with a baby.	C-RES	C-REC
I am planning to surrender this child for adoption.	C-RES	C-REC
I considered terminating this pregnancy.	C-REC	C-RES
My worth is determined by how good of a mother I am to my child.	C-RES	C-REC
My other children are supportive of this pregnancy.	C-REC	C-RES

APPENDIX Q

CHANGE-RESISTANT/CHANGE-RECEPTIVE
SCORING GUIDE FOR THE PREGNANCY
RELATED BELIEFS QUESTIONNAIRE RESEARCH STUDY

*C-RES- Change Resistant
*C-REC- Change Receptive

Belief: Answer each statement according to the way you think most of the time.	**Beliefs/ Feelings Category**	**Agree Response**	**Disagree Response**
I should not have to ask for help with my baby.	Self	C-RES	C-REC
I am as enthusiastic as I should be about my future role as a mother	Motherhood	C-RES	C-REC
I can cope with a baby on my own.	Self	C-RES	C-REC
If I do not keep up my appearance people will reject me.	Self	C-RES	C-REC
If people criticize my baby, it is not a criticism of me.	Self	C-REC	C-RES
If my home does not look absolutely right, I feel like a failure.	Self	C-RES	C-REC
If I do not feel maternal, it means I am bad.	Motherhood	C-RES	C-REC
I do not have to be a perfect mother	Motherhood	C-REC	C-RES
My independence is very important to me.	Self	C-RES	C-REC
During the time following childbirth my partner has as much responsibility as I have to make our relationship work.	Others	C-RES	C-REC
I expect my baby will be happy if I am around a lot.	Baby	C-RES	C-REC
If people only see me as a mother or wife I would feel diminished as a person.	Self	C-RES	C-REC
I should be able to control how I feel.	Self	C-RES	C-REC

Belief: Answer each statement according to the way you think most of the time.	**Beliefs/ Feelings Category**	**Agree Response**	**Disagree Response**
I can't keep my baby safe from all sources of infection.	Self	C-REC	C-RES
I should appreciate every single moment of the early part of my baby's life.	Baby	C-RES	C-REC
It is important for me to get back to my normal activities as soon as possible after the birth.	Self	C-RES	C-REC
I have to do all it takes to make my baby completely happy.	Self	C-RES	C-REC
People who cry for no reason are just being hysterical.	Self	C-RES	C-REC
I feel frustrated if I am prevented from doing the things I want to do.	Self	C-RES	C-REC
My wishes are no less important than those of other people in my life.	Self	C-RES	C-REC
If I ask for help with mothering my baby it is **not** a sign that I am failing.	Motherhood	C-REC	C-RES
I should try hard to keep my figure during pregnancy.	Self	C-RES	C-REC
I have a very clear picture in my mind of what it will be like to have a newborn baby.	Baby	C-RES	C-REC
Motherhood is an instinctive and natural state for a woman.	Motherhood	C-RES	C-REC
I have to be able to plan my day.	Self	C-RES	C-REC
I expect that my life will be generally improved as a result of this pregnancy.	Pregnancy	C-REC	C-RES
If my baby was unhappy it would be because of something I had not done.	Baby	C-RES	C-REC
Being a mother will be the most fulfilling experience I can ever have.	Motherhood	C-RES	C-REC

Belief: Answer each statement according to the way you think most of the time.	**Beliefs/ Feelings Category**	**Agree Response**	**Disagree Response**
Sometimes it is necessary to put my own needs before those of my baby.	Self	C-REC	C-RES
My immediate family should be the only ones I need.	Others	C-RES	C-REC
It is selfish to get upset in front of my family.	Self	C-RES	C-REC
I expect to just be able to see more people as a result of this pregnancy.	Others	C-RES	C-REC
I should be able to just cope like everyone else does.	Self	C-RES	C-REC
I expect my relationship with my partner might become very different after this pregnancy.	Others	C-RES	C-REC
It is important for me to make sure I look my best.	Self	C-RES	C-REC
People know what kind of person I am by the activities I do.	Others	C-RES	C-REC
If my baby is unhappy I will feel that it is my fault.	Baby	C-RES	C-REC
If someone important pays me less attention after the birth it is because the baby is more important to them than I am.	Others	C-RES	C-REC
If someone else's baby is happier than mine it is probably because I am an inadequate mother.	Baby	C-RES	C-REC
If I am unable to satisfy my baby I am a bad mother.	Baby	C-RES	C-REC
I have got to do regular exercise after the birth to get my figure back.	Self	C-RES	C-REC
I welcome the changes in my body, even those like odors (not including any illnesses).	Pregnancy	C-REC	C-RES
If I do not have lots of interesting	Self	C-RES	C-REC

