2016

Quality of Caregiving Representations Among Pregnant Mothers Experiencing Intimate Partner Violence

Kristina Borneman

Follow this and additional works at: http://commons.emich.edu/honors

Recommended Citation
Borneman, Kristina, "Quality of Caregiving Representations Among Pregnant Mothers Experiencing Intimate Partner Violence" (2016). Senior Honors Theses. 473.
http://commons.emich.edu/honors/473

This Open Access Senior Honors Thesis is brought to you for free and open access by the Honors College at DigitalCommons@EMU. It has been accepted for inclusion in Senior Honors Theses by an authorized administrator of DigitalCommons@EMU. For more information, please contact libir@emich.edu.
Quality of Caregiving Representations Among Pregnant Mothers Experiencing Intimate Partner Violence

Abstract
During pregnancy women typically reorganize their mental representations of themselves and others to make room for the internal representation of their new child and themselves as caregivers. Representations during this transformational period have been shown to predict postnatal caregiving behavior. The purpose of this study is to assess the influence of physical and psychological intimate partner violence on maternal prenatal representations, namely, through a qualitative analysis of maternal narratives from the Working Model of the Child Interview (Zeanah & Beniot 1995), a well-established, semi-structured clinical tool. Four predominant themes emerged: helplessness, caregiving abdication, rigid attitudes and beliefs about gender roles, and incoherent, mixed themes. Overall, this thematic analysis study allowed for a better understanding about the association between partner violence and maternal representations regarding the parent-child relationship from participants’ own words. Several identified themes were consistent with previous quantitative findings in the literature; other themes suggest important avenues for future research that have yet to be studied in depth.

Degree Type
Open Access Senior Honors Thesis

Department
Psychology

First Advisor
Dr. Alissa Huth-Bocks

Second Advisor
Dr. Angela Staples

Third Advisor
Dr. Natalie Dove

Keywords
intimate partner violence, pregnancy, attachment, maternal representations

This open access senior honors thesis is available at DigitalCommons@EMU: http://commons.emich.edu/honors/473
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

By

Kristina Borneman

A Senior Thesis Submitted to the

Eastern Michigan University

Honors College

in Partial Fulfillment of the Requirements for Graduation

with Honors in Psychology

Approved at Ypsilanti, Michigan, on this date: April 1st, 2016
During pregnancy women typically reorganize their mental representations of themselves and others to make room for the internal representation of their new child and themselves as caregivers. Representations during this transformational period have been shown to predict postnatal caregiving behavior. The purpose of this study is to assess the influence of physical and psychological intimate partner violence on maternal prenatal representations, namely, through a qualitative analysis of maternal narratives from the Working Model of the Child Interview (Zeanah & Beniot 1995), a well-established, semi-structured clinical tool. Four predominant themes emerged: helplessness, caregiving abdication, rigid attitudes and beliefs about gender roles, and incoherent, mixed themes. Overall, this thematic analysis study allowed for a better understanding about the association between partner violence and maternal representations regarding the parent-child relationship from participants' own words. Several identified themes were consistent with previous quantitative findings in the literature; other themes suggest important avenues for future research that have yet to be studied in depth.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Introduction

Bowlby and Ainsworth’s research in the field of attachment yielded many of the theoretical concepts and methods that are pillars in the field today (Bowlby 1969/1982; Ainsworth & Bell, 1970). Bowlby’s theory that the attachment behavioral system serves the goal of receiving protection and care, while the reciprocal caregiving system shifts the psychological focus to providing protection and care, has led to decades of research on the parent-child relationship (George & Solomon 1996; 2008).

The important psychological shift from receiver of care to provider of care usually occurs during pregnancy. During this time, women typically reorganize their mental representations of themselves as mothers to make room for the internal representation of their new child (Slade A, Sadler L, Miller MR, Ueng-McHale J., 2009). The desire and motivation to become a caregiver also leads to the development of internal models of the relationship that parents will have with their children via the caregiving system. The caregiving system is composed of mental representations of caregiving including thoughts and feelings about the infant, the relationship with the infant, and the self as a mother to the infant. Internal Working Models (IWMs) are cognitive frameworks that include mental representations for understanding the world, self, and others (Bowlby, 1969). Evaluating working models during pregnancy is one way to examine mothers’ relationships that are being re-organized, including the new mother-infant relationship. One of the most common tools to evaluate internal working models of caregiving is the Working Model of the Child Interview (WMCI; Zeanah & Beniot, 1995). This interview yields similar categories of attachment as those identified by Ainsworth and colleagues (Ainsworth, Blehar, &
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Waters, 1978); however, the identification of classifications on the WMCI is based on the quality of caregiver responses to interview questions as opposed to infant behavior.

Several psychosocial risk factors have been shown to influence the quality of mothers' representations of caregiving, both prenatally and after the birth of a child (Slade et al., 2009; Schechter, D. S., & Willheim, E. 2009). Several previous studies (e.g. Huth-Bocks, A. C., Levendosky, A. A., Theran, S., & Bogat, G. A. 2004; Levendosky, A. A., Bogat, G. A., & Huth-Bocks, A. C. 2011; Schechter, D. S., Kaminer, T., Grienenberger, J. F., & Amat, J. 2003) have, for example, examined the importance of intimate partner violence (IPV) as a risk factor for mothers' caregiving system and the quality of their infants' attachment. These studies have utilized a quantitative approach to examine associations, but few have qualitatively analyzed interview responses of mothers preparing to care for a new child. The few quantitative studies that have been published have found that IPV is related to both 'disengaged' and 'distorted' representations on the WMCI (both characterized by problematic thoughts and feelings and general 'insecurity' in the caregiving system), while an absence of partner violence is related to much healthier, adaptive representations known as 'balanced' representations (e.g., Huth-Bocks et al., 2004; Theran et al., 2005).

The present study aims to assess mothers' WMCI narratives that were obtained during pregnancy to qualitatively identify themes of adaptive or problematic thoughts and feelings about their expected relationship with their child. That is, the present study aims to closely examine mothers' internal working models through WMCI interview responses obtained during the last trimester of pregnancy. It is hypothesized that different types of experiences with IPV (physical and psychological partner violence) during pregnancy will be associated with problematic
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

themes in WMCI interview narratives, e.g., more negative thoughts and feelings about their child and their relationship with the child.

Attachment Theory and the Caregiving System

Inspired by John Bowlby’s work with infants and mothers, Mary Ainsworth’s work, in the 1950’s in Uganda, aimed to better understand the attachment relationship between mother and child. Initially, Bowlby’s work distinguished between an individual’s attachment behavioral system and attachment behaviors (Bowlby, 1969/1982). According to Bowlby, the attachment behavioral system functions to achieve the goal of receiving protection and care from others, can be “activated” and terminated depending upon internal and environmental threat cues, and is organized according to mental representations from past and present experiences. In other words, this system functions to promote the child’s development and adaptation to his or her attachment relationships.

The attachment behavioral system is comprised of attachment behaviors, which are the observable actions taken by an individual in order to meet the goals of the behavioral system. Attachment behaviors are believed to be influenced by attachment representations, or mental models about the self and the world. Attachment behaviors are activated when a threat is present and deactivated when the threat subsides or is absent (Ainsworth & Bell, 1970). Attachment behaviors are present at birth and change over time, but are believed to always serve the purpose of helping the child receive protection and care (George & Solomon, 2008). Some examples of infant attachment behaviors that are present at birth are smiling, crying, and clinging. Later in childhood, attachment behaviors may include walking to gain proximity to the caregiver and calling out to the caregiver using language. Although Bowlby made many theoretical
contributions to the field, it was Ainsworth who created and established a method to empirically study types of mother-infant attachments.

Specifically, Ainsworth developed the Strange Situation (SS; Ainsworth, Blehar, Waters, & Wall, 1978) in order to observe the “strategies” that are used by the child to maintain an organizational pattern (timing and quality of a set of behaviors) in the context of attachment relationships (Cassidy & Marvin, 1992). The SS allows researchers to view several ‘episodes’ between the mother and the infant, the infant and a stranger, the infant alone, and most importantly, the reunions between the mother and the infant. Several separation episodes are believed to trigger the infant’s attachment system. Following separations, reunion episodes are crucial for determining the quality of the child’s attachment due to the interactive behaviors (Ainsworth et al., 1978) that occur. Interactive behaviors are coded on the following scales: proximity and contact seeking behaviors, contact maintaining behaviors, resistant behaviors, and avoidant behaviors. However, coding the overall classification is based solely on infant behavior during these reunions.

Infants receive a classification (secure, avoidant, or ambivalent-resistant) based on their scores on the scales listed above (Ainsworth et al., 1978). Infants classified as secure exhibit a pattern of organization in which they frequently use the attachment figure as a secure base. From this secure base, infants feel as though they can explore their surroundings with minimal anxiety. Infants who display a pattern of avoiding intimate contact, displaying neutral affect, and behaving in a manner that suggests that the return of the attachment figure (e.g., the mother) is of no importance to them are classified as avoidant. Ambivalent-resistant infants present with behaviors such as: “ambivalence to physical proximity/contact, angry resistance (full-blown temper tantrums), little to no avoidance, and in some instances, extreme passivity (Cassidy &
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Marvin, 1992 p. 8). A fourth classification, disorganized, was added to categorize infants with no stable pattern for organizing behaviors in the context of the attachment relationship (Main & Weston, 1981; Main & Solomon 1986). Infants given the disorganized classification display contradictory behaviors (e.g. startle response movements) and generally behave in a manner that suggests confusion or fear. Ainsworth’s procedure to empirically study Bowlby’s theory about the attachment system is noted as one of the hallmarks of attachment research (Bretherton, 1992).

Caregiving behaviors can be seen as early as preschool (e.g., during play), but maturation of the caregiving system occurs during adolescence, largely due to the biological shifts that accompany puberty (Fullard & Reiling, 1976). However, the most prominent development of the caregiving behavioral system occurs during pregnancy (George & Solomon, 2008; Slade et al., 2009). The caregiving behavioral system is believed to be a reciprocal behavioral system to the child’s attachment system (Solomon & George, 2008) because the goal of the caregiving behavioral system is to provide nurturance, care, and protection to the child. Thus, the caregiving behavioral system is the behavioral system that guides a parent’s representations and behaviors within the attachment relationship.

During the perinatal period, parents typically make a critical psychological shift from being the receiver of care to the provider of care (Bowlby 1969/1982; George & Solomon, 1996; 2008; Slade et al., 2009). Furthermore, the caregiving behavioral system goes through various changes and matures in the months just before, during, and following pregnancy. This bio-social-behavioral shift is due to the transactions between the biological, social, and psychological factors that are exclusive to pregnancy (Emde, Gaensbauer & Harmon, 1976; Lee, 1995). An increase in thoughts and fears about the self as a parent and past experiences of being parented
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

occur, and some suggest that this anxiety is a fundamental part of the reorganization of mental states that occurs during pregnancy (Ammaniti, 1994; Benedict, 1959; Bibring, Dwyer, Huntington, & Valenstein, 1961; Brazelton, 1981; Cohen & Slade, 2000; Coleman, Nelson, & Sundre, 1999; Cowan, 1991; Deutscher 1971, Ilicali & Fisek, 2004; Lee, 1995; Liefer, 1980).

Ideally, the changes and maturation that the caregiving system undergo during pregnancy allow the system to achieve its goal: to provide care and protection of offspring. Nonetheless, due to some adverse factors, the caregiving system may fail to achieve this goal for some women. Some caregivers, for instance, develop 'conditional caregiving' (George & Solomon, 2008), which places the child in overly close proximity (limiting threats and, by extension, limiting exploration) or at a distance (failing to provide protection and care). Other caregivers may be labeled as disabled because they abdicate the caregiving role (George & Solomon 1999; Solomon & George 1996). That is, they give up the caregiving role entirely, presumably because they are not psychologically capable of, or prepared for, providing care and protection. Much like the attachment system, the caregiving behavioral system is also “activated” in the presence of a caregiving threat and “terminated” when the threat subsides. There may be instances, however, when the parent’s caregiving system is activated, but the child’s attachment system is not activated or vice versa. Repeated mismatches between the parent’s caregiving system and the child’s attachment system may result in significant parent-child relationship difficulties including insecure attachment.

As previously stated, the caregiving system is composed of representations of caregiving and caregiving behaviors. Representations refer to thoughts, feelings, or beliefs about the infant, the relationship with the infant, and the self as a mother to the infant. Similar to the attachment system, the caregiving system is comprised of caregiving behaviors that meet, or do not meet, the
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

goal of providing protection and care. Maternal representations of caregiving are believed to
guide caregiving behaviors (Dayton, C., Levendosky, A., Davidson, W., & Bogat, G, 2010; Solomon & George, 2008). Furthermore, caregiving representations show some stability from pregnancy to post-partum for the majority of women (Theran, Levendosky, Bogat, & Huth-Bocks 2005), although there are also notable changes in caregiving representations for some women.

Caregiving representations during pregnancy can be influenced by many factors. One major factor is a mother’s own experience of attachment and of receiving care (Stern, 1995). If a mother’s experience of receiving care has been negative and she has an insecure attachment history, then those past attachment experiences may manifest as “ghosts in the nursery” that may negatively affect the current relationship with her child (Fraiberg, Adelson, & Shapiro, 1975).

Other factors that influence the quality of prenatal caregiving representations include a reorganization of her other roles (e.g., self as daughter, sibling, friend, partner, etc., Stern, 1995), her own sense of connection and separateness with the infant, and current contextual experiences such as her romantic relationship, economic stability, mental health, and social support (Theran et al., 2005; George & Solomon, 2008).

The mother’s caregiving representations interact with her child’s attachment representations. Stern (1995) proposed a bidirectional model of influence between the infant and the mother. In this theoretical model of infant social-emotional development, the infant’s actions and the mother’s actions are linked inside a circle of observable, transactional actions. Extending outside of the circle is the unobservable, or intrapsychic, occurrences. These include both the mother’s representations of the interaction and the infant’s representations of the interaction. In this model, each of the following are bidirectional relationships: the mother’s representations and
the mother’s actions, the mother’s actions and the infant’s actions, and the infant’s actions and the infant’s representations. Therefore, a change in one element will presumably result in a change in each of the other elements. When empirical studies aim to measure one of these important elements of the mother-infant relationship, including predictors of said elements, changes in the other elements are often presumed. In the current study, the focus is on better understanding the mother’s representations of her infant during pregnancy.

In the empirical literature on mother-infant relationships, coded interviews are the most common method to assess caregiving representations because it is believed, as Bowlby initially speculated, that part of an individual’s representations of the self and the world are not conscious. The most well used interview to assess caregiving representations, specifically, is the Working Model of the Child Interview (WMCI; Zeanah & Benoit, 1995). The WMCI is a semi-structured interview with the purpose of having caregivers “reveal as much as possible in a narrative account of their perceptions, feelings, motives, and interpretations of a particular child and their relationship to that child” (Zeanah & Benoit, 1995, p. 539). These representations, revealed through the entire interview narrative, are later coded in such a way that yields three caregiving classifications, termed: ‘balanced’, ‘disengaged’, and ‘distorted’ (Zeanah et al., 1996).

Mothers classified as balanced are not only engaged in and value the relationship, but are also aware of the child’s individuality and subjective experiences (Vreeswijk, Maas, Van Bakel, 2012). This category is analogous to the child secure attachment classification. Mothers with disengaged representations speak about their relationship with their child with a cool indifference and use cognitive and intellectual vocabulary in order to emotionally distance themselves from the child. This category is analogous to the child avoidant classification. Representations classified as distorted are often incoherent and filled with inconsistencies, unrealistic
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

expectations, flooded affect, and even insensitivity toward the child. This category is analogous to the ambivalent-resistant child classification. A fourth classification, 'disrupted' (Crawford & Benoit, 2009), was recently added to the WMCI method of coding narratives to parallel the child disorganized classification from the SS. Therefore, disrupted maternal representations are characterized by contradictory or frightening thoughts and feelings about the relationship with the child. Previous research has shown that maternal representations classified as disengaged, distorted, or disrupted may be influenced by maternal experiences of interpersonal trauma.

Interpersonal Trauma

Trauma occurs when an individual has an experience that threatens a sense of physical or psychological safety which subsequently leads to significant anxiety and negative expectations concerning the future (American Psychiatric Association, 2013). There are various types of trauma that one can experience. War or political trauma can occur to those who are deployed and view “incidents such as bombing, shooting, looting, or accidents that are a result of terrorist activity as well as actions of individuals” or as a group of adversaries (Office of Head Start, Administration for Children, Youth and Families, U.S. Department of Health and Human Services, 2015). Experiencing trauma can also come from man-made or natural disasters which threaten people’s safety. Furthermore, trauma can be a result of experiencing interpersonal violence within close relationships such as IPV. IPV refers to the exposure to emotional, attempted or actual physical, or sexual assault that is perpetrated against a romantic partner (Office of Head Start, Administration for Children, Youth and Families, U.S. Department of Health and Human Services, 2015). The term ‘complex trauma’ typically refers to exposure to multiple or reoccurring traumatic events of an interpersonal nature such as prolonged IPV
The way in which humans experience and make sense of interpersonal trauma is unlike other species because humans ascribe meaning to traumatic events (Charuvastra & Cloitre, 2008). Much like attachment, interpersonal trauma is relationally-based and is appraised by the individual in the context of the individual's understanding of his or her social world. The meaning that individuals assign to a traumatic experience may prompt feelings of fear within important relationships (Charuvastra & Cloitre, 2008). Therefore, interpersonal trauma is of interest to attachment researchers, although empirical study of interpersonal trauma from an attachment theory perspective is surprisingly rare. As noted above, interpersonal trauma such as partner violence may involve a variety of types including: psychological, emotional, or verbal abuse (e.g., humiliation, insults, or threats of violence), physical abuse (e.g., hitting or choking), or sexual violence (e.g., threats of coercion to engage in sexual behaviors or forced sexual acts). Additionally, forms of interpersonal trauma are likely to co-occur. For example, a study by Mezey, Bacchus, Bewley, and White (2005) found that women who reported experiences of IPV were found to be significantly more likely to experience one or more other traumatic events compared to women who did not experience IPV (70.2% vs 48.4%, respectively). Furthermore, a history of partner violence was significantly associated with childhood sexual abuse and physical or sexual assault by an unknown assailant in this study.

