Maternity in the Wake of Terrorism: Rebirth or Retraumatization?

Author: Levy, Mindy

Publication info: Journal of Prenatal & Perinatal Psychology & Health 20. 3 (Spring 2006): 221-248.
ProQuest document link

Abstract: None available.

Full Text: Headnote ABSTRACT: This phenomenological study aims to portray the nature of the shared experiences of Israeli women who became pregnant and gave birth after surviving the trauma of terrorism in order to learn how maternity experiences can either augment the process of posttraumatic healing or exacerbate the wound inflicted by the trauma. Data was collected via open-ended interviews with eight women who shared the stories of their experiences. Data analysis revealed findings in four categories: losses, maternity through the prism of otherness, maternity as empowerment and transformational processes. Retraumatization can be avoided and healing promoted by ensuring sensitive and individualized perinatal care. KEY WORDS: trauma, terrorism, posttraumatic maternity, empowerment, Israel, maternity experiences, posttraumatic healing, perinatal care. INTRODUCTION Israeli women live in the shadow of the threat of terrorism. Caution is a way of life, terrorism is a daily reality and worry is a chronic state of mind. Terrorist attacks can occur anywhere, at any time, to anyone. Most Israelis know someone who has been involved in a terror attack. Few Israeli women feel safe; they lack a basic sense of security in their lives and are concerned about their own safety and the safety of their families and friends. Repeated terrorism in Israel causes a general feeling of uncertainty, vulnerability, a weak local economy and the curtailed freedom of movement and privacy. All leisure activities, including shopping in malls and eating in restaurants, entail repeated security checks (Gidron, 2002). When a terror attack occurs, an immeasurable number of people are caught up in traumatic ripple effects. Eyewitnesses, families, friends and peers are all victimized, as are doctors, nurses, social workers, teachers and psychologists who are exposed vicariously to the trauma (Ayalon, 2002). There were a total of 20,058 terrorist attacks in the West Bank, the Gaza Strip and on the Israeli home front between September 2000, considered the beginning of the "Al-Aqsa Intifada", and the end of December 2003. A total of 6049 civilians and soldiers were injured; 904 were killed (www.idf.il). Among the injured, 2943 were women, 1956 of them of childbearing age, between the ages of sixteen and forty-five (Israeli Ministry of Health). Many of these women were traumatized by these experiences. Some remain physically disabled as a result of their bodily injuries. For some of these women, their ability to reproduce is impaired or questioned. Others are emotionally debilitated by the stress they suffer subsequent to the incident, paralyzed by fear, haunted by flashbacks and socially isolated. Some develop unexplained medical symptoms as physiological reactions to psychological stress (Hassett &Sigal, 2002). Others, after surviving the trauma, reconcile their losses and find ways to normalize their altered lives. Terrorist attacks constitute acute and chronic stressors. They are deliberate, human made, unexpected and cause significant damage. This constellation of characteristics is known to elicit high levels of rage and annoyance. Repeated exposures to uncontrollable stress, together with negative causal attributions are known to bring forth feelings of hopelessness and depression. By combining the results of six studies done in and outside of Israel, Gidron (2002) found that the mean prevalence of Post-Traumatic Stress Disorder (PTSD) after a terrorist attack is estimated at 28.2%. Israeli women were found to be 5.54 times more likely than Israeli men to have symptom criteria for PTSD, trauma related symptoms and feelings of depression (Bleich et al., 2003). These findings are consistent with other reports in which women have been found to display more symptoms of PTSD than men following involvement in a traumatic event (Voges &Romney, 2003). Constant and chronic exposure to violence and stress, together with their learned powerlessness, shame, fear and vulnerability may explain why Israeli women are at high risk to develop PTSD, especially when exposed to a traumatic and violent event such as a terrorist attack. When a woman survives a traumatic and violent experience, the personal and social meanings

of the event are constructed around the disruption of her past history, her anticipated life course, her roles in her family and community, her identity and sense of self. Judgments about the significance of her disability and her subsequent response to her situation are rooted in her life and in her biography (Kearney, 1999). How a woman responds to violent assault is dependent upon her personal interpretation of the experience (Reich, 2002). The principal perception of physical damage involves the internal spaces of the body. Some experience their inner selves as wounded and defected, containing gaps and black holes (Attias &Goodwin, 1999). Pregnancy may be viewed as an intrusion into this dark, polluted and inner-most bodily space. Fear of birth may arouse the shock, hurt and outrage of a repressed or recalled trauma. (Raphael-Leff, 1993). Childbirth can be frightening; women fear for their lives and for their infant's life and physical well-being. Even a normal birth can be subjectively experienced as deeply upsetting. Medical procedures during labor can be invasive and associated with feelings of lack of control. The emergency nature of some