Belief: Answer each statement according to the way you think most of the time.	**Beliefs/ Feelings Category**	**Agree Response**	**Disagree Response**
news it shows I am a dull person.			
I should be cheerful and entertaining for people when they come to visit.	Others	C-RES	C-REC
My sense of worth entirely depends on my achievement at work.	Self	C-RES	C-REC
If I do not feel completely emotionally attached to my baby I should worry about what this means.	Baby	C-RES	C-REC
Even if I really let myself go my partner would not leave me or have an affair.	Others	C-RES	C-REC
If my baby loves me back (s)he will play with me better than anyone else.	Baby	C-RES	C-REC
Feeling continually tired is an unpleasant experience I could not bear.	Self	C-RES	C-REC
If my baby is able to rule my activities it is because I am too weak.	Baby	C-RES	C-REC
If I can’t look after my baby properly it shows I am useless.	Self	C-RES	C-REC
After my baby is born I will never be lonely in my life again.	Baby	C-RES	C-REC
Motherhood is a time when I should be calm and serene.	Motherhood	C-RES	C-REC

APPENDIX R

DESCRIPTION OF THE FEDERAL POVERTY LEVEL

The Federal Poverty Level (HHS, 2021) in the United States is based upon the annual income per household. Families earning at or below this rate can qualify for federal assistance through programs such as the Supplemental Nutrition Assistance Program (SNAP) and Children's Health Insurance Program. The table below illustrates the income guidelines based on household members for the 48 contiguous states and the District of Columbia as of 2021:

Persons in the Family/Household	Poverty Guideline
1	$12,880
2	$17,420
3	$21,960
4	$26,500
5	$31,040
6	$35,580
7	$40,120
8	$44,660
Add $4,540 per person for households above 8 members.	

APPENDIX S

PRBQ, ACE SCORE, AND DEMOGRAPHIC INFORMATION

Participant	ACE Score	"Yes"	Length of Pregnancy	Age	Race	AHI	Education	Marital Status	County
1	8	1,2,3,4,6,7,8,10	7-13	18-22	W	Less than $10,000	HS Diploma	Single	Jackson
2	9	1,2,3,4,5,6,7,8,9	28-35	18-22	W	Less than $10,000	HS Diploma	Single	Holmes
3	6	1,2,4,7,8,10	1-6	27-30	B	$31-50,000	Associate's Degree	Single	Columbia
4	8	1,2,3,4,6,7,8,10	14-20	36-42	H	$10-30,000	HS Diploma	Married	Columbia
5	2	3,6	28-35	23-26	H/W	$10-30,000	Associate's Degree	Single	Columbia
6	7	1,2,3,6,7,8,9	28-35	31-35	W	$31-50,000	Associate's Degree	Divorced	Columbia
7	2	4,9	21-27	18-22	B	$10-30,000	HS Diploma	Single	Columbia
8	1	6	*	*	*	*	*	*	*
9	0		14-20	23-26	W	$10-30,000	Did not finish HS	Single	Washing-ton
10	2	8,9	1-6	31-35	W	$51-70,000	Associate's Degree	Married	Holmes
11	0		7-13	23-26	W	$71-100,000	Bachelor's	Married	Lafayette

12	10	1,2,3,4,5,6,78,9,10	28-35	23-26	B	Less than $10,000	HS Diploma	Single	Columbia
13	0		14-20	27-30	B	$31-50,000	Master's	Single	Columbia
14	0		14-20	31-35	H	$31-50,000	Did not finish HS	Single	Lafayette
15	0		14-20	27-30	W	$10-30,000	Associate's Degree	Single	Suwan-nee
16	0		7-13	18-22	W/H	Less than $10,000	HS Diploma	Single	Washing-ton
17	8	1,2,3,4,5,6,7,9	7-13	23-26	W	$10-30,000	Associate's Degree	Single	Suwan- nee
18	1	6	1-6	27-30	W	$31-50,000	Associate's Degree	Married	Columbia
19	3	1,2,6	1-6	23-26	W	Less than $10,000	HS Diploma	Single	Suwannee
20	5	1,2,3,8,10	36-41	23-26	W/H	$10-30,000	Did not finish HS	Single	Columbia
21	2	6,8	1-6	23-26	W	$10-30,000	Did not finish HS	Single	Hamilton
22	1	6	14-20	18-22	W	$10-30,000	HS Diploma	Single	Suwannee
23	0		14-20	31-35	A	$10-30,000	Bachelor's	Widowed	Suwan-nee