Research has also found that not all traumas are equivalent when predicting the potential successive risk for Post-Traumatic Stress Disorder (PTSD), which is a mental health condition characterized by re-experiencing, avoidance, negative cognitions and mood, and increased arousal (American Psychiatric Association, 2013). Indeed, when the stressor is of "human
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

design”, PTSD is more likely and more likely to be severe and long-lasting (Charuvastra & Cloitre, 2008). A meta-analysis of studies conducted on risk factors for PTSD revealed that the predictive effect of perceived life threat on development of PTSD was greater when the traumatic event consisted of interpersonal violence (Ozer, Best, Lipsey, & Weiss, 2003). More specifically, “having had a prior trauma was more strongly related to PTSD when the traumatic experience involved noncombat interpersonal violence (e.g., civilian assault, rape, partner violence) than when the traumatic experience resulted from combat exposure or an accident” (p 57).

Interpersonal violence within attachment relationships, either parent-child or romantic partner, are particularly devastating because the violence is perpetrated by individuals who are expected to meet the needs of the other individual in the attachment dyad (Charuvastra & Cloitre, 2008). These types of interpersonal violence are qualitatively different from interpersonal violence that takes place in war or between individuals not in a close relationship. In warfare, for example, the expectation is that threats to a sense of physical or psychological safety will occur, and the interpersonal violence is expected and will be perpetrated by unknown assailants. However, when interpersonal violence is perpetrated within the context of an attachment relationship, the trauma is perpetrated by a caregiver or partner who is supposed to provide care and protection when attachment needs arise. The specific type of interpersonal trauma that will be closely examined in the present study is IPV during pregnancy. Partner violence during this time period can, as noted earlier, fall into one or more types of violence. The focus of the present study is on the effect of multiple types of partner violence on mothers’ internal representations of their child. This is an important area of study due to the high prevalence of women who experience IPV during pregnancy.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Research suggests that partner violence is highly prevalent among women across the lifespan, including during the perinatal period (Alhabib, Nur, & Jones, 2010; Black et al., 2011). In fact, previous research has demonstrated that the greatest risk for experiencing IPV is during the childbearing years (Walton-Moss, Manganello, Frye, & Campbell, 2005). Studies have shown that the prevalence of IPV during pregnancy is somewhere between 0.9% and 36%. Furthermore, IPV increases in severity and frequency for 13% to 71% of women during pregnancy (Devries K.M., Kishor S., Johnson H., Stockl H., Bacchus L.I., Garcia-Moreno C, Watts C, 2010; Taillieu & Brownridge, 2009). A large number of women who experience IPV are also mothers of young children due to the high prevalence (20.9% - 30%) of IPV during early postpartum (Charles & Perreira, 2007; Rosen, Seng, Tolman, & Mallinger, 2007). Several studies have also established that experiencing IPV during the perinatal period contributes to mental health problems, specifically depression, anxiety, and PTSD symptoms (Bargai, Ben-Shakhar, & Shalev, 2007; Karmaliani et al., 2009; Ludermir et al., 2010; Rodriguez et al., 2010; Stampfel, Chapman, & Alvarez, 2010).

Furthermore, some researchers have found evidence of an even more specific type of psychological IPV that involves using children against the victim and that severely undermines the parenting role (Ahlfs-Dunn & Huth-Bocks, 2016). In this recent study, the authors found that IPV involving children and the parenting role was fairly prevalent (28% endorsed this type during pregnancy) and significantly predicted outcomes such as mothers’ anxiety, hostility, and PTSD symptoms above and beyond the ways in which IPV is customarily assessed (in broader categories). Thus, there are many ways in which IPV can be examined, and further research should be conducted for a more comprehensive understanding of the effects of experiencing IPV on women during the peripartum period. For example, IPV is often chronic, and this type of...
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

threat may continually activate the woman’s caregiving system (George & Solomon, 1999). Furthermore, partner violence may result in re-imagining past traumas, feelings of helplessness and fear, and significant difficulty transitioning to a caregiving role during pregnancy; such feelings may be so severe that they could lead to disrupted representations.

The Effects of IPV on the Caregiving System during Pregnancy

Pregnancy, as a period of relational reorganization, leaves the woman more susceptible to psychological damage that can be caused from any meaningful relationship in her life, which may include her romantic partner (Levendosky, Bogat, & Huth-Bocks, 2011). IPV can, in fact, be considered an “assault” on the caregiving system (Huth-Bocks et al., 2004). Since pregnancy is a unique period of psychological reorganization (Slade et al., 2009), experiencing IPV during pregnancy can negatively affect the mother’s caregiving representations and her subsequent postnatal parenting behavior. There are several studies that have explored how partner violence is related to the caregiving system, specifically maternal representations, with findings suggesting that this type of interpersonal violence negatively affects the caregiving system in a number of ways.

For example, Huth- Bocks, Levendosky, Theran, and Bogat (2004) examined IPV and maternal representations of caregiving during pregnancy. Two hundred and six pregnant women were recruited into a larger longitudinal study. To measure levels of IPV, the Severity of Violence against Women Scales (SVAWS; Marshall, 1992) and the Conflict Tactics Scale (CTS; Straus, 1979) were used during pregnancy. Maternal representations of caregiving and the infant in utero were measured with the WMCI. When comparing women who had experienced IPV during the current pregnancy to women who had not, it was found that the women who experienced IPV had significantly different scores on all but two of the WMCI scales used to
assess caregiving representations. More specifically, women who had experienced IPV during pregnancy had representations marked by "less flexibility or openness to change, less coherence, less caregiving sensitivity, less acceptance of the child, greater perceived infant difficulty, less joy, more anger, more anxiety, more depressive affect, and less feelings of self-efficacy as a caregiver" (p. 88). Women in the two groups did not differ on richness of representations or intensity of involvement. These findings demonstrated that pregnant women’s representations of caregiving may be negatively affected by exposure to partner violence during this critical period of the mother-infant relationship.

A later study by the same research group examined risk and protective factors, including IPV, associated with the stability of caregiving representations across the birth of the child (Theran, Levendosky, Bogat, & Huth-Bocks, 2005). The WMCI was used to assess maternal representations during the third trimester of pregnancy (T1) and when the child was 1 year of age (T2). It was found that 44% of the women in the study had experienced physical IPV during pregnancy. Also, a high concordance in classification of representations (balanced or unbalanced) was found between pregnancy and 1 year postpartum for the majority of women (71%); however, a small group of women with balanced representations shifted to non-balanced representations over the course of the study (10%), and a slightly larger percentage of women with non-balanced representations changed to have balanced representations over time (19%). More specifically, women who were classified as ‘distorted’ or ‘disengaged’ on the WMCI were likely to remain stable in that classification when interviewed and classified at 1 year postpartum unless an internal or external change (e.g., experiences of IPV, symptoms of depression, and family income) occurred. The study found that “at T1, women who were in the became-non-balanced group were more likely to have lower income, to be single parents, and to have
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

experienced physical abuse during pregnancy than women who were in the remained-balanced group” (p 262). In other words, women who switched from balanced to non-balanced experienced distress in their environment, which may explain the instability (and worsening) of classification. That is, some women who experience IPV during pregnancy are able to fantasize about their relationship with their child in a balanced way, but have increasingly problematic representations of the actual child at age 1, possibly due to ongoing or later violence.

Thus, both theory and some empirical work suggest that the qualitative aspects and the content of maternal representations can be influenced by traumatic events (Fraiberg, Shapiro, & Cherniss 1980; George & Solomon 1999). Another study by Schecter and colleagues examined the link between past maternal traumatic experiences, maternal emotional dysregulation, and current maternal representations of the child (Schecter et al., 2005). This study sampled 41 mothers of children who were ages 8-50 months. All participants had been interpersonally traumatized as noted by their enrollment in an infant mental health clinic that specialized in serving families at risk for child abuse, neglect, or partner violence. To measure levels of trauma exposure, the Brief Physical and Sexual Abuse Questionnaire (BPSAQ; Marshall et al., 1998) was used. From that measure, a score for Maternal Interpersonal Violence Exposure Severity was calculated by summing several factors. Additionally, PTSD symptoms were measured using the Posttraumatic Stress Symptom Checklist-Short Version (PCLS; Weathers et al., 1996). The impact of the severity of interpersonal violence and symptoms of PTSD on maternal representations of caregiving were analyzed using scores from the WMCI, evaluated postnatally.

The results from this study indicated that the severity of interpersonal trauma predicted the severity of maternal PTSD symptoms. Additionally, the most severe PTSD symptoms were most prevalent among mothers classified as distorted on the WMCI, which supported the
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

authors' hypothesis. That is, "maternal dysregulation of negative affect in the wake of past interpersonal violent trauma skews the mother's mental representation away from an integrated or 'balanced' view of her child in the present" (Schecter et al., 2005, p. 325).

Another study of 100 African American mothers and their 17-20 month old infants—a high risk sample due to exposure to extreme poverty and violence within the community (Sokolowski, Hans, Bernstein & Cox, 2007). This study examined the associations between maternal psychological distress, maternal representations, verbal and physical relational conflict, and parenting behaviors. It was hypothesized that maternal representations would mediate maternal distress, relational conflict, and parenting behaviors. Similar to the previous studies mentioned, the WMCI was used to assess maternal representations about the relationship with the child postnatally. This study used the Conflict Tactics Scale (CTS; Straus, 1979) to measure verbal and physical relational conflict between the mother and the child's father. The Brief Symptom Inventory (Derogatis & Melisaratos, 1983) was administered for self-reported psychological symptoms, and the Parent-Child Observation Guide (PCOG; Bernstein, Percansky & Hans, 1987) was used to rate mothers' parenting behaviors from video-recorded observations.

The results of the study revealed that mothers who reported more relational conflict, specifically with the child’s father (also known as IPV), were more likely to be classified as having distorted WMCI narratives. One explanation for these findings, and similar findings described above, is that fathers' verbal and physical abuse may impede the mother's relationship with the child. Another possible explanation is that a third variable may be the cause of both the relational conflict with the father and the distorted representation of the child such as extreme poverty and other adversities. When the classification of narratives was compared with the observed parenting behaviors, it was found that mothers with disengaged narratives were
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

significantly different on the observed parenting behaviors than mothers with distorted or balanced representations. Thus, the original hypothesis was partly supported with the finding that parenting behavior of disengaged mothers was rated as lower on Sensitive/Responsiveness, lower on Encouragement/Guidance, and higher on Passive/Withdrawal compared to women not disengaged.

The work of Theran and colleagues (2005) demonstrated that caregiving representations can change or remain stable over time, but that study “did not investigate the ways in which prenatal representations may be directly related to postnatal parenting behaviors” (Dayton et al., 2010, p 225). Therefore, Dayton and colleagues assessed relations between mothers’ caregiving representations during pregnancy and parenting behaviors 1 year later among women who had experienced varying levels of IPV. It was hypothesized that postnatal exposure to IPV would override the positive effects of prenatal balanced representations on later parenting behaviors and would exacerbate negative parenting behaviors of mothers with previously unbalanced representations.

When controlling for prenatal IPV, women’s representations of her unborn child were associated with her parenting behavior when the child was approximately 1 year of age. More specifically, mothers with distorted representations displayed more hostile parenting and the mothers with disengaged representations showed higher levels of controlling parenting compared to other mothers. Although postnatal IPV was not a moderating factor between prenatal representations and parenting behaviors, the authors postulated that current trauma symptoms might be more important than postnatal IPV exposure in predicting parenting behavior from prenatal caregiving representations.

Although there have been several studies that have quantitatively examined the impact of
IPV on maternal representations, as described above, there have also been a few studies that have used a more qualitative approach to studying these associations. For example, Schecter and colleagues used a more qualitative approach and detailed a case study (Schecter, Kaminer, Grienenberger, & Amat, 2003). In this published report, an inter-city Latino dyad was assessed based on cultural factors, psychiatric and neurological assessments, observational assessments, features of disturbed attachment, and mechanisms for intergenerational transmission of trauma. An infant, carried to full term and with no medical complications present at birth, was reportedly having symptoms consistent with a seizure disorder. However, when hospital staff monitored the child on an electroencephalogram (EEG) scan, the child showed no signs of a seizure disorder. The mother disclosed severe and frequent interpersonal trauma exposure including: the death of her brother, physical violence inflicted by her father up to age 4 years, and repeated physical and sexual violence perpetrated by her uncle. These maternal experiences of interpersonal trauma led to a myriad of PTSD symptoms including pseudo-seizures in herself, which appeared to be transferring to her young child.

Through outpatient treatment, a maternal narrative was obtained using the WMCI, free-play interactions were video recorded, and video feedback sessions were conducted. The WMCI revealed that the mother had no indication that her experiences had any impact on the relationship with her child. The video recordings revealed a variety of frightening-frightened maternal behaviors. The mother struggled to read the cues of her child and to respond appropriately. This resulted in a child who was apprehensive about the type of care and protection she would receive from her mother and who began to respond physiologically with PTSD-like symptoms and neurologically with pseudo-seizures. Ultimately, this case study
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

helped demonstrate the intergenerational transmission of interpersonal trauma and how it affects maternal representation and behaviors and child adjustment.

In another qualitative case study, Levendosky, Bogat, and Huth-Bocks (2011) proposed that partner violence impairs the caregiving system because it unconsciously triggers feelings of fear and helplessness associated with threats to physical and psychological integrity. Subsequent dysregulation of emotions and behaviors then influence maternal caregiving representations. This case study reported on findings from measures that assessed maternal representations, as well as observed parenting behaviors, child behaviors, and parent-child attachment from pregnancy through the preschool years.

Like other studies have reported, the woman in this case reported high levels of IPV exposure and high scores on PTSD symptoms including re-experiencing memories of trauma, being easily startled, and experiencing nightmares. Furthermore, the woman’s responses on the prenatal WMCI revealed problematic representation themes including: role reversal (as she imagined the fetus helping her to grow up) and merging (evident by pronoun confusion and viewing her future child and herself as the same person). There was also evidence over the years that the woman’s IPV experiences were contributing to the way she resented the child and herself as a caregiver; for instance, the mother discussed the unborn infant’s “abusive tantrums” after feeling fetal movement. Other excerpts suggested feelings of being overwhelmed by the caregiving role and possible signs of dissociation and disorientation. Not surprisingly, the infant had a disorganized attachment classification at age 1 and at age 4 years. One major conclusion of the case study was that, when the mother’s own needs have not been met through exposure to IPV and failed protection by others, problematic feelings can become projected onto the unborn child, leading to severe distortions of the child and severe impairments in the relationship with
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

the child for many years following birth.

The Present Study

As previously mentioned, women make a critical psychological shift from receiver of care to provider of care during pregnancy. This psychological shift activates the caregiving system. However, the presence of IPV can be an “assault” on the caregiving system, making it much more difficult for women to identify themselves as a competent caregiver to the child who has attachment needs. Several studies by a select group of researchers have studied the associations between IPV and the caregiving system, including maternal representations, using a quantitative approach. Additionally, a few researchers have studied the links between IPV and maternal representations using a qualitative approach; however, the literature is sparse and mainly consists of postnatal assessments of maternal representations. The present study aims to use a qualitative approach to assess the themes that are present in the prenatal representations of women who have experienced severe psychological violence and/or any level of physical or sexual violence from a partner during pregnancy.

Method

Participants

Data for this study come from a larger longitudinal study conducted at Eastern Michigan University (EMU). The study, called the Parenting Project, is led by Principal Investigator Alissa Huth-Bocks, Ph.D., and began in the fall of 2007. Data were collected from 120 pregnant women who were originally recruited into the study. For the larger, longitudinal study, data were collected at five time points: during the last trimester of pregnancy (T1), 3 months postpartum (T2), 1 year postpartum (T3), 2 years postpartum (T4), and 3 years postpartum (T5). The current study only uses data from the last trimester of pregnancy (T1) for 10 participants (see details...
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

below).

All participants for the Parenting Project were recruited through flyers that were posted throughout southeastern Michigan, more specifically, in Washtenaw and Wayne counties. Participants were recruited into the study through various community organizations. Ultimately, participants came from community-based health clinics which served individuals who were uninsured or had low income (23%), the Women, Infants, and Children (WIC) social service program (18%), the local community college and the university through which the study was conducted (16%), a “community baby shower” supported by local programs (11%), word of mouth (another research study, friend, family, etc.; 10%), a daycare or head start program (7%), a temporary and/or subsidized housing facility (7%), donation centers for women and children (5%), and a parenting class (2%).

The longitudinal study maintained a high retention rate of 83% by 2 years postpartum (T4); retention rate was lower (68%) for the 3-year interview (T5), largely because this wave was added onto the study at a later time point and well after many women had been interviewed for T4. At the time of recruitment (pregnancy), the ages of participants \( N = 120 \) ranged from 18-42 years, and the average age of participants was 26 years old \( (SD = 5.7) \). The participants in the study self-identified as: African American (47%), Caucasian (36%), Biracial (12%), Asian American (2%), Arab American (2%), and other minority group (1%). Some participants were first time mothers (30%) and the remaining 70% had an average of 2.7 children. The majority of women reported being single (64%), while the remaining reported being married (28%), separated (4%), or divorced (4%) at study entry.