events may leave women unprepared and traumatized (Alien, 1998). There is evidence that a previous traumatic event may predispose women to a traumatic birth experience, and that trauma may be cumulative. Wounded and unsupported mothers may find it more difficult to cope with the overwhelming nature of the birth experience (Mauger, 2000). There is a tendency for women with PTSD to relive the traumatic event when reminded of it. Two common features of childbirth that make it potentially traumatizing are severe, unrelieved pain and feelings of lack of control. Birth also contains the potential for transformation, for implementing change. Giving birth may provide the wounded woman with an opportunity to reconnect with her social setting after feeling isolated by the trauma. A positive, empowering birth can be the experience that helps a woman to discover her power and her capabilities, and can change her forever. A traumatized woman may be able to rebuild her autonomous self "by having a child, transforming her body from a container of ashes to a container for a new human life." (Attias &Goodwin, 1999, p. 299). Childbirth is an experience of enormous proportions that changes the way a woman feels about herself and affects her transition into motherhood. Women want to experience the birth of their children as positive and fulfilling. They wish, sometimes unconsciously, to be affirmed or confirmed in their own ability to give birth; they want to be empowered by their experience of childbirth. Labor can provide a kind of behavioral therapy on the condition that the woman has effective prenatal counseling, social support, trust and courage. If she has a positive birth experience, it can have a therapeutic effect and provide a form of redemption and transformation for her. According to Reynolds (1997), two things are crucial during the birth in order to facilitate an empowering experience: good communication which fosters trust and gives the woman a sense of choice and control, and pain relief according to the woman's choice. For some mothers, a planned caesarian section is the optimum solution. They achieve a sense of control by knowing the date beforehand, planning in advance, and having the baby removed. They avoid the unpredictable and painful nature of labor and birth (Raphael-Leff, 1993). In a very physical manner, the birth of a child can bring about healing and rebirth for the woman who is a trauma victim. Levine claims that if we trust the body's natural arousal cycle, and are able to flow with it by allowing sensations to peak and diminish spontaneously, healing of the trauma will occur. The experience may entail trembling, shaking, vibration, waves of warmth, slowed heart rate, warm sweating, relaxation of the muscles and an overall sense of relief, comfort and safety (Levine, 1997). "The sheer enormity and primitive quality of the birth experience grants it a power that can have reparative or harmful ramifications. Endorsing a woman's trust in her own capacities, and increasing the opportunities for taking meaningful decisions based on real information can mean the difference between a thwarted or passive experience and one of exuberant empowerment." (Raphael-Leff, 1993, p. 110). Newborn babies are innocent and dependent on their parents' love; they stir up soft loving feelings. "Nurturing and protecting a newborn baby can help heal those wounds that are closest to the heart. Here the most profound healing takes place, for it is in the nature of things that the most damaging experiences are also the most profoundly transforming" (Mauger, 2000, p. 140). Infants are highly developed organisms at birth; they send signals activating their mothers' deepest sense of serenity, responsiveness and competence. "Mothers and babies feed off each other in an exchange of mutually gratifying

physiological responses, which in turn generate feelings of security and pleasure. It is here that the cycle of traumatic damage begins to transform." (Levine, 1997, p. 229). The mother suffering PTSD has difficulty maintaining a balanced perspective when life's challenges arise. Her high levels of anxiety can interfere with her child's developmental progress. Children's selfimage will be affected by their image of their parents (Portney, 2003). Offspring of parents suffering from PTSD often describe their parents as damaged, preoccupied and emotionally limited. Symptoms in parents such as emotional numbing, dissociation and traumatic reliving prevent the child from developing a normal sense of safety and predictability in the world (Portney, 2003). A view of the world as a dangerous place can be transmitted without the child ever knowing the roots of the feelings of lack of safety (Abrams, 1999). METHODOLOGY Qualitative phenomenological research methods were employed in order to focus on the personal descriptions and perceptions of the maternity experiences of women who survived terrorist attacks. The phenomenological approach was chosen because phenomenology is committed to descriptions of experiences, not explanations or analyses. "Descriptions retain, as close as possible, the original texture of things. Descriptions keep a phenomenon alive, illuminate its presence, accentuate its underlying meanings, enable the phenomenon to linger, retain its spirit, as near to its actual nature as possible" (Moustakas, 1994, p. 58-59). This phenomenological study aims to portray the nature of the shared experiences of Israeli women who became pregnant and gave birth after surviving the trauma of terrorism in order to learn how maternity experiences can either augment the process of