24	1	6	14-20	18-22	H	$10-30,000	Associate's Degree	Married	Taylor
25	1	6	14-20	18-22	W	Less than $10,000	Did not finish HS	Single	Holmes
26	1	10	14-20	36-42	B	$31-50,000	Associate's Degree	Single	Washing-ton
27	0		7-13	36-42	B	$10-30,000	Master's Degree	Married	Leon
28	3	1,3,4	7-13	27-30	W	$31-50,000	HS Diploma	Married	Suwannee
29	0		7-13	27-30	B	Less than $10,000	HS Diploma	Single	Leon
30	1	6	7-13	36-42	B	$10-30,000	Associate's Degree	Single	Leon
31	1	6	28-35	27-30	B	$31-50,000	Master's Degree	Single	Leon
32	0		14-20	27-30	B	Less than $10,000	HS Diploma	Single	Leon
33	0		14-20	31-35	W	$71-100,000	Master's Degree	Married	Holmes
34	1	6	7-13	23-26	B	$10-30,000	HS Diploma	Single	Holmes
35	1	6	7-13	31-35	B	$31-50,000	HS Diploma	Divorced	Leon

36	8	1,3,4,6,7,8,10	14-20	18-22	W	$10-30,000	HS Diploma	Married	Suwannee
37	1	10	7-13	23-26	W	$10-30,000	HS Diploma	Divorced	Suwannee
38	2	8,9	14-20	23-36	H	$10-30,000	HS Diploma	Single	Leon
39	1	9	21-27	18-22	W	$10-30,000	HS Diploma	Married	Suwannee
40	5	2,3,4,6,8	1-6	31-35	*	$10-30,000	Associate's Degree	Divorced	Suwannee
41	1	6	1-6	18-22	B	Less than $10,000	HS Diploma	Single	Columbia
42	0		7-13	31-35	W	More than $100,000	Associate's Degree	Married	Jackson
43	0		14-20	23-26	W	$71-100,000	Bachelor's	Married	Holmes
44	2	2,3	7-13	31-35	Other	$31-50,000	HS Diploma	Married	Gadsden
45	9	1,2,3,4,5,6,78,9	7-13	23-26	W	$71-100,000	Doctoral Degree	Married	Leon
46	2	6,8	7-13	18-22	W	Less than $10,000	HS Diploma	Single	Columbia

47	1	6	14-20	18-22	W	*	Did not finish HS	Single	Holmes
48	0		21-27	27-30	B	Less than $10,000	HS Diploma	Single	Union
49	5	1,2,4,6,8	7-13	27-30	W	$51-70,000	Bachelor's	Married	Suwannee
50	8	1,2,4,5,6,8,9 10	21-27	23-26	W	$71-100,000	Associate's Degree	Married	Other

APPENDIX T

ACE SCORE/PRBQ SCORE, ACE TYPE, AND ATTITUDE CATEGORIES
Attitude Guide: Positive +, Negative -, Neutral or Cannot be Determined /

Participant #	ACE Score/PRBQ Score	ACE Type	Herself	Others	Pregnancy	Baby	Motherhood
1	8/141	1,2,3,4,6,7,8,10	+	+	+	+	+
2	9/153	1,2,3,4,5,6,7,8,9	+	+	/	+	/
3	6/170	1,2,4,7,8,10	+	+	+	+	-
4	8/149	1,2,3,4,6,7,8,10	+	/	+	+	+
5	2/178	3,6	+	+	+	+	-
6	7/250	1,2,3,6,7,8,9	-	/	-	-	-
7	2/189	4,9	/	/	/	+	-
8	1/147	6	+	+	+	+	+
9	0/202		-	+	-	+	/
10	2/139	8,9	+	+	/	+	+
11	0/144		+	/	+	+	+
12	10/234	1,2,3,4,5,6,78,9,10	-	/	/	-	+
13	0/193		+	+	+	-	-
14	0/186		+	/	/	+	-
15	0/183		/	/	/	/	/
16	0/243		-	-	+	-	-
17	8/205	1,2,3,4,5,6,7,9	-	/	+	+	-
18	1/230	6	-	-	+	-	-