Furthermore, the education levels of this sample varied. Fifty-seven percent of the individuals reported having some college or trade school, 20% reported having a high school
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

diploma or less, 14% reported having a four-year degree, and 9% reported some graduate school.
Economic disadvantage was common among participants in the study, on average. During the first wave of data collection, the family income ranged from $0 to $10,416 per month with the median monthly income of participants at $1,500 per month. At the first wave of data collection, 45% reported being employed, and 76% of the sample received public health insurance (Medicaid, Medicare, or MI-Child), 73% received services from WIC, 62% reported receiving food stamps, and 20% received public cash assistance.

The 10 participants chosen for the present study \((n = 10)\) were recruited from various locations in the community, similar to the larger sample. Forty percent were recruited from community based health clinics that served uninsured or low income families, 20% were recruited from the WIC social service program, 30% were recruited from the community college and university in the area, and 10% were recruited by word of mouth (another research study, friend, or family).

The ages of the 10 participants chosen for the present study ranged from 19-38 years, and the average age of the participants was 27 years old \((SD = 5.8)\). The participants for the present study identified as: African American (40%), Caucasian (40%), Biracial (10%), and Native American (10%). From the sample of 10, 10% were first time mothers, and those who had previously had children had an average of 2 children. Similar to the larger longitudinal study, the majority (70%) of the participants in the current study reported being single. The remaining participants described their marital status at the start of the study as: married (10%), separated (10%), and divorced (10%).

The current sample reported the following education levels: 70% completed some college or trade school, 20% reported having a high school diploma or less, and 10% had a four-year
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

degree. Similar to the participants of the larger longitudinal study, economic disadvantage was common among the sample chosen for the present study. At study entry, the monthly family income ranged from $300 to $2,500, with a median monthly family income of $1,100. Also at study entry, 40% reported being employed outside of the home, 100% received public health insurance, 100% received services from the WIC program, 90% received food stamps, and 30% received cash assistance. Results from t-tests and chi-square analyses revealed that the sample for the current study ($n = 10$) did not significantly differ from the larger sample on any demographic variables with two exceptions; there was a significant difference between groups on the receipt of WIC services ($\chi^2 = 3.967, p. = 0.046$), and there was a significant difference between groups on the receipt of food stamps ($\chi^2 = 6.284, p. = 0.012$). Specifically, women in the current study were more likely to receive WIC and food stamps compared to women from the larger study who were not included in the present study.

Procedures

In order to be eligible, participants were required to be pregnant, at least 18 years of age by the start of the study, and be able to speak fluent English. The women agreed to participate in the study by giving verbal consent and agreed to a meeting with the research assistants in one of the following places: the participant's home (78%) or in a research office at EMU's campus (22%). At study entry, 9 of the participants selected for the current study had the interviews conducted in their homes and 1 was conducted at the university's campus. Interviews typically took 2.5 to 3 hours to conduct and were conducted by two research assistants. One research assistant took the lead on the interview while the other research assistant either provided child care to assist with the completion of the interview, or observed the interview. Before any measures were filled out, each participant was given an informed consent form. The informed
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

consent was read out loud and signed by each participant. The interview at pregnancy (T1) was composed of a demographics questionnaire and a variety of self-report measures as well as a semi-structured interview to assess the way the participants felt and thought about their unborn child (the WMCI). The principal investigator trained all research assistants on appropriate administration of all measures and questionnaires, study procedures, and protocol for conducting home visits (including appropriate conduct, safety, ethical issues, etc.).

Because the present study is a qualitative analysis of a smaller number of women ($n = 10$) from the larger study, using T1 data only, procedures needed to be developed to appropriately choose these 10 participants. First, due to the overall aims of the study, it was decided that only participants with severe psychological partner violence and/or any level of physical or sexual partner violence during the current pregnancy would be included. After excluding everyone who did not meet this criterion, prenatal WMCI transcripts were examined in order to choose the 10 longest ones conducted by the same interviewer, in this case, the interviewer who completed the most WMCI during the T1 wave of data collection. Although there was a training protocol which attempted to standardize the administration of the WMCI, there may have been differences in the way that the interview is administered based on interviewer style. Restricting the current sample to one interviewer reduced the chance of qualitative differences that may have been more likely to between different interviewers. Finally, among the transcripts that met these criteria, 10 were chosen that spanned the time period of the T1 data collection such that participants across the duration of this wave of data collection (i.e., from beginning to end) could be included. A member of the research team, who was not the investigator of the current study, used these criteria to select the 10 participants in order to minimize the possibility of any bias in the selection of participants.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Measures

Intimate Partner Violence.

The Revised Conflict Tactics Scale (CTS-2; Straus, Hambly & Warren, 2003) is a self-report measure that was used to assess the frequency and severity of psychological, physical, and sexual violence perpetrated by one romantic partner toward another romantic partner. The CTS-2 consists of separate subscales that assess physical, sexual, and psychological violence. For both the Parenting Project study and the current study, only the 33 items which assess victimization were used. For the current study in particular, only items evaluating victimization during the current pregnancy were used.

Responses for each item indicate the frequency of the event within the time period in question (in this case, the current pregnancy). Responses range from 0 = never, 1 = once, 2 = twice, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = more than 20 times, and 7 = the event had not happened at all during the time period of interest. These scores can be summed to create a total score for each of the subscales/types of partner violence. Furthermore, for each subscale/type of partner violence, separate ‘mild’ and ‘severe’ totals can be calculated. As noted earlier, only women who reported severe psychological violence and/or any level of physical or sexual violence were included in the current study. An example of severe psychological violence is “My partner destroyed something that belonged to me.” An example of physical violence is “My partner used a knife or gun on me,” an example of sexual violence is “My partner used threats to make me have oral or anal sex.”

Maternal Representations

The WMCI (Zeanah & Benoit, 1995) was used to assess caregivers’ mental representations of the self-as-a caregiver and the relationship to their infant. This hour-long semi-
structured interview was originally designed to assess parents with 1-year old infants; however, it
has been adapted and been successfully used with women during pregnancy to evaluate prenatal
maternal representations. During the Parenting Project study, the WMCI was administered
during pregnancy and at age 2. The current study only examines WMCIIs collected during (the
last trimester of) pregnancy.

The WMCI is audio-recorded, transcribed, and then typically coded on 13 5-point Likert
scales. The Likert scales assess qualitative features (Richness of Perceptions, Openness to
Change, Intensity of Involvement, Coherence, Caregiving Sensitivity, and Acceptance) of the
interview narratives. The WMCI also assesses content scales (Infant Difficulty and Fear for
Safety) and affective features (Joy, Anger, Anxiety, Indifference, Depression) of the interview
narratives. All of these scales are detailed in the original coding system developed by Zeanah and
colleagues (1996), and scales are used to help determine an overall classification to the narrative.
As noted earlier in this paper, classifications are analogous to other attachment classifications on
different measures such as the Strange Situation Procedure. In the current study, the T1 WMCIIs
were coded using this system by trained and reliable coders. However, the current study does not
use these codes; instead, a qualitative approach is used to examine possible themes that
participants reveal through their narratives.

Data Analytic Approach

A Computer Assisted Qualitative Data Analysis Software (CAQDAS) was used during
the coding process for the current study. According to The Coding Manual for Qualitative
Researchers, “CAQDAS itself does not actually code the data for you; that task is still the
responsibility of the researcher. The software efficiently stores, organizes, manages, and
reconfigures your data to enable human analytic reflection” (Saldana, 2009 p. 22). Therefore, a
Initial coding, an open-ended process that sorts responses into general themes, was utilized on a first read through of the transcripts. A theme was given after reading each question and its subsequent response if it was deemed what Auerbach and Silverstein (2003) define as, “relevant text.” The themes were not based off of specific words or phrases, but were broad topics that began to emerge. According to Saldana, a theme is “an outcome of coding, categorization, and analytic reflection, not something that is, in itself, coded.” After the initial read through, several topics were identified as being present based on: similarity, difference, frequency, and sequence within and across participant transcripts (Saldana, 2009).

Three additional readings of the transcripts resulted in refining, subsuming, and deleting some initial themes. It was also found that some sections of “relevant text” within a theme had important differences. Therefore, themes were further divided into sub-categories in order to extract and demonstrate the differences. These categories were more strictly defined by particular words or phrases that were explicitly stated. This analytic process created the overall hierarchical nature of categories within themes, further described below in the Results section.

**Results**

Based on the qualitative analysis of participants’ interview narratives, four predominant themes emerged: helplessness, abdicated caregiving, rigid attitudes and beliefs about gender roles, and incoherent, mixed themes. Across all 10 interviews, there were 22 examples of helplessness, 20 examples of abdication, 63 examples of rigid attitudes and beliefs about gender roles, and 5 examples of mixed themes. Each theme will be discussed below, with a few examples (see all identified examples in the Appendix).

**Helplessness**
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Throughout initial coding, the theme of helplessness was evident among the majority of women’s narratives. Helplessness is characterized as the inability or lack of strategy to provide protection and care to the infant and, sometimes, the feeling of being completely incompetent in the caregiving role. Upon subsequent readings of the transcripts, it was evident that women attributed their caregiving helplessness to different causes. Therefore, the categories biological predisposition, inefficacious behaviors, and hypervigilance were created to illustrate how women attribute their helplessness to different sources.

Relevant text was identified as helplessness due to biological predispositions if the woman used words or phrases that specified absolutes (it doesn’t matter, no matter what, always, etc.) with a mention of a driving biological force (naturally, genes, genetics, hereditary, etc.). If the woman acknowledged that biology played a role in shaping an individual, but also acknowledged that experiences played a role, it was not coded as relevant text for helplessness due to biology. Similarly, if a woman used absolute language (always, never, etc.), but failed to attribute the unchanging nature of behaviors to biology, it was not coded as relevant text. The coded text, therefore, indicated absolute biological predispositions that could be in regards to her or her baby’s behavior or feelings.

Some women in the current study also discussed feeling a loss of control in relation to the behaviors of their child or to their abilities as caregivers due to biological predispositions. In the example below, one mother described a loss of control of her child’s behaviors due to genetic or biological factors. This woman seemed to believe that her child would have a genetic predisposition to behave in a certain way, and consequently, her caregiving behaviors would have no effect on the child’s outcome. In the examples throughout, the interviewer’s comments will be noted in bold.
I'm kinda worried about, about him doing the same thing my first son did and being extremely independent, like, being like 'I can do this on my own', even though like you should before you do it on your own, you know, so I, I worry about that a little bit.

Mmhmm. Why do you think these behaviors will be difficult, and how often do you think they will occur?

Well, like, I'm sure like I'm sure being, independent or whatever, is being like that, I know that at some point like... I hope that, like I said I hope that he like gives me a chance ... (1 second pause) ... you know. I don't know ho- but like I said if, you know, things are hereditary, it's probably gonna happen (participant voice gets SOFTER) always. **laugh**... (3 second pause)

The mother explained that she hopes the child will give her the chance to be in the caregiving role, but the mother feels that, due to the biological predisposition to be independent, the child would not seek out nor need her caregiving. The mother ended her response with a soft-spoken absolute-type statement and, what seemed to be, nervous laughter. Although she appeared to want to assume the caregiving role, she felt as though she would not have the chance, and there would be no way to change that.

Another woman also used biological factors to describe the helplessness she felt. The following example is in regards to her behaviors toward the child. She seemed to feel as though her behaviors were warranted because they were involuntary behaviors that were rooted in biological processes.

Do you think your baby will get upset often in his or her first 12 months? And what will you do at those times, and what do you think your feelings will be like at those times?
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Well like, I realize that like, honestly like all kids, like all kids get upset, that’s just how it is, like, you know, they can’t talk, so of course they’re upset they’re like trying to say something to you, and it’s like so of course they’re getting angry about it...(later in the interview) you know so I get stressed out easily and I’m scared that maybe I ...(1 second pause)... passed that on, you know? I don’t want to. I try really hard not to be stressed out. I do a lot of like awkward things to not be angry. But like your hormones are crazy and, I don’t know, things happen.

The mother in the excerpt above expressed her concern that her tendency to be easily stressed will be biologically passed on to her infant. She explained that she attempts to control her feelings and behaviors, but they can happen almost against her will. Her hormones, a biological factor, are controlling her emotions (feeling angry), and consequently, her behaviors (acting ‘awkward’ to not feel angry). She also stated that she is scared about the uncontrollable nature of these things, and she does not offer any nurturing or experiential influences that may combat the biological circumstances.

For some of the women in the current study, helplessness appeared to come from not knowing how to adequately act in caregiving situations. This fear of inadequacy may make women feel uncomfortable and inefficacious in their attempts to provide care. Therefore, some mothers reported feeling very incompetent, which could influence their caregiving behaviors. Here is one such example:

After your baby is born, what behavior in his or her first year of life do you think will be the most difficult for you to handle? Can you give an example?

Like ...(3 second pause) ... potty training maybe?...That and maybe ...(2 second pause) ... disciplining although I don’t think I’m gonna be able to do that either
**laugh**

Do you think your child will know you don’t like that?

(2 second pause) … I know with the baby… (2 second pause) … uhm, they feel when you’re frustrated, so yes…(2 second pause)...I, I think, ya know, that they’ll feel some when I’m frustrated when I’m trying to take care of them or figure out what’s wrong and then that in turn doesn’t help them. And you’re like, I understand it also whatever cause that’s usually really comforting to, to babies, to nurse but, so I think they’ll feel some emotions from me, they usually tell you to calm down, or what not, before, which is hard to do when you’re dealing with a crying baby, if it’s sick, you’re just wanting to help ‘em, but you **laughs** can’t figure out what’s wrong or why they’re sick.

Helplessness is conveyed in the above passages as ‘inefficacious behaviors’, the inability to respond to or influence the relationship with the child, and it is another way that helplessness was presented in the maternal representations in the current study. In the first example, the mother explained that she feels as though she will not be able to perform responsibilities that she views as components of effective caregiving (teaching skills and disciplining). In the second passage, the mother noted that she will feel frustrated when she tries to figure out what’s bothering the infant when s/he is sick, and her inability to do so will make the infant feel frustrated. Therefore, this mother acknowledged that her emotional responses can affect the infant, but she appears helpless to behave in a way that accurately responds to the infant’s needs. Further, she laughed when she exclaimed that she can’t figure out what is wrong. This illustrates a lack of efficacy to perform caregiving abilities despite the infant’s cues.

For other women, helplessness was manifested as hypervigilance about stressful situations and high levels of anxiety. For example, some responses regarding caregiving and the
unborn child brought about feelings of a loss of control resulting in a state of hypervigilance.

Hypervigilance is an enhanced state of sensory sensitivity accompanied by an exaggerated intensity of behaviors whose purpose is to detect threats (such as those that 'activate' the caregiving system). Hypervigilance is also accompanied by a state of increased anxiety which can cause exhaustion. This renders individuals helplessly anxious, in regards to possible dangers and threats in caregiving situations.

Helplessness manifested as hypervigilance was coded as relevant text when words such as “scared,” “anxious,” or “nervous” were used frequently within a response regarding the mother’s feelings. Additionally, hypervigilance was coded when extreme words were used to describe feelings or behaviors in response to possibly threatening scenarios. Examples of this could include: hysterical crying, “flipping out,” or being “hyper.” Often women would remark that they would feel or behave in this manner in absolutes, such as “always” or “never.” Furthermore, hypervigilance was coded as broad generalizations about the world as an evil, dangerous, crazy, or scary place. This view of the broader world as a place of constant threats seemed to enhance mothers’ sensitivity to stress and increased general anxiety.

In the following examples, the mothers’ narratives are filled with illustrations of hypervigilant feelings in relation to pregnancy and in relation to the child once s/he is born.

Do you ever worry about your unborn baby? And what do you worry about?

I worry constantly. **laugh** like I am alw- like I am always cautious like nobody’s allowed to be within a few feet of me... And like, so like, beyond that like, any, just anything that happens I always like ... (1 second pause) ... I always like, think over things way too much and I analyze the situation I’m like, this could happen, like I could walk out the door and break my water, or like, I’m always scared I’m gonna slip on ice or
some dumb you know ...(1 second pause) ... I, I’m just like ...(1 second pause) ... I myself am aware of things that, probably don’t even (participant whispers) exist.... (later in the interview) I don’t know. I’m scared though. At the same time.... (1 second pause) ... because, we live in like a crazy world. And, sometimes they don’t even make it to be that old. Or sometimes things happen to them that are out of your control. They’re also like, crazy things going on right now, in the world... like, everybody’s dying and, kids getting’ shot and like it’s so sad... Like the world is so gross.

In this example, the mother expressed her feelings of worry and fear as an absolute and began to discuss various possibilities of frightening scenarios. Although quietly, she also noted that she is hyperaware, and might be paying attention to things that do not exist. Later in the interview, she described her view of the world as a dangerous place in which it is possible to die young. She seemed overwhelmed by the amount of danger and the horrifying circumstances that could befall her child. Further, she did not seem to have a strategy to cope with or combat the possible threats. The following mother expressed similar concerns about her child.

How about when your child becomes sick, like he or she gets a fever? What will you do at those times and what do you think your feelings will be like at those times? I’m always really worried, cuz you never know, you know? Like stuff could start out as a fever and you- (participant voice goes DOWN in PITCH) you die or something. I know that’s extreme, but you know what I mean... like, my kids don’t cry at night, I still don’t go back to sleep though, I just watch. Cuz, you know how you bring the baby home and they talk about SIDS and all that crazy. And you all like, watchin’ ‘em, and then, well I watch ‘em, and ... (2 second pause) ... so I know I’m not gonna get, you know, too much sleep.
Again, this mother explained constant worries and fears, and she was quick to transition from a typical aliment to death. Similar to the first example, she seemed aware of her hypervigilance when she mentioned the intensity and severity of her statement by referring to it as ‘extreme’. In addition, this mother explained that she alters her behavior, by staying awake to watch over her sleeping child, to attempt to quell her fears of infant disease or death. This example demonstrated elevated anxiety to the point of exhaustion. Although not as explicit as the first example of hypervigilance, this passage also demonstrated that the mother views the world as a place of various potential threats from which she attempts to protect her infant. Although she may try to (by constantly watching over her child), she cannot possibly attend to all of the potential threats to her infant’s health and well-being.