posttraumatic healing or exacerbate the wound inflicted by the trauma. Data was collected from a small purposive sample by conducting semi-structured open-ended interviews with eight women who shared their stories and interpretations of their experiences. Acquaintances with these women were made via midwives, doctors and clinical psychologists who cared for them before, during or after their births. A digital voice recorder was used to document the interviews which were subsequently transcribed verbatim. The interviews took place in a location chosen by the interviewee; seven out of eight chose to meet in their homes. The women were encouraged to feel free to refuse discussing any topic that was too painful for them. The narratives created by these in-depth interviews revealed the diversity and richness of their insights and perceptions. Written diaries provided added validity to the verbal materials collected in the interviewing process. Reading and analysis of these materials revealed emergent themes. The Participants All eight interviewees were Jewish Israeli women between the ages of twenty-four and fifty-four. Their ages at the time of the incident ranged from sixteen to thirty-three. The time period that passed between the incident and the interview ranged from six months to thirty years. All of the women are married. Five of the women classified themselves as non-religious; two described their religious orientation as traditional, one as religious. The women reside in small towns or cities in northern and central Israel. None of the interviewees reside in outlying settlements or disputed regions. The incidents in which they were involved included: two hostage situations which resulted in crossfire between Israeli army rescue units and terrorists, two bus bombings, two restaurant bombings, a bombing in a public market and one in a shopping mall. In all of the incidents there were numerous fatalities and injuries. Three of the eight interviewees were seriously injured and required long term hospitalization and rehabilitation. Three sustained injuries that weren't life-threatening, but suffered from numerous shrapnel wounds and required short-term hospitalization and treatment. One suffered minor hearing loss only; one wasn't injured physically at all. One interviewee lost her husband and six-year old son in the incident. Another lost her sixteen-year old sister; a third lost her mother-in-law. One woman was taken hostage in an incident in which twenty-two sixteen-year-old classmates of hers were killed. Three of the interviewees were pregnant at the time of the incident, one in her fifth month, one in her seventh month, and one in her ninth month. Two women, both with two small children at home, became pregnant immediately following the incident. One woman became pregnant intentionally four years after the incident at age twenty after one year of marriage. One woman with a thirteen-month old baby, found herself unintentionally pregnant five months after the incident. One interviewee discovered that she was pregnant at age forty, much to her delight and surprise, after she had been told that she was infertile and had adopted and

raised two children. All of the pregnancies of the interviewees came to their completion at full term with infants of average weight and size. One baby was born by cesarean section, one by vacuum extraction and six by normal vaginal deliveries. FINDINGS AND DISCUSSION The woman who has experienced terrorism will never again be the woman she was before. Traumatic events breach the attachments of family, friendship, love and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order; they cast the victim into a state of existential crisis (Herman, 1997). Analysis of the materials revealed findings in four major categories: losses, pregnancy, birth and mothering through the prism of otherness, maternity in the wake of adversity as empowerment and shared transformational processes. The Losses The woman who experiences trauma experiences loss. Traumatized people feel lost, abandoned and alone; they are alienated from their surroundings. The woman who has been injured loses her taken-forgranted body as the familiar dwelling place of the self (Kearney, 1999). Her social identity as a woman is put in jeopardy. She doesn't recognize herself emotionally; she may be angry, terrified, tearful, weak, helpless and lifeless. Guilt may haunt her thoughts incessantly. Terrifying images fill her mind days and nights; she may feel like she is going insane. S: Before the incident, my life was filled with colors; I was happy, contented. I had the pink of flowers, greens, the sun, the blue sea and all the colors of the setting sun. After the incident, it was as if I passed through a dark tunnel and there I heard the echoing voice of the angel of death. When I came out of the tunnel I had only shades of grey and black. I was left with sadness, fear, pain and trauma. Physical wounds blend together with the emotional pain of fear and anguish to form a long-lasting memory of overwhelming violation. Wounding is about pain; it is the body's way of recognizing harm and a threat to its existence. The victim encounters the social message of the terrorist as soon she responds to the realities of her bodily pain. Z: Only someone who has experienced excruciating pain can understand what I felt. I wanted to die. If living meant feeling so much pain, I was ready to stop living. I so was filled with fear that I hid under the bedcovers for hours at a time. I was sure I was losing my mind. The only thing I saw was the pain. Surviving the bombing does not translate