19	3/180	1,2,6	+	/	+	/	/
20	5/197	1,2,3,8,10	-	/	+	-	-
21	2/177	6,8	/	/	+	-	-
22	1/199	6	+	/	/	+	-
23	0/152		+	+	+	+	+
24	1/194	6	-	/	/	-	/
25	1/186	6	+	+	+	+	-
26	1/221	10	-	/	/	-	/
27	0/191		+	+	/	-	-
28	3/179	1,3,4	+	+	+	+	/
29	0/209		+	-	+	-	-
30	1/183	6	+	/	/	-	/
31	1/220	6	-	+	-	+	/
32	0/228		-	+	/	-	-
33	0/192		-	/	/	-	/
34	1/255	6	-	-	+	-	-
35	1/193	6	+	/	+	+	/
36	8/157	1,3,4,6,7,8, 10	+	+	+	+	/
37	1/223	10	-	-	/	-	-
38	2/234	8,9	-	-	/	-	-
39	1/204	9	-	-	+	-	-
40	5/207	2,3,4,6,8	/	+	+	+	-
41	1/220	6	-	/	/	-	/
42	0/187		-	-	/	/	+
43	0/164		+	-	+	+	+
44	2/207	2.3	-	+	/	+	-

45	9/250	1,2,3,4,5,6,78,9	-	-	-	-	-
46	2/256	6,8	-	/	/	/	-
47	1/206	6	+	-	/	-	+
48	0/206		-	-	/	-	-
49	5/162	1,2,4,6,8	+	+	/	+	+
50	8/206	1,2,4,5,6,8,910	-	-	-	+	+

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Educational Attainment

PhD in Holistic Child Development, Asia-Pacific Nazarene Theological Seminary

Master of Social Work, Asian Seminary for Christian Ministries (April 2014)
Thesis Title: "Aspirations, Dreams, and Social Work among Young Muslim Women in Metro Manila"

Bachelor of Arts, English, University of Florida (May 2011), Graduated, Cum Laude

Work Experience

Holmes District Schools
Bonifay, Florida
June 2019-Present

Social Worker

- Coordinate intervention and prevention strategies to meet the needs of Tier 1 students and universal populations
- Facilitate interagency meetings to meet the holistic needs of students
- Assess and refer students in crisis to appropriate services
- Train and advise school personnel in Youth Mental Health First Aid and trauma awareness strategies
- Advocate for the health and wellness of students in the Holmes County School District

Holmes County High School
Bonifay, Florida
August 2018-May 2019

English 3/Intensive Reading Teacher

- Planned and implemented lessons according to the Florida State Standards
- Designed lessons to enhance student skills in reading, writing, critical thinking, and communication
- Led discussions to enhance critical thinking based on source material
- Participated in IEP and parent meetings to support student learning and success
- Collaborated with coworkers to implement learning strategies and enhance classroom effectiveness

Gentle Hands Inc.
Quezon City, Philippines
January 2012-July 2018

Guidance Counselor

- Oversee and monitor educational sponsorship program for grades Kindergarten-College; responsibilities include: develop and implement policy for sponsorship program, conduct weekly group meetings, assess and develop educational interventions, coordinate with teachers to provide supplemental educational services

Caregiver

- Caregiver for female residents ages 11-17; Responsibilities include: manage schedules and create activities, mediate conflict, life skills training, nutrition and health training, empowerment through spirituality; facilitate group sessions when necessary; provide individual support

Ballet Teacher

- Promote health and wellness among clients through ballet and other forms of dance; choreograph and plan performances and recitals; promote expression and confidence through dance for clients ages 2-16

Licensed Foster Parent

- Provided holistic and therapeutic interventions through individualized care for three children under two years old.

Child Development Coordinator

- Oversee and monitor the developmental progress of all clients, from newborn to sixteen years old.
- Conduct pre-admission case conferences and assessments with referring agencies
- Evaluate client holistic development upon intake
- Create detailed intervention plans
- Coordinate intervention strategies and monitor effectiveness with the Multi-Disciplinary Team
- Create assessment tools and train staff in client assessment
- Develop methods to promote holistic client development

Trainings

- Offering Healing and Hope for Children in Crisis (2012)
- Managing Behavior of Sexually Abused Children in Institutional Care: Life Skills Training (2014)
- Trauma Management Strategies for Sexually Abused Children (2016)
- Case Management for Sexually Abused Children (2016)
- Play Therapy 1 (2016)
- Trauma Competent Caregiving (2017)
- Basic Counseling (2017)
- Crisis Prevention Intervention (2019)
- Youth Mental Health First Aid (2019)

Certifications

- School Social Worker- Effective until June 2026
- Social Science Education Grades 6-12- Effective until June 2026
- Youth Mental Health First Aid Trainer- May 28, 2019