**Caregiving abdication**

Abdicating refers to an extreme withdrawal from the caregiving role (George & Solomon, 2008). Rather than identifying with the caregiving role, some women give up their role as provider of protection and care, which occurs for a variety of reasons. George and Solomon claim that abdicating mothers may feel totally incapable of providing protection and care to their child, which leaves them feeling helpless, dysregulated, and fearful (often unconsciously).

Abdicating shares many characteristics with helplessness; however, there is a key difference that possibly makes it more severe. Helplessness refers to the overall feeling of incapability, but typically comes with an effort to combat those feelings. Abdicating is the overall feeling of incapability accompanied by the need to remove oneself from the situation. Therefore, in their state of extreme helplessness, dysregulation, and fear, these mothers fail to assume the caregiving role.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

After the process of initial coding, further inspection of interview narratives revealed that women abdicate their role as caregiver in different ways. Some women showed abdication by acknowledging their relationship to their child, but failing to respond to any attachment behaviors emitted by the infant, while other women denied a relationship with their infant all together. Therefore, categories were created to help distinguish different ways that women abdicated their role as a caregiver.

Women who acknowledged a relationship with their infant, but failed to respond to attachment cues, tended to use words that implied child cues were meaningless, described the child’s cues as malicious or purposely irritating, or expressed beliefs that the infant was capable of developing and providing caregiving to him/herself. Consequently, when the child produces attachment cues, these mothers seemed to feel the need to physically and/or mentally separate (withdraw) herself from her infant.

The following excerpt illustrates abdicated caregiving despite acknowledging a relationship with the infant.

After your baby is born, what behavior in his or her first year of life do you think will be the most difficult for you to handle? And Can you give an example?

I don’t like crying...Like I (participant voice goes DOWN in PITCH) hate it. ... (2 second pause) ... with a passion. ... (1 second pause) ... but I know ... (1 second pause) ... under, like under 1 year old I’m gonna hear some crying ... (1 second pause) ... that baby cry ... I just hate crying I don’t know. Like she still whines, and it, oh my god, I have to like separate us, because I don’t wanna like, (participant voice goes UP in PITCH) oh my gosh, like go away. And I think she does it cuz she know I hate it. So... more. **laugh** ... (2 second pause) ... do it on purpose.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Mmhmm. Why do you think it will be difficult, and how often do you think it will occur? I don't like the crying if, you don't need anything you just wanna be, whiny. So...

(I second pause) ...hopefully she won't, cry too much...please don't cry for no reason.

This mother expressed her dislike of hearing the infant cry and that she would need to physically separate herself from the child. She further explained that she equates crying with whining, which is crying without a reason to cry. This woman also attributed malicious intent to the infant because she claimed that the infant would purposely whine in order to aggravate her. Although this mother said she has a relationship with her child, she viewed the child's cues as irrelevant and not her responsibility to attend to.

Another type of abdication is when women deny a relationship with their child. These women usually expressed that they considered terminating the pregnancy, but decided against it. Although these women did not terminate the pregnancy, they seemed to mentally terminate the relationship with the infant in order to abdicate their caregiving role. Relevant text was coded when women explicitly mentioned previous thoughts of abortion or a desire not to be pregnant. Additionally, relevant text was coded when the mother mentioned a complete disregard of the fetus as a infant or a complete disregard for a relationship to the child in utero.

In the passage below, for example, the mother described how she interprets her relationship (or lack thereof) with her infant.

How would you describe your relationship with your baby now, while your pregnant? Uhhh, we don't have one right now, I talk to him, he doesn't really react to me. Like he reacts to daddy so, we really don't have quite a rela... We really don't have a relationship right now but it definitely change once he, once he get here. (Later in the interview) Mhmm can you think of any experiences you've had during your
pregnancy that might have been a set back for your baby? Me thinkin of abortin, that was a set back cause, he felt the emotion, he probably heard the emotion also, cause people, cause ya know the circumstances saying their baby really can’t hear you till the third, second or third trimester, I don’t believe that, if he can’t hear you he can definitely feel that bad vibe and emotion.

This mother explained that she does not feel as though she has any relationship with her infant at the moment. It is interesting to note that she stated that her infant reacts to the father and not her while she explained the absence of her relationship to the infant. However, she assumes that she will have a relationship with the infant once s/he is born. She also explained that her thoughts and feelings about abortion may have negatively impacted her relationship to her infant. She seemed to be somewhat aware of the transactional relationship that she has with her infant in utero, but paradoxically, denied the relationship. Finally, the passage below demonstrates a mother who acknowledged being able to have a relationship once the infant is born, but doesn’t seem to acknowledge a relationship during pregnancy.

How would you describe your relationship with your baby now, while you’re pregnant? … (6 second pause) … we’re fine, like …(3 second pause) … it’s still not like, she’s a baby yet, until she comes out …(2 second pause) … like I talk to her and stuff but …(3 second pause) … have to like physically, you know, like … (1 second pause)… hold it, in my hand. S’know I’m holding in my belly but … (3 second pause)

In this passage, the mother described her child as “it” and did not seem to accept that the child she is carrying is an infant until she can physically hold and see the infant. The mother seems to remove herself from any responsibility to provide care and protection during pregnancy because she denied that there is any need for such caregiving behaviors until the infant is born.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Rigid Attitudes and Beliefs about Gender Roles

After the initial coding, another theme emerged regarding attitudes and beliefs about gender roles. Specifically, it was noted that the sex of the child, and the gender roles that typically accompany each sex, seemed to be really important and meaningful, even when the interview question did not specifically ask about the sex or gender of the infant. Upon further readings, it became clear that women had very strong preferences for one sex or the other, which may inform, or be a result of, rigid beliefs and expectations for each sex as defined by gender roles. Explicit preferences were noted by words that indicate strong desire: hope, want; prefer, and excited. One mother, who did not yet know the sex of the child, expressed her implicit preference for a boy by stating her fear of having a girl.

Of the 10 women in the current study, 5 had a strong preference for a boy, 4 had a strong preference for a girl, and 1 did not indicate a strong preference for either sex. Based on an interview question that asks about the sex of the infant, it was expected that 4 were having a boy, 4 were having a girl, and 2 did not know the sex of their child. When comparing the preferred sex to the expected sex, 6 women’s preferences were not consistent with the expected sex of the child (see Table 1). Similar to other themes, categories began to emerge that helped explain the various reasons for strong preferences of sex, as well as rigid beliefs about gender roles; these categories included economic hardship and projection of self and partner.

Table 1 Gender Preference and Expectations

<table>
<thead>
<tr>
<th>Subject</th>
<th>Preferred Sex</th>
<th>Expected Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Girl</td>
<td>Boy</td>
</tr>
<tr>
<td>2</td>
<td>Boy</td>
<td>N/A</td>
</tr>
</tbody>
</table>
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

<table>
<thead>
<tr>
<th></th>
<th>Boy</th>
<th>Girl</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Boy</td>
<td>Girl</td>
</tr>
<tr>
<td>4</td>
<td>Boy</td>
<td>Girl</td>
</tr>
<tr>
<td>5</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>Girl</td>
<td>Girl</td>
</tr>
<tr>
<td>7</td>
<td>Boy</td>
<td>Boy</td>
</tr>
<tr>
<td>8</td>
<td>Boy</td>
<td>Girl</td>
</tr>
<tr>
<td>9</td>
<td>Girl</td>
<td>Boy</td>
</tr>
<tr>
<td>10</td>
<td>Girl</td>
<td>Boy</td>
</tr>
</tbody>
</table>

*Note: N/A indicates that the woman did not find out the infant’s sex in utero*

For some women, the strong preference for one sex over the other seemed to stem from concerns about economic stability to care for the new child. This was a relevant concern for many of the women who knew the sex of their child in utero (based on ultrasound). Additionally, preference based on economic stability was usually revealed from mothers with previous children who had hoped to have another child of the same gender. Relevant text was coded when words such as “buy,” “purchase,” or any words to indicate the use of “hand-me-down” items were present.

For instance, the following excerpt is from a mother who explained that she has been having a difficult time emotionally during pregnancy because she is in denial that she is having a boy.

*What about if it is a girl? What do you think your reaction will be?*

(participant voice gets LOUDER) *YAY! I don’t have to buy that many more clothes! um, ... (1 second pause) ... Wow! I may not have to move because I’m*
already in a two bedroom and I have two girls and all their toys can go down to
the little girl, and, um all their snowsuits and things can go down you know...

This mother explained the economic benefits to having another girl. She displayed a
strong preference for a girl because she would be able to continue to afford her place of
residence and she would not have to purchase new clothes or new toys in order to support her
child. Although there were other coded references for this category among participant interviews,
this was the most notable example. This mother explicitly mentioned that the money that will not
be spent purchasing new items for the child will impact other economic resources to provide care
(such as housing) for the child. See the Appendix for other examples of strong preference for sex
based on economic stability.

Although some interview questions explicitly ask feelings regarding child sex or gender,
there were many instances that mothers spontaneously incorporated their strong and/or rigid
beliefs about gender roles into their responses. Women’s rigid beliefs about gender roles
manifested differently, however. Consequently, the categories, ‘perceived temperament’,
‘sensitive/insensitive caregiving’, and ‘participation in gendered activities’ were created to help
better characterize this theme.

Perceived temperament is the perceived personality characteristics that are believed to be
innate to each individual, and in this context, was in reference to infant gender. Responses were
considered relevant text when the word “boy” or “girl” was explicitly stated in addition to words
that describe personality characteristics (such as “bratty,” “sneaky,” etc.).

The following passage depicts the way in which one mother perceived the temperament
of her unborn daughter.

After your baby is born, what behavior in his or her first year of life do you think
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

will be most difficult for you to handle, and can you give an example?

Um... (3 second pause) ... if, if, (2 second pause) ... if she starts acting like a bratty little girl. Um *laugh* I, I don’t know it’ll it’ll just, it’ll just be hard. This whole girl thing is just, hard. **laugh** ... (3 second pause) ... so. Just... (1 second pause) ... You know like if she’s whining... (2 second pause) ... (later in the interview) it’s just, it’s the whole girl thing, it’s just difficult to... (1 second pause) ... just difficult to imagine because I didn’t really think that mattered if it was a girl or a boy but when I found out, it did.

**laugh** so... (3 second pause) ... (later in the interview) And why do you think he or she will act like that? Um, ... (1 second pause) ... well... I don’t know, girls now a days, act, awful **laugh** they don’t act like they used to.

What do you imagine will happen to this behavior as your child grows older and why do you think so? Um, hopefully it’ll stop, but, probably not ...

This mother explained her belief that girls are bratty and whiny and how that has influenced her experience during pregnancy and her perceptions of what it will be like to care for her daughter once she is born. She stated that she perceives all girls to act in a certain (rather negative) way and that the behavior would not likely change even when the child grows older.

Another way in which strong attitudes about gender were displayed was through descriptions of sensitive and insensitive caregiving behaviors. Ainsworth defined sensitive caregiving as the ability to be aware of and respond to the child’s needs in a way that is timely, meaningful, and accurate to the emotion (Ainsworth et al., 1978). Therefore, insensitive caregiving is defined as the inability to be aware of and respond to the child’s needs appropriately.

The example below illustrates one mother’s insensitive caregiving toward her son and
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

how this seemed to be informed by her inflexible attitudes about boys in general.

What will you feel like doing when your child behaves like that? How will you feel if your child acts this way? And what will you do about the behavior?

I am a very trained person on getting em to understand that the corner wise. I, I am a very corner person. My children hate it but I love it **laughs**... And my other son if I tell him to the corner automatically he’s screaming and crying. Soon as I say okay that’s it I’ve had it, youuu’ve had your warnings, I’m done, corner, and when I say tha he breaks down... so that’s his form of punishment right now so, I’m a corner person and I like to threaten them with daddy too. I threaten em with telling daddy and once I say daddy they kinda straighten up **voice PITCH goes UP** they threaten each other with daddy too!

Okay, (child’s name) I’m telling daddy! Ya know? **voice PITCH returns to NORMAL**... So, uhm daddy and corner is the, is the disciplinarians. **laughs**...(later in the interview in reference to her daughter) So, she’s the baby, she’s tryin’ to discover everything right now so I really don’t discipline her so...

In this passage, the mother described how she disciplines her previous children. She stated that she uses a corner “time-out” as punishment and uses the children’s dad to invoke fear. It is notable that the mother mentioned that she only uses these harsh disciplinary techniques on her son, but not with her daughter.

Rigid beliefs about gender roles seem to manifest in regards to participation in gendered activities as well. In these passages, relevant text was coded when the child’s sex was mentioned and paired with an activity or personality trait that is stereotypically defined as either masculine or feminine.

Mhmm...(3 second pause)...Uhm, who do you think your baby will be most like?
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Uhm, well I wanna say me but **laughs** I, I think he’ll be more like his dad, uhm, well at first I think he’ll be like me but once he starts to get older I think he’ll be more like his dad. Mhmm. I think so, cause I guess ya know my luck, they first start out like me and look like me and then they turn into their dad **laughs** **laughs** So, I think so.

And, what traits will your child inherit from the baby’s father?

Uhm, his uh, coordination **laughs** Mhmm. And uh, his probably his like ath...ya know his athletic type, things and uhm, his ability to like fix things like take things apart and more ya know use of his hands.

Mhmm... (2 second pause)...Do you expect that to change as the child gets older for instance? How do you expect it to change?

I think so, uhm, I think it’ll change ya know he’ll be close to me but then once he gets older and actually be able to do things I think he’ll be kinda closer to his dad cause his dad will be able to ya know take him out fishing or work in the garage or ya know show him things in the yard or on the car so I think he may ya know change in that way, verses ya know it’s like cause I mean mommy likes to fish but uh, mommy don’t do well with worms and dad does so, I think he’ll kinda have that little bonding there. (later in the interview when asked about adolescence) ... (2 second pause)...that way he’ll ya know, it’s like okay well if I ya know get involved in sports or something like that my ya know parents come to my games ya know that’ll make him feel good about themselves... Or how, ya know people around him will ya know, if you wanna fit in or if you wanna hang ya know with our group you have to do that sorta thing and uhm, its just ya know we have to stay firm and teach him that ya know you don’t if someone’s pressuring you than obviously they’re not your friend, you don’t wanna be a follower, you wanna be a leader.
And, uhm, if you lead, and you set a good example, then others will follow you.

In this example, the mother consistently mentioned the similarities that her unborn son would have to the father based on stereotypically gendered traits and activities. She mentioned that her son would possess many similar traits to the child’s father, such as athleticism, coordination, and leadership skills. Additionally, she mentioned that the child and the father would have a closer relationship based on their ability and penchant for similar activities (sports, fishing, tinkering with things, and working on cars); further, all the activities she mentioned are stereotypically masculine activities.

Incoherent, mixed Themes

The themes and sub-categories mentioned above were not the only themes that emerged, but they were the most prevalent ones. Although the previous examples are presented as separate, these interview characteristics are not mutually exclusive. In fact, there were many responses that included the themes mentioned above in complex ways. Such passages were identified as relevant when there were multiple types of relevant text which made it hard to fit examples into just one of the themes. Therefore, if two or more themes were present in one response, the response was coded as ‘incoherent, mixed themes’. Below are a few notable examples that illustrate mixed themes.

In the following passage, a mother described how often she thinks her infant will be upset within the first 12 months and what her feelings will be at those times:

Well like, I realize that like, honestly like all kids, like all kids get upset, that’s just how it is, like, you know, they can’t talk, so of course they’re upset they’re like trying to say something to you, and it’s like, so of course they’re getting angry about it. And so like, ...(1 second pause) ... you know, the- I, I have to admit there is like, there’s been some
times with my first son where I like, he'd be screaming for no reason at all, ...(1 second 
pause) ... and I just put him like, I'd be like sitting right next to him and I'd put on like 
metal music and turn it up really loud. And he either does one of two things, he either 
tries to scream over it, or he stops. **laughing a bit** so like you know he either stops 
screaming or passes out because that's what he needed to do anyway **laugh** you 
know, so ... (1 second pause) ... um ... (1 second pause)... you know I'll just...(1 
second pause) ... do what I can to makes sure that it has, that he has all his needs, and, 
you know, if there's nothing else then I guess ...

This passage demonstrates several themes: helplessness, abdicating the caregiving role, 
and possibly even rigid beliefs about gender roles. The mother described how her child cries to 
signify a need or frustration, and in her state of helplessness to comfort the child, her strategy to 
respond is to turn music on to drown out the infant's cries. She also mentioned that his behavior 
(screaming and crying to the point of unconsciousness) is her perception of meeting the child's 
needs because it is “what he needed to do.” This signifies her extreme level of helplessness. 
Although she is not physically abdicating the caregiving role, she is mentally and emotionally 
abdicating the caregiving role. Additionally, the mother described the child’s behaviors and 
emotions in a way that is consistent with possible stereotypes of masculine frustration 
(frustration leads to anger, which results in the behavior of screaming). Therefore, various 
themes are intertwined within this one interview response.

The following is another example of a single response in which several themes were 
integrated and related to one another. This mother explained what she believes it would be like 
for her infant if she were to be separated from him/her.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Um, ...(1 second pause)... I'm sorta spoiled to my kids, too, so when they're not around, um, like in there when I'm at work like for example tonight when I go to work, ...(1 second pause)... **sigh** (participant voice goes DOWN in PITCH) oh god **sigh** i-I'm so used to bein' around 'em that, when they're not here like when they spend the night at grandmas, or you know if they're at a birthday party, I'm like man it's quiet here...Um, so, when I'm not around 'em I'm like man what are they doin' you know? ...(1 second pause)...now as far as for him, I believe he's gonna be a (Participant voice goes UP in PITCH) spoiled little boy so it might be hard, I think that uh, I think that he's (participant voice gets LOUDER and DOWN in PITCH) gonna be a crybaby. I mean I hate to say it because they're cry babies, you know, and it's like you know they have a close bond with me.