into a cessation of the pain. Hospitalization, surgical procedures, recovery and rehabilitation force the survivor to deal with numerous sources of additional suffering. Having been socialized to be passive and vulnerable, women's ability to withstand pain is doubted both by themselves and by others. Because women's pain is often over or under-estimated they often experience under and over-medication (Taylor et al., 2000). C: The treatments were more traumatic than the bombing itself. My wounds were open and every hour they came and poured antiseptic on my open wounds. They refused to give me any medication to relieve the pain because of the baby. Suffering the loss of bodily functions is work that is done gradually over time. Scars of internal and external wounds are permanent reminders of injury and trauma. The women interviewed carry reminders of the physical violations of their bodies in various forms: chronic pain, gruesome scars, permanent disabilities, shrapnelimbedded limbs, hearing loss, lung damage, and intestinal adhesions. S: I still can't straighten my arm. Thirty years later, it still hurts, especially when the weather changes. I have a piece of shrapnel in my lung. I prefer not to talk about my pain, even when I really hurt. Who doesn't hurt? Just imagine me sitting around all day complaining about my pain. Who would want to be with me? We all need to learn to live with our pain. A woman who has been in a terrorist incident may scream and struggle without making a sound and no one hears her cries. She searches for someone who will listen, but her narrative is confusing and often has no words. She searches for contact and affiliation with her girlfriends, her mother or her sister. Her stories are upsetting and they remind others of their own fears. She yearns for someone to hear and understand her, but she knows that no one will ever be able to comprehend what she has experienced. Her voice becomes silenced with time. Loneliness eventually overcomes her and becomes a part of her life. S: People don't like to hear about how much pain you're in, how hard it is for you, how sick you are. People stay away from those who complain. Some of the survivors complain all the time and nobody likes them. When I look back, I really wanted people to know that I needed help, but at the time, I said nothing. I wanted everyone to think that I was okay. I thought

everything would work itself out, but it didn't happen that way. C: I am dying to express myself about what happened but I don't really have an outlet. People don't want to hear. Whenever I start to tell, I get the feeling that they don't want me to continue. They don't know what to say. What is there to say? So they ask me how I am. When I went back to work, people were shocked to see me. They were talking about me all the time, feeling sorry for me. O: I have trouble swallowing, drinking, eating, and speaking. I feel like I'm choking. Now my speech is better, but for a while I couldn't speak at all. I still stutter, but not as badly as before. Sometimes I feel like screaming to the heavens. Why did this happen to me? No one hears my voice. No one understands me. No one hears my words. Everyone acts as if they pity me. Their pity is annoying; I don't want to be pitied. I want to be understood. It's as if I'm different from everybody else, as if I'm polluted and they're clean. Suffering involves facing a painful confrontation with a loss of parts of self, affiliations with others and the world at large. Pain and hurt may surface on many different levels. They can exist in the present, reemerge from the past or involve dread of the future. Experiences of helplessness and powerlessness make trauma victims vulnerable to feelings of anger, fear, frustration, blame, grief and emptiness. C: I am very angry and a nervous wreck lately. I am easily annoyed by small things, silly things. It's as if I've been taken over by my nerves. I wasn't like this before. I forget things like dates. I used to remember everything. S: I am afraid of everything. I can't get on a bus or into a car. I'm afraid of being run over by a truck and of being hit by lightning. If I go somewhere where there are more than five people, I feel pressure in my chest and have trouble breathing. I can't stand the sight of meat or blood. I'm afraid of dying. I want to get over all this and go on with my life. I get upset, anxious and angry so easily that I have no strength left to do anything. I've lost so many things, my memory and my ability to organize my life. A woman who is wounded or traumatized is overcome by her losses and becomes confused about the way she sees herself as a woman. She experiences threats of dissolution of her essential feminine self. There is strong social pressure for Israeli women to procreate. In Israel, the desire of women to have children is a collective assumption. Women who don't have children are different and are considered outside the realm of normal; they are social outcasts, anomalies. Women who have been wounded in bombings fear losing their capacity to procreate, ceasing to be like everyone else. If they do not succeed in becoming mothers, they become even further distanced from normal. S: When the terrorists were shooting and I was perched on the window sill, about to jump, for a split second I thought about the future. I questioned whether I would ever be able to have children? I was so relieved when I found out I was pregnant. Now I can play my role properly. Now I can be like everyone else. Women with physical disabilities that restrict their mobility and impede upon their ability to conduct