In this passage, the mother explained her hypervigilant state of helplessness when she was separated from her other children. She stated that she wants to know where her children are at all times and what they are doing at all times. In this case, she did not overtly express the fear of an impending danger, but it is implied from the passage. Further, the mother explained her rigid beliefs about her child's gender role. She described that her son would be spoiled and he will be a "crybaby" when separated from her, which was clearly unacceptable to her. She also implied that his "crybaby" trait is part of being a "spoiled little boy."

Overall, the themes of helplessness, abdication of caregiving, and rigid attitudes and beliefs about gender roles were notably present in the 10 narratives from the prenatal interviews. These themes also contained sub-categories (or types) that further delineated the ways in which the themes were present throughout the narratives. Further, these themes were observed to be interwoven into one response for many women, which illustrated a more complex representation
Discussion

Throughout the attachment and parenting literature, there has been little focus on the influence of IPV on the caregiving system. Some studies have used a qualitative approach to understand the relationship between experiences of IPV and the caregiving system (Levendosky et al., 2011; Schechter et al., 2003), but the vast majority have been quantitative studies. Therefore, this study sought to better understand the influence that experiences of severe psychological IPV or any severity of physical or sexual IPV may have on a mother’s caregiving system at the representational level during pregnancy. Caregiving representation themes were coded (helplessness, caregiving abdication, rigid attitudes and beliefs about gender roles, and incoherent, mixed themes) from the WMCI, which was administered during pregnancy. Results from this qualitative thematic analysis are anticipated to further contribute to the literature on how experiences of IPV may influence the caregiving system. The results from the current study are also expected to stimulate more research on IPV and the caregiving system using a qualitative approach.

Findings Regarding the Theme of Helplessness

Maternal helplessness was identified in many of the participants’ narratives. The mothers’ experiences of IPV may be a contributing factor to the helplessness felt surrounding caregiving, for instance, due to attributed genetic predispositions. The first example demonstrated maternal feelings of helplessness surrounding the child’s behavior in particular. It was noted that helplessness emerged only when concerning possible paternal traits in this example, but was typically not present when considering maternal traits. If the perpetrator’s violent behavior is attributed to biological characteristics, then the mother’s representations of
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

her child may reveal beliefs about the child having biologically-determined behaviors. The second example of helplessness rooted in biological predispositions demonstrated helplessness regarding maternal behaviors and feelings. The mother's view of her own behaviors as involuntary due to biological factors also demonstrates passive helplessness. In both examples, the mother is not engaging in what Stern’s (1995) bidirectional model of influence suggests. More specifically, these examples show that each woman proposes that her actions will have no influence on the infant's actions, and she fails to connect either her representations or the infant’s representations to the actions of the infant. As a result, after birth, both the mother and the child are likely to become dysregulated at the behavioral and representational levels.

Conversely, in the examples of helplessness rooted in inadequacy, mothers seem to make connections between her representations and behaviors and the infant's feelings and behaviors, which is consistent with Stern’s bidirectional model of influence. However, the examples of helplessness rooted in inadequacy reveal a tendency to slip into second person within the response. The use of second person might be an attempt to create distance from feelings of helplessness. One possibility is that feelings of extremely low self-efficacy might be due to mothers’ adverse experiences of IPV, which can negatively affect the mother-child relationship, a similar conclusion of previous research (Huth-Bocks et al., 2004).

For representations with examples of hypervigilant helplessness, there seems to be no effective organizational strategy to deal with the fear and anxiety that accompany helplessness. The mother’s hyperarousal and fear may leave her dysregulated and without an organizational strategy to respond to stressors and threats. Consequently, the mother may be easily overwhelmed by cues from the infant, from her own physiological responses, and from the surrounding environment. As stated in the review of the literature, increased arousal is a
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

symptom of PTSD (American Psychiatric Association, 2013). It seems possible that the intensity and pervasiveness of hypervigilance within maternal representations comes from the interpersonal trauma (IPV) that the mother has experienced. Furthermore, IPV may unconsciously trigger fears associated with threats to physical and psychological safety. Thus, representations of impending and uncontrollable dangers of interpersonal violence may generalize to uncontrollable dangers of the world, leaving the mother helpless and overwhelmed by the caregiving role. This is consistent with and supports previous findings by Levendosky and colleagues (2011). Therefore, it is possible that the state of hypervigilant helplessness leaves the mother in a state of ‘disabled caregiving’.

Findings Regarding Themes from Abdicated Caregiving

Abdicating the caregiving role was displayed in two ways throughout women’s narratives in the present study: acknowledging a relationship to the child, but failing to respond to the child’s caregiving cues, or a denial of any relationship with the child. Some narratives acknowledged a relationship to the child, but revealed abdicated caregiving by physical or psychological separation and withdrawal from the child despite attachment cues. This is also consistent with extreme maternal passivity noted in a previously mentioned study (Sokolowski et al., 2007). Being passive is the act of submitting with no resistance and/or not participating willingly or actively. One possible explanation is that women who have experienced IPV have experienced violence that is perpetrated by an individual who was supposed to respond appropriately to attachment needs, but failed to do so. As a result, women who have experienced IPV have not had a model, or do not have a romantic relationship script, of what it looks like to have attachment needs met or to appropriately meet the needs of others in a close, interpersonal
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

relationship. One possibility is that without such a script, there is no strategy of the way in which to respond; therefore, some women abdicate their role as caregiver.

The women whose narratives illustrated a denial of any relationship to the child usually expressed having considered an abortion. While these women chose not to physically abort the child, they seem to have psychologically aborted or abdicated their role as caregiver. These women may feel incapable of providing protection and care, which leaves them feeling helpless, dysregulated, and fearful (George & Solomon, 2008). Interestingly, it appears that some mothers are aware of the influence that their absence (as caregiver) will have on their relationship with their child, but they are unable to change their thoughts, feelings, or behaviors, in order to have a more positive influence on their child. One possible explanation for this type of abdication is that the mother does not want to acknowledge a relationship with the child, in fear that this relationship will share similar characteristics to her relationship with her abuser.

Findings Regarding Themes from Rigid Attitudes and Beliefs about Gender Roles

The maternal narratives revealed a large amount of concern regarding the sex of the child due to apparently rigid attitudes and beliefs concerning gender roles. Most participants expressed a preferred sex, and over half were expected (due to results from ultrasounds) to have the opposite sex than their preferred sex. Possibly due to this discrepancy, strong and rigid beliefs were expressed throughout the interview responses.

Social factors, such as gender roles and expectations surrounding infant items (clothing, toys, etc.), give an economic advantage to women raising children who are all girls or all boys and place an economic strain on women raising children of opposite sex. In the example that illustrates strong preferences due to economic resources, the mother described the possibility of moving in order to afford gendered, socially-appropriate clothing and toys to the new child. The
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

strong preference for one sex due to perceived economic (in)stability is consistent with findings of a previous study which found that violence-exposed mothers who went from 'balanced' to 'non-balanced' representations over time generally had less economic stability (Theran et al., 2005).

For some women, a rigid and inflexible attitude regarding the perceived temperament and expectations about gendered activities was evident. This is comparable to results from a previous study that stated that women who experienced IPV during pregnancy had less flexibility or openness to change regarding how they believed their child would be (Huth-Bocks et al., 2004). Huth-Bocks and colleagues did not quantitatively highlight gender as a primary correlate of inflexibility; however, the current qualitative study seems to illustrate that a component of inflexibility is centered around beliefs about gender roles. One possibility is that the women's feelings or beliefs about IPV experiences may be projected onto her child and generalized to character and temperament of the sexes. In other words, women who have experienced IPV perpetrated by a male partner may be more likely to view gender roles as more distinct and more tied to traditional masculine and feminine roles (e.g., power versus submission). Future research should further explore the relationship between inflexibility, specifically regarding gender roles, in the context of IPV.

The final finding from the theme 'rigid attitudes and beliefs about gender roles' is how attitudes and beliefs related to sensitivity (or insensitivity) of maternal caregiving behaviors. From previous research, it is known that women who experience IPV during pregnancy have representations marked by less sensitivity (Huth-Bocks et al., 2004). The current qualitative study theorizes that representations that have strong negative beliefs about the expected gender
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

of the child, believed to be possibly influenced by IPV experiences, are generally marked by insensitive caregiving responses.

Findings Regarding Themes from Incoherent, mixed Themes

The examples that are used to illustrate mixed themes indicate that themes of helplessness, caregiving abdication, and rigid beliefs are often not mutually exclusive. For example, the passage in which the mother explains that she turns up music and her son screams over it until he stops crying because “that’s what he needed to do” illustrates that helplessness and rigid beliefs about gender possibly are inter-related. Perhaps a woman’s sense of helplessness is due to rigid beliefs about one particular gender, and when the child behaves inconsistently with those beliefs, the mother does not know how to respond to the inconsistency, which results in helplessness. Alternatively, through past experiences of IPV, women may have learned that they are helpless to control the thoughts, feelings, and behaviors of another person, in this case the male perpetrator. Further, based on positive or negative attributions given to males and females, women may determine that sensitive or insensitive caregiving behaviors are the appropriate way to respond to each gender respectively. For example, based on previous IPV experiences, a woman might determine that men need to be aggressive (by screaming in the example previously mentioned) in order to display their frustration and meet their need to express their feelings. Also, based on previous IPV experiences, a woman might determine that women should let boys/men get their anger out by screaming while the girl/woman passively ignores the violent behaviors associated with male emotions.

Strengths and Limitations

This study had several strengths which give it merit. One major strength of the study was its qualitative approach. Using a qualitative approach allows for the data to be presented in the
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

participant's own words. This is helpful when describing complex phenomena such as caregiving abdication. A qualitative approach allows the researcher to use pre-established theory to generate a tentative explanatory theory for complex phenomena. This tentative explanatory theory may inform future qualitative or quantitative research. Another strength of the study was that this sample was racially diverse with a variety of IPV levels and experiences. With 40% of the sample being African American and 90% being unmarried, this study was able to examine a racially diverse and high-risk sample, which is generally not well-represented in research.

Although there were strengths of this study, there were also limitations. One limitation is the sample size for the current study. The small sample size may limit the findings to this sub-sample and, thus, not generalize to other groups. A larger sample size would have allowed for the possibility of more themes to emerge or to strengthen support for themes found within the 10 participants' narratives. Further, because of the qualitative approach, the findings may be more easily influenced by this investigator's personal biases despite efforts to remain neutral and unbiased. Future research should include a qualitative approach with a larger sample size to gain the most generalizable knowledge about the associations between IPV and the caregiving system. Finally, the current study looked at psychological, physical, and verbal IPV together without separating them. Therefore, future studies should look more closely at themes related to specific types of IPV.

Summary and Conclusion

Overall, there is a clear need for more research to be conducted using both qualitative and quantitative approaches to study the associations between the caregiving system and IPV. Findings of the current study are largely consistent with previous studies, which suggest that helplessness and abdicating are prevalent among mothers who have experienced IPV.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Importantly, the present study found this to be true even before the infant was born. Furthermore, the current study speculated about possible sub-categories within helplessness and caregiving abdication, as well as identified a new theme surrounding rigid beliefs about gender roles not previously described in prior studies. While this study had many strengths, the limitations must be taken into account to help inform future research studies. An important next step for future research studies would be to conduct qualitative thematic analysis with a larger sample. Larger sample sizes would allow for findings to be more generalizable and may yield more insight into possible sub-categories or distinctions within broader themes. In addition, future research should aim to qualitatively study maternal caregiving themes at multiple time points, e.g., prenatal to postpartum time periods. Longitudinal research could explore the consistency or inconsistency of themes over time, as well as themes that emerge once the infant is born. Finally, another objective for future research is to study racially diverse samples that are of high economic risk. Samples that include racially diverse and economically low-income groups are often harder to contact and more difficult to keep in longitudinal studies. However, researchers need to include these typically underrepresented groups so that results represent their experiences and guide future research and new types of thinking. Ultimately, results from this study and future studies should help inform interventions for women experiencing IPV as they prepare to become mothers and begin to form a new relationship with their infant during and after pregnancy.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

Appendix

Helplessness

1. Mmhmm. Ok. What about when he becomes sick, like when he gets a fever.

Ooh. What will you do at those times and how do you think your feelings will be at those times? Panic. I panic. I panic fever, ... (1 second pause) ... anything that relates to the doctor or ER, or, the baby’s not drinking milk, I panic. I flip out. Um ... (1 second pause) ... I don’t care if it’s in the middle of the night, snow blizzard, we’re going. You know

2. How old do you think your baby will be when he or she sits up? ... (3 second pause) ...

well, like, it’s hard for me to say all those kinds of, like, all of these questions, because my first son was so big that like, he just kinda like, naturally did things on his own, you know what I mean? Mmhmm. Like he naturally did like, things earlier or whatever than most kids. So, I don’t know. I don’t really ... (2 second pause) ... um, and like he also went to daycare so like all the kids there kinda helped him, like, you know what I mean?

3. I hope that, like I said I hope that he like gives me a chance ... (1 second pause) ... you know.

I don’t know ho- but like I said if, you know, things are hereditary, it’s probably gonna happen (participant voice gets SOFTER) always. **laugh** ... (3 second pause) ...

4. Ok, pick five words or adjectives to describe your relationship, and for each word describe and incident or memory that describes what you mean. Uh ... (1 second pause) ... I don’t know... (1 second pause) ... I don’t know how to. Really. Like I know we have a, like,
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

it’s obvious you have a relationship with something that’s growing inside you or whatever, so you like coincidence? but ...(1 second pause) ... mmm mmm noise indicating ‘I don’t know’ ...(1 second pause) ... Ok. It’s a hard question.

5. Like I’m scared, like, I don’t know. There’s like, I’m not, like, ... (2 second pause) ... it’s n-this is, this is just like, all, the whole pregnancy has just been like, ...(1 second pause) ... you know whatever happens happens. so I li- I guess I wish ... (2 second pause) ... I wish I was a little more intuitive with him. Than, you know what I mean?

6. Um ... (5 second pause) ... well... (3 second pause) ... I think like if I didn’t acknowledge that he was there, that that could possibly like cause some ... (1 second pause) ... something you know later on, like, you know what I mean? If I was just like oh this is just a baby it doesn’t matter like it doesn’t know anything? Until it comes out, like ... (2 second pause) ... I ?don’t know? **laugh** I think that could cause a problem like, some separation things kinda late on in life or something. Mmhmm ... (5 second pause) ... I don’t know how to answer some of your questions, to be honest with you **laugh**

7. ?you know? Like, they just, they’re like closer to their mom no matter what, even like, even if you take a kid’s mom away like, that kid will like, want and need their mother, so

8. Mmhmm. Do you think your baby will get upset often in his or her first 12 months? And what will you do at those times, and what do you think your feelings will be like at those times? Well like, I realize that like, honestly like all kids, like all kids get upset, that’s just how it
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

is, like, you know, they can't talk, so of course they're upset they're like trying to say something to you, and it's like so of course they're getting angry about it. And so like, ... (1 second pause) ... you know, the- I, I have to admit there is like, there's been some times with my first son. I do a lot of like awkward things to not be angry. But like your hormones are crazy and, I don't know, things happen.

9. Mmkay. ... (2 second pause) ... um ... (2 second pause) ... do you ever worry about your unborn baby? And what do you worry about? I worry constantly. **laugh** like I am always cautious like nobody's allowed to be within a few feet of me. Another thing that's really weird is no one, I don't like people (participant voice gets SOFTER) touching me. Like I always hug my friends and stuff when they come in and leave or whatever, and like if they're sad or something, but, like I have this thing like I don't like people (participant whispers) touching me. And like, so like, beyond that like, any, just anything that happens I always like ... (1 second pause) ... I always like, think over things way too much and I analyze the situation I'm like, this could happen, like I could walk out the door and break my water, or like, I'm always scared I'm gonna slip on ice or some dumb you know ... (1 second pause) ... Mmhmm. I, I'm just like ... (1 second pause) ... I myself am aware of things that, probably don't even (participant whispers) exist. Like you know like I'm scared of the ... (1 second pause) ... I don't know. That's about how I think I'll answer your question **laugh**

10. I don't know. I'm scared. Though. At the same time. ... (1 second pause) ... because, we live in like a crazy world. And, sometimes they don't even make it to be that old. Or sometimes things happen to them that are out of your control. They're also like, crazy things going on right
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

now, in the world that like, people say we might not even live that long you know? So sometimes I worry that like I won’t be able to, and I want to get old. ..?eh? like a like you know like I’m pr-like ...(1 second pause) ... I don’t know. I I’m kinda excited so I hope that I get to be that. you know ... (1 second pause) ... I hope I get to see him. ... (2 second pause) ... and ...(1 second pause) ...

11. Has your relationship with your baby changed during the pregnancy, in what ways, and what is your feeling about the change? ... (2 second pause) ... mm ...(2 second pause) ... I wasn’t sure in the beginning, cuz of everything that was happening, like I said, my, my grandma died, I wasn’t pregnant then though, so my grandma had died and then like 4 weeks later, my brother was killed, s’like I was just like ... (1 second pause) ... (participant voice goes UP In PITCH) what else! Goodness! Like ... (1 second pause) ... just the wors-like, (participant voice goes UP in PITCH) am I bout to die like is, felt like u- the longest time I was gonna die for some reason, I don’t know why, probably cuz I experienced it like, back to back you know? ... (1 second pause) ... and I just like **sigh** ... (1 second pause) ... **sigh** like, what else? My toe gonna fall- like, I just knew it was gonna be something else was gonna happen. So at first it was just like, whatever, and I knew that I didn’t wanna like, get rid of it ... (1 second pause) ... but, it wasn’t like, (participant voice goes UP in PITCH) oh! I’m pregnant! You know like, so I kinda felt sad a little bit becuase I wanted, cuz I know? this is? Gonna be my last baby. And I wanted like, my last pregnancy to be all happy and, you know, since I was like angry with her, and then like, the first one I was just like whatever, you know, so, kinda feel bad that, I wasn’t all like (participant voice goes UP in PITCH) woo I’m pregnant! You know? Cuz It was just so much going on that ... (1 second pause) ... everything else was like so much bigger than, ... (1
second pause) ... I figured she’d be ok by the time I had her. She had time to like, you know, chill out in there and, wait for me to come around? unintelligible? so ... (6 second pause)...

12. How about when your child becomes sick, like he or she gets a fever? What will you do at those times and what do you think your feelings will be like at those times? I’m always really worried, cuz you never know, you know? Like stuff could start out as a fever and you— (participant voice goes DOWN in PITCH) you die or something. I know that’s extreme, but you know what I mean, Yea

13. If your child could be any age right now, unborn, one month, one year, anything, what age would you choose and why? newborn so I wouldn’t be pregnant anymore **laugh** ... (1 second pause) ... I’m just so tired. ... (3 second pause) ... I just ... (1 second pause) ... I’m just so tired of being pregnant. ... (2 second pause) ... can’t even sleep good, so irritating. I know when I have her, I’m not gonna sleep, cuz I’m gonna be watching over her, like, my kids don’t cry at night, I still don’t go back to sleep though, I just watch. Cuz, you know how you? bring the baby home and they talk about SIDS and all that crazy? boo haha? And you all like, watchin’ ‘em, and then, well I watch ‘em, and ... (2 second pause) ... so I know I’m not gonna get, you know, too much sleep, and then I’m gonna have to like ... (2 second pause) ... still mother my other 2 children, so I know it’s not gonna all like, oh me and baby’ll just sleep all day. So. I just want- wish I could just like, sleep. ... (1 second pause) ... all the way through. and not watch so many informercials. ... I ... **laugh** and wake up? still? tired. ... (2 second pause)...

14. ... I don’t know I just ... (1 second pause) ... the world’s so jacked up and, everything so
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

crazy and, so many things can influence people, I just hope that, like, I don’t lose a child early or ... (1 second pause) ... like that scares me a lot. Just because like my brother, he was like, 2 years older than me. So like, ... (1 second pause) ... and then like my little brother, he’s ... (1 second pause) ... in jail and **Groan** so just like, I just hope, that ... (1 second pause) ... ?cuz I know? If anything, you know, bad was to happen or something I don’t know if I could take it. So I just pray that they ... (4 second pause) ... kinda shelter them, and I know that’s not good either, cuz then when they get to the real world it’s gonna like shock ‘em, but ... (2 second pause) ... like seein’ the stuff that goes on now, like, everybody’s dying and, kids getting’ shot ?an? like it’s so sad. I just hope to god that... (1 second pause) ... nothing ...(1 second pause) ... bad happen an, kids getting arrested and s-**ugh** it’s just, gross. Like the world is so gross. So I just hope that ... (4 second pause) ... we can all be old together. ... (1 second pause) ... Type thing. Like I wanna be a gramma. And ... (1 second pause) ... I want them to all be old, I don’t wanna ...(1 second pause)... have to deal with ... (2 second pause)... craziness.

So. I know I will though, I just know it’s, something’s gonna happen, you know like, nobody’s life goes by with nothing, you know, but I just, pray that it’s not nothing, horrible.

15. And what makes you say easy-going? ... (2 second pause) ... once again the third child ?would? just have to be she’s gonna have to be laid back and go with the flow of things and... (2 second pause) ... try to ?do? his or her best to ... (2 second pause) ... to make it through the .... (2 second pause) ... ?some things? ...(2 second pause) ...

16. one of us is gonna have two and if they’re all sick then one of us is just gonna have the one to take care of but, you feel for em, it’s sad and when they’re sick, they just look at you to take care
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

of it and you’re doing the best you can but you can’t like snap your fingers and take it away.

I ??? I have, that’s why it’s so difficult, is, you feel for em and you’re tryin to take care of it and they want you to, there’s only so much you can do. Mhmm. So I’d say that’s the most difficult, not actually taking care of them, I can get somewhat use to that.

17. is hard to do when you’re dealing with a crying baby, if it’s sick, you’re just wanting to help em, but you **laughs** can’t figure out what’s wrong of why they’re sick but yeah, definitely think the baby will feel it.

18. Mmhmm ... (4 second pause) ... After your baby is born, what behavior in his or her first year of life do you think will be the most difficult for you to handle? Can you give an example? Like ... (3 second pause) ... potty training maybe? Ok That and maybe ... (2 second pause) ... disciplining although I don’t think I’m gonna be able to do that either **laugh**

19. He just, just like wearing me out at night**laughs** **laughs** So he’s probly gonna do that when he gets here.

20. That’s just something that the trait that his father has and I know definitely he’s gonna have that.

21. Mhmm. What about when your child becomes physically hurt a little bit such as hitting his or her head against the crib? What will you do at those times? And what do you think your feelings will be at those times? Oh I gonna cry**laughs** I’m gonna get really emotional
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

then, like, my worst fear is, is seeing someone hurt and it's like I'm, I got my medical assistant (unintelligible?) so I kinda know what to do but I'm be hyper and hysterical and crying and like oh my kid he just hit his head, especially if there's blood involved, then I'm really rush him to the hospital, prolly for nothin' **laughs**

22. so, I think I'm gonna have some help with going to the potty from my friends and my daughter she needs, at one she was completely potty trained, I didn't even have to try ... (tape skipped unintelligible?) ...oh that's what you do and she did it and I didn't have to buy no more diapers or anything so, that's one thing, **laughs* 

Abdicating

1. Mix the formula in the nursery water shake it up boil it, ... (1 second pause) ... rather than pump it, then, it just seems like it's too much for me.

2. How old do you think your baby will be when he or she sits up? ... (3 second pause) ... well, like, it's hard for me to say all those kinds of, like, all of these questions, because my first son was so big that like, he just kinda like, naturally did things on his own, you know what I mean?

3. um ... (4 second pause) ... I'm kinda worried about, about him doing the same thing my first son did and being extremely independent, like, being like I can do this on my own, even though like you should before you do it on your own, you know, so I I worry about that a little bit.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

4. Mmhmm ... (1 second pause) ... knowing what you know now, if you started all over again with your pregnancy, what would you do differently? ... (1 second pause) ... um I wouldn't be pregnant **laugh** um ... (1 second pause) ... that's probably the biggest thing. Is that I I probably wouldn't be pregnant. ... (2 second pause) ... 

5. Like I (participant voice goes DOWN in PITCH) hate it. ... (2 second pause) ... with a passion. ... (1 second pause) ... but I know ... (1 second pause) ... under, like under one years old I'm gonna hear some crying ... (1 second pause) ... that baby cry ?feels? ill ...(4 second pause) ... I just hate crying I don't know. Like she still whines, and it, oh my god, I have to like separate us, because I don't wanna like, (participant voice goes UP in PITCH) oh my gosh, like go away. And I think she does it cuz she know I hate it. So... (2 second pause) ... hopefully she’s not like her sister ... (1 second pause) ... irritates me more. **laugh** ... (2 second pause) ... do it on purpose.

6. Mmhmm. Why do you think it will be difficult, and how often do you think it will occur? ?i meant? crying if you need something, I don’t like the crying if, you don’t need anyting you just wanna be, whiny. So ... (1 second pause) ... hopefully she won’t, cry too much ...(1 second pause) ... because she needs something ...(1 second pause) ... cuz that’s only reason why baby’s cry in the beginning anyway. ... (2 second pause) ... hopefully I can, try to, get it in, right at the, moment where they start to, you know like ... (1 second pause) ... become their own, please don’t cry for no reason.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

7. **laugh** ... (3 second pause) ... How would you describe your relationship with your baby now, while you’re pregnant? ... (6 second pause) ... we’re fine, like ... (3 second pause) ... it’s still not like, she’s a baby yet, until she comes out ... (2 second pause) ... like? I talk to her and stuff? ... (3 second pause) ... have to like physically, you know, like ... (1 second pause) ... hold it, in my hand. S’know I’m holding in my belly but ... (3 second pause) ...

8. I didn’t know the kidney infection because more if not worse vomiting, so my relationship then was just really sick and exhausted and not really paying too much attention about the baby

9. Mhmm... (2 second pause) ... What do you like about this story? ...(3 second pause)... I just, I love this story and the fact that ya know, it’s just uhm, one, my daughter seems like she’s prepared and she’ll be alright when the baby comes...(2 second pause)... and uh, two it’s just really cute to see her with a smile on her face say pick-a-boo and the fact that she already loves this baby and she hasn’t even seen this baby or know when this baby’s gonna come out or anything like that.

10. Do you think your baby will get upset often in her or her first 12 months? What will you do at those times, what do you think your feelings will be at those times? My mom said I didn’t cry that much and, all that so I’m hoping maybe she won’t do that. But if she does ... (2 second pause) ... (DOWN In PITCH and SOFTER) then I’ll probably, figure out, see what’s wrong **laugh** take her to the doctors to ?see if nothing? Wrong to see if she’s sick or something er- ... (2 second pause) ... feed her change her diaper and, all that. ... (4 second
11. What about when your child becomes physically hurt a little bit, like hitting his or her head against the crib, what will you do at those times and what do you think your feelings will be like at those times? Probably scared and call the doctor... (1 second pause)... see what I should do **laugh** because they have real soft heads and I'd see if she, get brain damage or, a concussion or, (DOWN in PITCH) something really wrongs? So... (3 second pause)... 

12. What about when your child becomes sick like with a fever or something like that? What will you do at those times and what do you think your feelings will be like at those times? I'll take her in **clear throat** to the (UP in pitch) doctor if she's got a fever. Give her medicine make her feel better. ... (2 second pause)... and I'll probably be sad cuz she sick **laugh** something's wrong? cuz she's sick. ... (4 second pause)... 

13. Oh, okay. How do you think the first few weeks at home**clears throat**excuse me, with the baby will go? Crazy...(2 second pause)...cause I'm gonna have to uhm, my other children probly are not gonna adjust to the fact that I can't pick them up and play with them. So, it's gonna be difficult for them the understand, I'm a mo...I'm more worried about my other children than I am myself. Mhmm. Cause they're gonna have to get use to the fact that there's another baby and my youngest daught...my youngest, my daughter, she's really not gonna understand cause she's not even one yet. Ya know? Mhmm. She's really not gonna understand ya know, why mommy can't hold me or why mommy can't play with me but I'm a ma try to do my best to try to let them know this is why cause you have a baby brother now. Mhmm. So that's
how I’m gonna do it. A lot of organization and a lot of explaining**laughs**

14. Mhmm. Do you have any sense yet of what your baby’s intelligence will be? Why do you think that? No...(4 second pause)...uhmmm, I have no idea what intelligence wise he’ll be. I imagine he’s gonna be pretty intelligent cause he has a older brother that loves to sing and talk in Spanish so, Hmm. He’ll be definitely probly ahead of a lot of things that’s not supposed to be doin yet, he’ll be doing on his own.

15. Mhmm...(3 second pause)...How would you describe your relationship with your baby now, while your pregnant? Uhhh, we don’t have one right now, I talk to him, he doesn’t really react to me. Like he reacts to daddy so, we really don’t have quite a rela...well we have a relationship that okay, you’re, you’re in my rib now, ya know, get out my rib but, he doesn’t wanna get out of there**laughs** **laughs** Mhmm. We really don’t have a relationship right now but it defininetly change once he, once he get here.

16. Mhmm can you think of any experiences you’ve had during your pregnancy that might have been a set back for your baby? Me thinkin of abortin, that was a set back cause, he felt the emotion, he probly heard the emotion also, cause people, cause ya know the circumstances sayin their baby really can’t hear you till the third, second or third trimester, I don’t believe that, if he can’t hear you he can definitely feel that bad vibe and emotion.

17. 6 months. Mhmm. Giggalin, Cooin, uhm, smilin, touchin mommy’s face and sayin dada. Those are my favorite moments, I like, I like for the baby say momma too but I know that’s not
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

gonna happen till he get’s older so, it's just those moments, I would say 6 months of life for him to be right now.

18. What will you feel like doing when your child behaves like that? Uhm, locking myself in the bathroom**laughs**taking asprin **laughs**...(3 second pause)...How will you feel if your child acts this way? And what will you do about the behavior? Well this is, can you repeat it? How will you feel if your child acts this way, crying all the time? And what will you do about the behavior? Frustrated, uhm, what would I do about the behavior? Mhmm. I guess just deal with it as long as I can, and when I can’t anymore have somebody else deal with is like her father, or my daughter.

19. Mhmm... (3 second pause) ...Do you think your child will know that you don’t like that behavior? Why do you think he or she will act like that?
Uhm, I hope they don’t, ya know, cause it’s not their fault, I’m sure they wouldn’t cry all the time, unless there was something wrong. And I don’t want to really act negatively, uhm, I want the baby to know that it’s wanted and even though it’s doing something that bothers me that ya know, it’s okay, and uhm just so it has a good feeling and good sense of self worth...(3 second pause)... Mhmm. I’ve seen people ya know when their babies crying all the time they start saying negative things to the baby, ya know and it really does have a big impact on the baby, later on. Mhmm. So, I don’t want to be like that at all. So I’ll try to deal with it as best I can. And if I can’t, If I find I’m coming to a point where I can’t deal with it well anymore, I would ya know, leave the room for a minute, or ya know, make sure the baby’s safe, leave the room and find somebody else that can deal with it, so I don’t have to get upset too much
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

20. Mhm... (3 second pause) ... What will you feel like doing when your child behaves like that? Sleeping**laughs**

Rigid Attitudes and Beliefs About Gender Roles

1. Mhhmm. ... (2 second pause) ... And how have you felt physically and emotionally throughout your pregnancy? ... (1 second pause) ... physically ... (1.5 second pause) ... tired ... (1 second pause) ... um, emotionally ... (1 second pause) ... I've been s, I've been in denial, ... (1 second pause) ... um, because it's a boy, actually. Mhhmm. I thought it was a girl just because of the way I carried my other two kids.

2. Just because in delivery room with me it's real real funny um, ... (1 second pause) ... I'm either eatin' a popsicle watching television screaming, complaining, but I think when I see the baby, I'll just laugh. I will. I'm just gonna probably laugh like I did this last two times and, Mhhmm just shake my head because this is a boy and I cannot, it's not like reality is not lettin' makin' me believe that. I think it's a girl but the ultrasound says it's a boy.

3. Mhhmm. What about if it is a girl? What do you think your reaction will be? (participant voice gets LOUDER) YAY! I don't have to buy that many more clothes! um, ... (1 second pause) ... Wow! I may not have to move because I'm already in a two bedroom and I have two girls and all their toys can go down to the little girl, and, um all their snowsuits and things can go down you know Mhhmm. Um, but, ... (1 second pause) ... I don't know
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

ultrasound says it's 99.7? Child *cough* percent right

4. Mmhmm..(1 second pause)... can you tell me a favorite story about your pregnancy? Perhaps one you've told to a family or friend? If you need a minute to think about it that's fine too....(1 second pause)... a favorite story...(2 second pause)... mm, well, the most recent story I have was um...(1 second pause)... I went to have a fetal survey, which, is basically an ultrasound, and, um, I went, not wanting to go, um, I basically wanted to, have my baby and not know what it was. Oh! Sex, boy or girl-wise. Right! I didn't, it really, I mean I didn't want to know, because I had this like, (participant voice gets louder) fear that it was a boy... (1 second pause) ... just due to no monrnng (participant voice goes UP in PITCH) sickness, I'm eatin' everything I mean I'm not having any problems! Now with my last little girl ... (1 second pause) ... I have morning sickness, **sigh oh!** I felt terrible. ... (1 second pause) ... But, wi- I'm-like (participant voice gets SOFTER) man, everything just's going so smooth, how'm I able to eat just eat eat eat eat it's nothing that I don't wanna eat! I go in, me and my um kids' dad, and I say **sigh** I hope this is a girl. have the fetal survey and ?now? he says oh do you see that? I'm like what is that? oh that's a boy. I'm like (participant voice goes UP in PITCH) can you check again? So she's checks about 4 times and she's like well we're usually 99.9. so... (1 second pause) ... I had a dream that the baby came out a girl. and I'm like oh! God! You know? So. that's basically the only story, I mean, i-i- other than that everything's been going, great. I mean **Sigh (1 second)** I just ?wanna digest how this food on thanksgiving day? But, you know other than than everything's been fine. So I don't really have too many stories, or, anything like that, I don't have nightmares or anything like that.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

5. **laugh** ... (3 second pause) ... what will be your reaction if the baby’s a boy? And what about if the baby is a girl? ... (1 second pause) ... um ... (1 second pause) ... I- like honestly? I don’t- like, I’m not someone who really cares, which one it is, you know what I mean, I will be alittle surprised if it’s girl cuz I’m told it’s a boy, but, **laugh** like you know ... (1 second pause) ... it’ll be a little different, but I mean it- it’s, there’s really no, matter to me. Either way it’s a pretty baby I’m sure so, you know I’m sure it’s gonna be, long as it’s healthy I don’t care **laugh** it could be both you know, just long as it’s healthy. **laugh**

6. Mmhmm. What do you wish you could change about your relationship with your baby? ... (2 second pause) ... like, now? Like, like while I’m pregnant? Yeah.Um ... (3 second pause) ... I don’t know. ... (1 second pause) ... I think ... (1 second pause) ... I don’t know. Like, ... (7 second pause) ... i-I don’t feel as in tune with this baby as I did the first one. because, I thi- I think what it is though is that this baby is meant to be a big surprise. ... (1 second pause) ... like I’m kinda scared that it might be a girl, it might come out, you know what I mean? Like I’m scared, like, I don’t know.