their daily activities suffer from low self-esteem. They feel useless and worthless. They feel that they have become burdens on their loved ones. They may need to be cared for by those they are used to nurturing. Foremost in the minds of the women interviewed was their inability to fulfill their roles as mothers to their children. From Z's Diary: I am like a wounded lioness whose cub had been taken away. Strangers are taking care of my son, playing with him, smiling at him. He needs his mother. I need him. He's used to me. I haven't left him for a minute since the day he was born. He's only seven months old. S: My lifelong dream has been shattered. I feel like a failure. All I ever wanted was a family of my own. My eleven-year-old daughter won't let me be her mother anymore. She wants to be my friend. She wants to mother me. She no longer accepts my authority. I barely function like I should. Look at my house. After suffering the traumatic experience of a terrorist incident, the survivor may feel like her life is out of control and that sanity is out of reach; she may fear that she is losing her mind. Death seems to play games with her by hovering overhead and peeking behind every corner. The interviewees described how their lives were permanently altered after being exposed to the sights, sounds, smells and tactile sensations of the devastation that follows a bombing incident or a shooting. Experiencing the event over and over in the form of flashbacks and nightmares was a common complaint. The event never seems to be over. These experiences cause healthy women to feel they are nearing insanity. C: Often when I am in the supermarket, I wonder how the place would look after a bombing. People are doing their shopping, but I can see their faces blackened and their hair singed. It's a picture that comes into my mind time and again.

S: Three years have passed and I can still smell the odor. I can still see the shoes on the feet scurrying by me, the shattered glass everywhere, the bus stopped awkwardly in the middle of the intersection. There was so much blood; it was like water, flowing like a river. Many of the women interviewed told of spending days upon lonely days plagued by guilt, wondering whether or not they had behaved appropriately during the bombing, whether they had been altruistic enough, why they had been spared and others died. S: Twenty-two classmates of ours were killed. Their parents are our neighbors. We meet them everyday in the supermarket, on the street and on our way to work. Their looks leave us with the feeling "You are guilty!" We see questions in their eyes: "Why were you saved? Why didn't my son survive?" (Saban, 1990). C: I didn't think much about myself because my mother-in law died in the bombing. Nothing really tragic happened to me. This story wasn't about me. It seems egotistical to think about myself under the circumstances. I sat outside the restaurant and could see my husband and father-in-law inside together with her and I felt that I was acting wrongfully. I should have been inside with her too. I could see that she wasn't moving. I should have gone in but I couldn't force myself to do it. I was drained and I felt my eyes closing. I fell asleep on the sidewalk. It was a kind of betrayal. She'll never forgive me. Maternity through the Prism of Otherness After suffering a series of fundamental losses, the wounded woman feels different from other women. Her otherness becomes painfully evident, especially to herself. This condition of otherness enables women to stand back and consider the norms, values, and practices that the dominant culture seeks to impose on everyone, including those who live on its periphery. Thus, otherness, for all of its associations with oppression and inferiority, is much more than an oppressed and inferior condition for women. It is also a way of being, thinking, and speaking that allows for openness, plurality, diversity, and difference. This is a major theme of deconstructionalist feminism, which recognizes the advantages of not being one of society's favored members, of being excluded, shunned, frozen out, disadvantaged, unprivileged, rejected, unwanted, abandoned, dislocated, and marginalized (Tong, 1998). Women who have experienced terrorism learn to understand new forms of otherness: as trauma victims, as grievers, as emotionally and physically disabled and as the survivors of terrorism. This rich compilation of otherness provides them with a different perspective on the values, beliefs, norms and practices that the dominant culture associates with pregnancy, birth and mothering. After staring death in the eyes, life seems tenuous and fragile; it is difficult to accept the concept of pregnancy. Surviving is a difficult task; pregnancy and birth seem like impossible missions. Pregnancy is a tremendous challenge both emotionally and physically. These women doubted whether or not they were capable of carrying a pregnancy to term successfully. Z: Pregnancy wasn't even a possibility. I was unnerved when I found out. The pregnancy was filled with anxieties, especially when I was told that it was a girl. I didn't want to bring another girl into the world who might suffer the way I did. O: On one hand the idea of being pregnant gave me hope for change, renewal and hope. On the other hand, there were the doubts and uncertainty about the future. I thought about killing myself, about killing the baby. Abortion was an option that was too traumatic for me. I cried day and night. I decided to keep the baby and slowly learned to live with the idea, one day at a time. I had my ups and downs. I had no