7. Mmhmm ... (4 second pause) ... what have been your impressions about the baby while you’re pregnant? What do you sense the baby might be like? ... (1 second pause) ... Um, I think it’s probably gonna be like the rest of ‘em except that it’s a girl and, it’ll be different **laugh**

8. Mmhmm ... (2 second pause) ... what will be your reaction if the baby is a boy, and if the baby is a girl? **laugh** If it’s a boy I’ll be really excited, if it’s a girl, well I guess we’ll
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

have to be excited to, but I’m trying to come to terms with that. **laugh (1 second)**

9. Mmhmm ... (2 second pause) ... how old do you think your baby will be when he or she sits up? ... (1 second pause) ... um ... (2 second pause) ... four months probably. Maybe six. ... (1 second pause) ... probably four. Mmhmm. I don’t know it’s a girl, it might be different. **laugh** ... (1 second pause) ... my boys were all really early.

10. Mmhmm ... (1 second pause) ... um so, will you pick a name that has some kind of special meaning for your family of the baby’s father’s family? Um, ... (1 second pause) ... probably something special for our family, but I don’t know. Mmhmm ... (1 second pause) ... Kinda, I’m kinda getting blockage problems when I start thinking about names. Mmhmm. **laugh** it’s hard. Yeah. ?yeah? it’s kinda like I was at the store trying to look, look at girl stuff and I just, can’t.

11. After your baby is born, what behavior in his or her first year of life do you think will be most difficult for you to handle, and can you give an example? Um ... (3 second pause) ... if, if ... (2 second pause) ... if she starts acting like a bratty little girl. Um **laugh** I, I don’t know it’ll it’ll just, it’ll just be hard. This whole girl thing is just, hard. **laugh** ... (3 second pause) ... so. Just ... (1 second pause) ... You know like if she’s whining. ... (2 second pause) ...

12. Why will this be difficult, and how often do you think it will occur? Um, I don’t have a clue how often, and ... (1 second pause) ... unless things change, you know when the baby
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

comes, it's just, it's the whole girl thing, it's just difficult to ... (1 second pause)... just difficult to imagine because I didn't think that it really mattered if it was a girl or a boy but when I found out it did. **laugh** so. ... (3 second pause) ...

13. What will you feel like doing when your child whines like that, how will you feel if you child acts this way and what will you do about the behavior? Um it'll bother but, I'll have to like hold the baby close, and, and console 'em and try to, to teach 'em not to do that. ... (2 second pause) ...

14. Mmhmm. Do you think your child will know you don't like that behavior? And what do you think he or she, or why do you think he or she ill act like that? Oh, I'm I'm sure the child will know because kids know everything. they just sense it **laugh** ... (2 second pause) ... And why do you think he or she will act like that? Um, ... (1 second pause) ... well ... I... I don't know, girls now a days, act, awful **laugh** **laugh** they don't act like they used to.

15. Mmhmm ... (3 second pause) ... what do you imagine will happen to this behavior as your child grows older and why do you think so? Um, hopefully it'll stop, but, probably not ... (1 second pause) ... um, ... (1 second pause)... girls, ?seem to be? Growing up faster and ?faster?

16. **laugh** ... (4 second pause) ... um, can you pick 5 words or adjective to describe your relationship with your baby? And for each word describe an incident or memory that
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

illustrates what you mean? ... (1 second pause) ... uh ... (2 second pause) ... um ... (3 second pause) ... kinda standoffish, ... (1 second pause) ... mmkay. um, it’s just hard to deal, with being pregnant, and, and having a girl. Um ... (1 second pause) ... um ... (4 second pause) ... kinda, kinda happy, when when she kicks. ... (1 second pause) ... cuz then I know that it’s real. Um ... (4 second pause) ... five? Yeah. **laugh** um you’ve got 2 ?um? ... (1 second pause) ... scared ... (1 second pause) ... um ... (3 second pause) ... because I’m just, scared to have a girl. Cuz I don’t know what to do with a girl.

17. What do you wish you could change about your relationship with your baby? ... (1 second pause) ... um I wish I could be a little more excited that it’s a girl. ... (1 second pause) ... um ... (2 second pause) ... i-i- ?so that? hoping to feel some ?thing that it’s good.? ... (3 second pause) ... **laugh** um, ?probably? that’s probably the biggest thing. Mmhm. That I could I could be actually happy, you know, that it’s a girl. Mmhmm. So, I mean I know it’ll be different when it pops out but you know right now it’s just not **laugh**

18. Has your relationship with your baby changed during the pregnancy? In what ways, and what is your feeling about the change? Um, biggest cha-, I was I was pretty ?mystified? that I was pregnant until I found out it was a girl, then I freaked out, and, now, it’s getting better.

19. Mmhmmm ... (2 second pause) ... what about when your child becomes physically hurt a little bit, like hitting their head on the crib? What will you do at those times and what do you think your feelings will be at those times? **exhale** (participant voice goes UP in PITCH) oh goodness I dno’t know because it’s suppsed to be a girl and I can’t say oh
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

(participant voice goes UP in PITCH) you’re ok brush it off! Well I mean I can I don’t know, it might be different because it’s a girl. Um … (3 second pause) … I don’t know. Thinking I’d probably kiss it. I don’t know **laugh** **laugh** it’s gonna be different.

20. Mmhmm … (1 second pause) … as you look ahead, what will be the most difficult time in your child’s development and why do you think so? … (1 second pause) … um, that would be age 13. Maybe 12. Maybe 12 and 13. Um, cuz if it’s a girl it’s gonna be nuts. **laugh** (1 second)**laugh** ?no? I mean my 13 year old boy’s hard enough that, I have neighbor’s with teenage girls and, it’s scary. **laugh** … (1 second pause) … so … (3 second pause)…

21. What do you expect your child to be like as an adolescent, what makes you feel this way and what do you expect to be good and not so good about this period in your child’s life? … (1 second pause) … um … (2 second pause)… hopefully it’ll be fine, hopefully she be more like me but um, …(2 second pause) … I’m just I’m a little worried because, um … (1 second pause)… a lot of the bi-racial girls are… (1 second pause)… are just … (1 second pause)… they’re kinda frustrating. And, and um, so I’m hoping she’s more like me. Than like like her dad’s side. … (2 second pause) … mhm …(2 second pause)…they just have attitudes **laugh** uh huh… (1 second pause)… what do you expect to be good and not so good about this period in your child’s life? Um, … (3 second pause) … well it’ll be learning experiences. um … (2 second pause) … I don’t know. … (1 second pause) … um … (6 second pause)… um it’ll be good because I’ll be learning to develop with a girl, and I don’t know how to be around girls? cus I don’t have one? Um, **laugh** and … (4 second pause) … and hopefully hopefully there won’t be an attitude because that would be not so good.
22. What will be your reaction if the baby is a boy? ...(2 second pause) ... I’ll be so upset because I already have everything pink. And took the tags off of it. And washed it. So I can’t return it. **laugh** so I’ll be a little upset about that part, but I actually wanted a boy. So ... (1 second pause) ... he would just have to wear pink until he was like one and **laugh** ...(1 second pause) ... and then we’ll dress him in blue.

What will your reaction be if the baby is a girl? ... (1 second pause) ... (participant voice goes UP in PITCH) fine. Cuz, that’s what I was expecting. ... (3 second pause) ...  

23. Have you decided on your child’s name? How did you decide, and how will you decide?  
I like j’s. so it had to be a j. and then ... (1 second pause) ... for a long time I know it sounds totally weird, but, my brother that died, I was gonna name her after him, even though he doesn’t have a unisex name, and everybody was getting so angry. Cuz his name was totally boy. ... (2 second pause) ... so, I named her something just like, randomly. I didn’t even like it. And then everybody started to call her that name, and I really didn’t like it, so then I changed it again ... (1 second pause) ... and now it’s jinay. So we went through three names **laugh** just, I don’t know why, I pick, ... (1 second pause) ... i-I don’t know like ... (2 second pause) ... well I wanted to do it for my brother as like, you know ... (2 second pause) ... tribute or something ... (1 second pause) ... but his name is Jeff. ... (1 second pause) ... so that’s not a girl name, like at all. And ... (1 second pause) ... her dad’s like, no, and then I got so mad he kept saying no so I thought it was smthng like personal, like, you know cuz it’s your brother type, but it wasn’t it’s just cuz it was jeff, and then, I said Jessica, ... (1 second pause) ... because I was reading an article about the baby jessical girl, I don’t know, in the well, I don’t know, and I
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

was like oh it’s a j, whatever, and I really don’t like that name. so now I say jinay. Tha’ts pretty, but I know somebody named jinay and I don’t like her ... (3 second pause) ... but I still like the name so I’ll just keep jinay.

24. Do you think your child will know you don’t like that behavior? Why do you think he or she will act like that? ... (3 second pause) ... well I have to let them know that I don’t, like the behavior. Bef- cuz before with my daughter I was just like (participant voice goes UP in PITCH) oh, she’s a baby, ... (1 second pause) ... and she’a girl, and ?it was so? She was so cute, and, she could do no wrong... (1 second pause) ... but like, now I’m just like ... (1 second pause)... gosh, why’d I let her thing that? And now, like, she just runs with it and there’s nothing anyone can say to her. ... (1 second pause) ... she’ll cry for no reason. so ... (4 second pause) ...

25. We just w- ... (2 second pause) ... we don’t know if it’s a boy or girl, too, so that’s gonna be kind of ?fun? surprise ????

26. Oh, anything, um ... (4 second pause) ... I don’t know I guess in a way we’ve kinda pictured whether it will be a boy or a girl we’d like to have a redhead, my husband’s a redhead ... (2 second pause) ... um names picked out so I guess we kinda, in a way picture a baby that’ll match the names boy, boy or girl, um ...(3 second pause) ... I, I I assume that it’s gonna be a really happy baby because both of my kids are really excited and they’re really good helpers

27. Mmhmm ... (3 second pause) ... What will be your reaction if the baby is a boy? And what If the baby is a girl? ... (3 second pause) ... really would love to have my son have a- a
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

brother, really close ... (2 second pause) ... um, ... (2 second pause) ... but he would really like
to have a little sister. Another one so I think I would be happy either way cuz he’s he’s. he’s
really cute with his little sister now and uh we bought ??? little girl, so, either way I think I’m
gonna ??? I’m not gonna be disappointed **laugh** ??? I’ll be really excited whichever one,
cuz I know ?that? he’ll do really good if he has 2 little sisters, or if he has a brother then he’ll
have someone to wrestle with ?when? he gets old enough ?and?

28. Yeah, yeah, that’s good**laughs** What personality traits do you think your child will
inherit from the baby’s father? ...(3 second pause)...hopefully not biting her nails.

**laughs** Uhm... (4 second pause)... They’re prolly not gonna inherit like the hard working,
uhm, part, hopefully the smart, intellectual part that he has, and I lack... (2 second pause)...

29. Mhmm... (2 second pause)... Do you expect that to change as the child gets older for
instance, and how do you expect it to change? Yeah, I mean depending on uhm like I said as
he’s gotten older, he’s more of a daddy’s boy. Mhmm. Uhm, Danny, she’s as she’s gotten older,
she’s become a daddy’s girl, it’s just uh... (2 second pause) ... my husband... (2 second
pause)... uhm, plays??? in relief, in, in the summer while there are some things that I can’t do
with them everyday and they don’t see him as much so they kind of attach more so to their, to
their dad and I assume the same thing will happen with this baby. Mhmm. As the baby gets
older, but... (4 second pause) ...

30. ... (2 second pause) ... Think for a moment about your child as an adult. What hopes
and fears do you have about this time? ... (2 second pause) ... well if it’s a girl
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

I ??more??than I do for a boy, I think it’s harder for a girl, so I mean… (2 second pause)... If this baby’s a girl I’d say more I have with my daughters…(5 second pause)...oh, it’s something uhm**baby talking in the background**…(2 second pause)...hold on.

31. So I’ll go ahead and repeat the last question uhm, Think for a moment about your child as an adult. What hopes and fears do you have about this time? Oh okay, so for a girl I said I have more fears. Right. Because I think some girls are just really uhm vulnerable. Uhm, so I, I worry about like rape or molestation and ya know things like that for, for a girl uhm. For a boy, I don’t have as many, many worries but I do worry about them getting bullied or uhm, made fun of, both, both get made fun of or bullied… (2 second pause)...kidnapped I guess or ya know, all those bad things that you read about. Ya never know. Uhm, want for you’re children uh, it, it’s maybe I should stop that question sorta shift.

32. What will be your reaction if the baby is a boy? or If the baby is a girl? ... (1 second pause) ... Well I, they told me it was a girl, so if it comes out a boy **laugh** I’m gonna have to buy new stuff. And, I’ll be kinda shocked, too

33. ... (1 second pause) ... and what about if the baby is a girl? ... (3 second pause) ...? oh let’s see?, I’ll be excited cuz, then I’ll have a little (UP in PITCH) girl, and then I get to do her (UP in PITCH) hair, and paint her (UP in PITCH) nails and all that fun (UP in PITCH)stuff!

34. What do you expect your child to be like as an adolescent? What makes you feel this way? What do you expect to be good and not so good about this period in your childs life?
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

is that like a teenager? Mmhmm. ... (2 second pause) ... I have not idea to what to expect ...(1 second pause) ... when she uh, becomes a teenager. ... (2 second pause) ... cuz then you start ... (2 second pause) ... hatin’ the world I guess **laugh** I don’t know. Tha’ts what I did. My parents. I didn’t like them and I didn’t have to answer to nobody **laugh** so, hope she don’t act that way ?and um? **laugh** ... (4 second pause) ... What do you expect will be good and not so good about this period in your child’s life? Think it’ll be good cuz I can, bond with her more an’, c- go clothes shopping and all that stuff and, the (UP in PITCH) not good part will probably be, her wantin’ to skip school hang out with all of her friends. Maybe hang out with the bad, type of people that, don’t go to school and ... (2 second pause) ...? gettin’? Boyfriends I don’t know **laugh**, I don’t know. ... (5 second pause) ... 

35. This for a moment about your child as an adult. What hopes and fears do you have about this time? ... (5 second pause) ... when she becomes an adult (SOFTER) hope she don’t wanna live with me forever. ... (1 second pause) ... I hope she can, you know, go out there and ... (1 second pause) ... finish school and become something. Nice and important. Make change in the world. That’s what I hope she does. And ... (2 second pause) ... the fear is that she ain’t gonna do none of that. She’s gonna ?decide to take a different route? **laugh** ... (2 second pause) ... (LOUDER) which I hope she don’t **laugh**

36. Uhm, doesn’t really respond to my voice like I would hope he would’ve but he doesn’t, but he responds to daddy’s voice though, that’s a little upsetting. Mmhmm. **laughs** Heh, but he responds to his voice right now but not mine.
37. **laughs** What will your reaction be if the baby is a boy and what about if the baby is a girl? Good question! **sigh** if he is a girl, I'm gonna be usp...well I'm not gonna be...it doesn't matter. God uhm, he's a blessing regardless of, I really wouldn't care, just I had to do a lot of changing of the colors**laughs** **laughs** and the shopping all over again**laughs** **laughs** but other than that, uhm, it really wouldn't matter, I think I, either way it goes as long as he's healthy or as long as she's healthy, but I know for sure he's a boy, but, any way he's gonna be well wanted a child period.

38. Why will this behavior be difficult? How often do you think it will occur?
Cause his brothers very sneaky right now so, if he's quiet for more than 10 seconds I'll say he's quiet for more than 10 seconds and he's out of my sight and I know he's up to no good.
**laughs**

39. What will you feel like doing when your child behaves like that? How will you feel if your child acts this way? And what will you do about the behavior? I am a very trained person on getting em to understand that the corner wise. I, I am a very corner person. My children hate it but I love it**laughs** Mhmm. If I said the word corner sometime they'll either straighten up or cry. And my other son if I tell him to the corner automatically he's screamin and cryin. Soon as I say okay that's it I've had it, you've had your warnings, I'm done, corner, and when I say that he breaks down, really breaks down, this is my 5 year old and my oldest 2 year old who's about to be 3. Jr. hasn't got my, my other two years old, he's, he's the baby out of the boys right now so he doesn't understand that I did something bad and now I got in a corner Mhmm. So, with him I just take away baby. Mhmm. Just take it. I take away the teddy bear's
and he's ballin, absolutely ballin, so, that's his form of punishment right now so, I'm a corner person and I like to threaten them with daddy too. I threaten em with tellin daddy and once I say daddy they kinda straighten up **voice PITCH goes UP** they threaten each other with daddy too! Okay, Shamal I'm telling daddy! Ya know? **voice PITCH returns to NORMAL** So, uhm daddy and corner is the, is the disciplinarians. **laughs** **laughs** But, uh, other than that I, that's how I handle him, but if he's younger like Samalia, play pen, she doesn't like her play pen so she has her own little form of punishment also. Mhmm. So, she's the baby, she's tryin to discover everything right now so I really don't discipline her so, until he's about 2, 2, 3 years old that's when he gets, gets the punishment in handlin his behavior.

40. Mhmm. Do you think your child will know that you don't like that behavior? Why do you think he or she will act like that? I have a way of lookin at children and they know they've done something wrong so hopefully he gets to pick it up by the age of 3 my uhm, but I don't know how I'm gonna let him know that when he does something wrong up uhm, I true, I just try to do the best I can. And tryin to let him know ya know you not supposed to do that or, why you doin this**sniffles** So, that's how it works. So, I have a little way of looking very mean towards a child and they know they shouldn't be doin it.

Mhmm. So hopefully he gets that, picks up that trait like his brother and his sister, well his sister still hasn't got it yet either. So, hopefully he'll pick it up too. Mhmm. And why do you think he'll behave like that? Children will be children that's, that's my form of sayin that. Children will be children*screaming and laughing in the background*like right now.

**laughs**
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

41. Agitated is one, and a memory or something that illustrates what you mean?

Cause it's hard for me to get about the day and as soon as I move to one side he likes to move to that spot too so Mhmm. So, we don’t understand each other right now so he agitates me when he gets to movin in those certain spots it, I can’t move or it’s hard for me to get up or I have to wait until he moves out that spot for me to get up. Mhmm...(3 second pause)...

42. Mhmm. What pleases you most about your relationship with your baby while you are pregnant?...(3 second pause)...the fact that he reacts to daddy's voice already.

Mhmm. That’s funny.**laughs** that’s funny how he kicks when he hears him and when he feels him well when, when he feels him I'm like rubbin on my stomach he reacts already so, I think they’re gonna have a good relationship and I think with me and him gonna have a good relationship cause the breastfeedin thing. I feel like that’s a really important thing for mothers to do cause that’s your time to bond with your child.

Mhmm. So I think, that’s why our relationship is gonna be good. Mhmm. When that time comes**laughs**

43. Has your relationship with your baby changed during the pregnancy? In what ways?

What is your feeling about the change? Uhm, our relationship has changed cause he really doesn’t react to me like the day before. Mhmm. He just bugs my stomach and my body. He’s, he takes over now, he’s taken over my body now so,**laughs** that’s, that’s changed with us...(2 second pause)...What is your feeling about the change? I really don’t like it. But, I know that he’s ready as well as I’m ready so were both irritated by each other**laughs** **laughs**
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

44. Mhmm. When your baby is born what parent do you think he or she will be closest to and why? Daddy. No! He’s gonna be closer to me. Cause I’m mamma, I have the milk. **laughs** **laughs** Cause, I’m mamma so he’s definitely gonna be closer to me. Definitely daddy, uhm, daddy has his little girl so I have mommy’s little boy so, Mhmm He’s gonna be a mama’s boy definitely.

45. Do you expect that to change as the child gets older for instance? How do you expect it to change? Oh, it’s gonna change cause he’s gonna give on his dad cause my two year old little boy right now he loves bein around his daddy, once his dad walk out the door, he has a fit. So, it’s gonna change once he get to understandin, I have a daddy and ya know we can go outside, we can wrestle, we can do this, we can do that, so, he’s gonna be closer to him as he get older.

46. Mhmm... (3 second pause)... If your child could be any age right now, unborn, one month, on year, etc., what age would you choose and why? 6 months. Mhmm. Giggalin, Cooin, uhm, smilin, touchin mommy’s face and sayin dada. Those are my favorite moments, I like, I like for the baby say momma too but I know that’s not gonna happen till he get’s older so, it’s just those moments, I would say 6 months of life for him to be right now.

47. Think for a moment of your child as an adult. What hopes and fears do you have about that time? Oh, going to jail, that’s my most fear. One of my children going to jail Mhmm

And being a complete... (3 second pause)... negative type, uh, I’m just afraid about him going to jail... (2 second pause)... or, him being gay. Those are my two most biggest fears. Mhmm. But,
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

as long as he doesn't have those type of role models around, ya know, I, I really, I'm a firm believer of bible and everything else so those are my two biggest things that I'm worried about because I've been to jail before and I do not want my sons to go through that at all. Mhmm. So, as long as I install in him that whatever you do there's a consequence behind it and if you break a law this is a consequence behind it than I think that he's gonna be perfectly fine. Mhmm But those are my two biggest fears and being gay, I mean, if it makes him happy sure, but, I know that's not the way I was raised. Mhmm. And that, I know that's not how I'm gonna, and that's not the way I'm gonna raise him. Mhmm. So, those are my two biggest fears. But, I'm just gonna leave that in God's hands, oh God... I don't wanna think about it**laughs**

**laughs** Next question.**laughs**

48. What will your reaction be if the baby is a boy?

It's against, it's definitely a girl. And if the baby is a girl? it's already, we, had a four ultra sounds, so we know for sure it's a girl. Mhmm. So, uhm...(2 second pause)... So what will your reaction be? I'm happy it's a girl, uhm, at first, when I first found out, it was kinda before I knew the sex, I was hopin for a boy just because my boyfriend has two daughters so I though it would be neat for him to have a son, but Mhmm He's happy it's a girl. Mhmm So... (2 second pause) ...

49. Okay. How much is the baby wanted or not wanted?

Oh he's definitely wanted, it's another boy by the way. Oh okay! I was, I was hopin for a girl ya know cause everything was different and I'm like, it's a girl, it's a girl! She, we go for the ultra sound and as soon as she turns the machine on it's like, no mom I'm a boy, I was like okayyyy,
**laughs** but, it's better that way cause my first son, that way they can actually, play and I don't have to worry about him ya know rough housing his sister's Mhmm **smacks lips** but, he's definitely wanted.

50. What will your reaction be if the baby is a boy? What will it be if the baby is a girl?

Uhm, about the same, as long as the baby's born healthy, it was, I mean I'd... (2 second pause)... like to have a girl so that way we can be done, but it's better to have a boy. So, as long as either one's healthy, that's all I'm really concerned about.

51. Mhmm... (3 second pause)... Uhm, who do you think your baby will be most like?

Uhm, well I wanna say me but **laughs** **laughs** I, I think he'll be more like his dad, Uhm, well at first I think he'll be like me but once he starts to get older I think he'll be more like his dad. Mhmm. I think so, cause I guess ya know my luck, they first start out like me and look like me and then they turn into their dad **laughs** **laughs** So, I think so.

52. Mhm... (2 second pause) ... And, what traits will your child inherit from the baby's father? Uhm, his uh, coordination **laughs** Mhmm. And uh, his probably his like ath... ya know his athletic type, things and uhm, his ability to like fix things like take things apart and more ya know use of his hands.

53. Mhmm... (2 second pause) ... Do you expect that to change as the child gets older for instance? How do you expect it to change? I think so, Uhm, I think it'll change ya know he'll be close to me but then once he gets older and actually be able to do things I think he'll be kinda
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

closer to his dad cause his dad will be able to ya know take him out fishing or work in the garage or ya know show him things in the yard or on the car so I think he may ya know change in that way, verses ya know it’s like cause I mean mommy likes to fish but uh, mommy don’t do well with worms and dad does so, I think he’ll kinda have that little bonding there.

54. What about when your child becomes physically hurt a little bit such as hitting his or her head against the crib? What will you do at those times? And what do you think your feelings will be at those times? Uhm, just to make sure he’s okay and a little bit guilty at the fact that I wasn’t like paying ya know closer attention like oh my gosh ya know which I think every mother goes through that but ya know obviously kids are gonna fall and ya know, ya know get scrapes and cuts and that sorta thing, especially little boys because they’re a little bit more of dare devils, verses little girls. Mhmm.

55. ...(2 second pause)...that way he’ll ya know, it’s like okay well if I ya know get involved in sports or something like that my ya know parents come to my games ya know that’ll make him feel good about themselves uhm, the bad thing about ya know the adolescence part is all like the peer pressure. Of how, ya know people around him will ya know, if you wanna fit in or if you wanna hang ya know with our group you have to do that sorta thing and uhm, its just ya know we have to stay firm and teach him that ya know you don’t if someone’s pressuring you than obviously they’re not your friend, you don’t wanna be a follower, you wanna be a leader. And, uhm, if you lead, and you set a good example, then others will follow you.

56. **laughs** What do you think your first reaction will be when you see the baby?
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

I be happy, cause it’s a boy and I gotta tell ya I’ve been wantin my boy first but it went backwards, it usually goes that way with my family but I’m gonna be happy, real happy

happy**laughs**

57. What will your reaction be if the baby is a boy? And if the baby is a girl? Oh if it was another girl I would be even happier cause I did want a girl too, I wanted a girl more than I wanted a boy but my daughter wanted a brother so I kinda went with the flow but I wanted a girl more so I can name her Katanya cause my daughters name is Diashi and I wanted Katanya and Diashi, it’s just something I had stuck in my head and then when I found out it was a boy I was like huh, now I gotta find a boy name. Thanks!**laughs**

**laughs** but yeah, it doesn’t matter, as long as it’s healthy and alright I’m happy.

58. just, with a boy, I heard it’s a little more difficult, like with me watchin my cousin with her son now, like wow you gotta do all that for a boy, you ain’t gotta do half a that for a boy**laughs**

59. Talks? Uhm, I dunno, they usually start that mom and dad around 9, 10 months, so, so around 10 months, hopefully I hear mom and not dad **laughs** **laughs** even though I know it’s gonna be dad cause all babies say dad first I dunno why, it’s like why’d you say that**laughs** yeah so, about 9, 10 months.

60. every body else but ya know I’m just gonna go with the flow and see how he turn out.

Mhmm. I’m gonna try my best to raise him to do right and hopefully he be different then all
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

those teenage kids runnin around now cause I don't want him actin like that. That's kinda why I wanted a girl**laughs** **laughs** like yeah**laughs** But that's I dunno...(3 second pause)

61. Mhmm, Can you pick five words, adjectives, to describe your relationship?
Uhm, happy, loving, uhm, fighting, uhm...(3 second pause)

62. **laughs** When your baby is born what parent do you think he or she will be closest to and why?
Me cause he not gonna know his dad and he's obviously a jerk**laughs**

63. Mhmm. As you look ahead what will be the most difficult time in your child's development? Why do you think so? Potty training, cause it's always hard to potty train a boy. Like my nephew, he's two not, still don't go to the potty. **laughs** **laughs** so, I think I'm gonna have some help with going to the potty from my friends and my daughter she needs, at one she was completely potty trained, I didn't even have to try ...(tape skipped ?unintelligible?)...oh that's what you do and she did it and I didn't have to buy no more diapers or anything so, that's one thing, **laughs**

Incoherent, Mixed Themes

1. Mmhmm. Can you pick five words that describe your relationship? ?no? **laughs** and for each work, like, try to describe an incident or memory that illustrates what you mean?
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

What? Um, **laugh** yeah? how do people answer that question? Go ahead and take your time if you want, if it just have to think more that’s fine, too. Um, pick five words that describe your relationship, and an incident or a memory that illustrates what you mean? ...

(2 second pause) ... What? Ok, pick five words or adjectives to describe your relationship, and for each word describe an incident or memory that describes what you mean. Uh ... (1 second pause) ... I don’t know... (1 second pause) ... I don’t know how to. Really. Like I know we have a, like, it’s obvious you have a relationship with something that’s growing inside you or whatever, so you like? coincide? but ...(1 second pause) ... mmm mmm noise indicating ‘I don’t know’. (1 second pause) ... ok. It’s a hard question. I really don’t know how to answer, to be honest with you....(1 second pause) ... like, ...(2 second pause) ... um ...(2 second pause) ...

hmm ...(1 second pause) ... I don’t know. ...(1 second pause) ... d- I don’t really, it’s kinda hard, there’s like, it’s kinda hard to describe like, the relationship between like you and your unborn cuz you know it’s like close, I guess ... I don’t (participant voice gets LOUDER) know! **laugh** I seriously don’t like, ugh! Huh ...(3 second pause) ... I don’t know. Um ...(4 second pause) ... It’s kinda, it’s spiritual. Ok yeah it’s a good one. ...(2 second pause) ... Because, you know, it’s, it’s re- like, it’s pretty awkward, that you know ...(2 second pause) ... I mean like. ...(2 second pause) ... even though it is it is breathing and living inside you, but you have this connection, you know just like know when, things, are to be done or not done. Mmhmm Um ...(2 second pause) ... I don’t know, uh ...(1 second pause) ... geez, uh ...(4 second pause) ... um ...(1 second pause). ... I don’t kn- um **laugh** there’s like, I guess like, ht- being, I guess like being anxious like, not not like so much anxiety because it’s like you know ...(1 second pause) ... to me that has a different definition but s- s- besides anxious, you know, because you’re both like waiting, to like come out it, you know you’re both like waiting for like
change. ... (1 second pause) ... and so like, even though he’s like unborn or whatever he’s
definitely like, he might not be saying it but I’m sure he’s feeling it, you know? ... (1 second
pause) ... um ... (6 second pause) ... wow, how do you, do people answer these, like so easily?
Not always easily, **laugh** takes a lot cuz it feels ?like? I don’t really know. Ok, well you’ve
got some we can ... (1 second pause)... go from there. Ok

2. Mmhmm. Do you think your baby will get upset often in his or her first 12 months? And
what will you do at those times, and what do you think your feelings will be like at those
times? Well like, I realize that like, honestly like all kids, like all kids get upset, that’s just how it
is, like, you know, they can’t talk, so of course they’re upset they’re like trying to say something
to you, and it’s like so of course they’re getting angry about it. And so like, ... (1 second pause)
... you know, the- I, I have to admit there is like, there’s been some times with my first son
where I like, he’d be screaming for no reason at all, ...(1 second pause) ... and I just put him
like, I’d be like sitting right next to him and I’d put on like metal music and turn it up really loud.
And he either does one of two things, he either tries to scream over it, or he stops. **laughing a
bit** so like you know he either stops screaming or passes out because that’s what he needed to
do anyway **laugh** you know, so ... (1 second pause) ... um ... (1 second pause) ... you
know I’ll just... (1 second pause) ... do what I can to makes sure that it has, that that he has all
his needs, and, you know, if there’s nothing else then I guess ... (4 second pause)... (to other
person: will you go upstairs, when you’re done) so I guess that’s how I would handle it.

3. Do you think your child will know you don’t like that behavior? Why do you think he or
she will act like that? ... (3 second pause) ... well I have to let them know that I don’t, like the
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE

behavior. Bef- cuz before with my daughter I was just like (participant voice goes UP in PITCH) oh, she's a baby, ... (1 second pause) ... and she'a girl, and ?it was so? She was so cute, and, she could do no wrong... (1 second pause) ... but like, now I'm just like ... (1 second pause) ...
gosh, why'd I let her thing that? And now, like, she just runs with it and there's nothing anyone can say to her. ... (1 second pause) ... she'll cry for no reason. so ... (4 second pause) ...

4. Like the crying and stuff that you talked about. What do you think will happen? As they grow older? ... (4 second pause)... mm ... (7 second pause)... I don't know. ... (3 second pause) ... it will irritate me. s- like she doesn't really do it with other people, she just does it with me. Cuz she know, like, I guess I let her get away with it, so now ... (2 second pause) ... but like people, ... (2 second pause) ... that she see like a lot, like she'll do it at daycare, cuz she know. ...
... (1 second pause) ... they used to call her the (participant voice goes DOWN in PITCH) baby, and they let her do whatever she wanted and now she's bigger, and she'll still cry like ...(2 second pause) ... like she's a baby. Because she know that they let her get away with it. And I let her get away with it. ?if? she doesn't...(1 second pause)... If my friend or something babysitting she's like perfect. as soon I walk in the door, it's like (participant voice goes UP in PITCH) raaaar! Cuz mommy's home or something. I don't know.

5. How do you feel your relationship with your baby while you're pregnant will affect the baby’s personality? ... (2 second pause) ... I just think like whatever you did ... (1 second pause) ... the, baby ends up ... (2 second pause) ... you know, like, showing something about it like, for my son, when I was pregnant, I was sad for like, a couple weeks, I remember. And that was it, like, I was determined not to be a sad pregnant person. And then my daughter, I was
always so like, m- like me and her dad fought allllllll the time. 'slik,e I kinda think that's why she's so feisty ...(1 second pause) ... and that's why she looks exactly like him ... (1 second pause)... like **sigh** maybe I shouldn’ta fought with him. I hated him. So now ... (1 second pause) ... I didn’t actually hate a person, I was just really sad, so I hope she doesn’t come out like ... (1 second pause) ... like evil or something you know ... (1 second pause) ... but I haven’t been sad lately, it’s just, in the beginning ... (2 second pause) ... until I realized like dang, shes gonna be like the poopy baby ... (1 second pause) ... crying all the time so maybe I should try to cheer up or something, so ...(2 second pause) ...
References


QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE


QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS
EXPERIENCING INTIMATE PARTNER VIOLENCE


QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE


QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS
EXPERIENCING INTIMATE PARTNER VIOLENCE


QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS EXPERIENCING INTIMATE PARTNER VIOLENCE


Sokolowski, M. S., Hans, S. L., Bernstein, V. J. and Cox, S. M. (2007), Mothers' representations
of their infants and parenting behavior: Associations with personal and social-contextual
doi: 10.1002/imhj.20140

Solomon, J., & George, C. (1999). The measurement of attachment security in infancy and
childhood. In J. Cassidy & P. Shaver (Eds.), Handbook of attachment: theory, research,
and clinical applications (pp. 287-316). New York: Guilford.

posttraumatic stress disorder among high-risk women: Does pregnancy matter? Violence
Against Women, 16, 426-443. doi: 10.1177/1077801210364047


patterns, risk factors, theories, and directions for future research. Aggression and Violent
Behavior, 15, 14-35. doi: 0.1016/j.avb.2009.07.013

in mothers' internal representations of their infants over time. Attachment & Human
Development, 7(3), 253-268. doi:http://dx.doi.org/10.1080/14616730500245609

the working model of the child interview. Infant Mental Health Journal Infant Ment.
QUALITY OF CAREGIVING REPRESENTATIONS AMONG PREGNANT MOTHERS
EXPperiencing intimate partner violence

intimate partner violence and associated injury among urban women. *Journal of*
Community Health, 30, 377-389. doi: 10.1007/s10900-005-5518-x

Weathers, F.W., Litz, B.T., Keane, T.M., Herman, D.S., Steinberg, H.R., Huska, J.A., &

infant mental health. *Child and Adolescent Psychiatric Clinics of North America*, 4, 539
554.

Interview Coding Manual. Unpublished manuscript. Louisiana State University School of
Medicine, New Orleans, LA.