strength, even for my self, let alone for a baby. There were days of total despondency. It was a nightmare. Then she would kick, and I would feel that she was with me, and that I was with her. The pregnancies of all of the women who were interviewed were categorized as "high risk" by their attending obstetricians. The risk approach in obstetrics is aimed at screening out women in the general population who are at risk for developing problems during their pregnancies and giving them special attention, further tests and referrals to specialists. Being categorized as a high risk pregnancy is a status that is known to raise fear and anxiety levels. The pregnant woman placed in this category absorbs the idea that pregnancy is a risky and dangerous situation (Wagner, 1994). Her pregnancy seems tenuous, dangerous and fragile. The high risk pregnancy label and these women's relationships with their doctors enhanced feelings of frailty, dependence, alienation, low self-esteem and high anxiety states. They realized that their pregnancies couldn't be like other women's pregnancies and they began to abandon their hope to reclaim normalcy. E: The doctor was very responsible. He put me into a clinic for high

risk pregnancies. Everyone knew that this was a very special pregnancy, a precious pregnancy. I related to it like any other pregnancy, but the doctors treated me like it was something special. S: Dr. K. put me into the clinic for high risk pregnancies when he heard that I had been in a terrorist bombing. He took care of me like people grow flowers in a hothouse. That was how much he worried about me. He did an ultrasound scan on me every time he saw me and arranged for a social worker to come talk with me. The fetuses of interviewees were considered to be at risk because of two known effects of maternal stress that have been observed on unborn fetuses: preterm labor and impaired intrauterine growth. Routine ultrasound scans are performed to monitor the growth of the fetus. The three women who were pregnant at the time of the bombings were worried that their fetuses were affected by the trauma as a result of the fears, the mourning and the emotional upheaval they had experienced together, as two bodies in one. They were concerned mostly about long term neurological and emotional damage. M: I first started worrying about my son when he was inside my womb during the bombing and I've been worrying about him ever since. C: I went to the doctor who does the ultrasound scans and he didn't do very much. He showed me the baby's heart beating and his legs moving and that was it. I expected more. I wanted to be reassured that the baby was really OK. The problem with doctors is that if the baby isn't dead or dying, they really don't know anything for sure, and they talk in a manner which you can't really understand. How many cases have they seen of women who were pregnant and were in bombings anyway? Even though it is a very personal, private and physical experience, pregnancy never occurs in a vacuum. It is an experience that has social, religious and cultural implications. According to the experience of the interviewees, the way in which the environment reacted was in sharp contrast to the feelings experienced by the post-traumatic pregnant woman. The partner, family, community and nation were often ecstatic, and the woman, less so. This contrast augmented her alienation and her feeling that nobody really understood what she was going through. Z: My husband was so ecstatic that he picked me up in his arms. I sat and cried. I felt like a newborn baby that just got over her own birth and here I was doing this all over again. S: A year after my wedding I finally got pregnant. My mother and mother-in-law had been anxiously waiting, worrying that I wouldn't succeed. I was afraid that the pregnancy wouldn't go to term because I had adhesions in my uterus and everything grew crooked. In Israel there is a popular belief, which is reinforced by the media, that pregnancy is a panacea for wounded women. The womb of the Israeli woman is public property and is used as a tool for political, religious and nationalistic purposes. The pregnant terror survivor is often transformed into a national heroine by the media. The public participates in her pregnancy, waits for her to give birth and celebrates her victory over the "enemy". Not all women agree to play a part in this game; not being manipulated by the media was a source of empowerment for one survivor: M: One of the reasons I decided not to go to the hospital was because I didn't want to see in the newspaper tomorrow a headline reading "Pregnant Woman in Her Ninth Month Saved in Bus Bombing". I didn't want anyone to use me for their political interests. It was my own private experience, my own private concern, my own private pregnancy and I wanted it to be my own private birth. As the pregnancy draws to an end, the birth comes into sight. The interviewees expressed many fears that surfaced as they entered their ninth month. Specific and identifiable fears surrounding their return to the hospital included: seeing blood, being poked with needles and cut with knives, being out of control and being at the mercy of the decision-making power of others. Independent of the hospital-associated fear was the traumatic memory of the incident which reappeared in many of the women. This memory attached itself to the prevalent fears of normal, nontraumatized women who are often consciously and unconsciously afraid of childbirth. There is an archetypal fear of losing the child or dying that seems to be imprinted in the collective unconscious of pregnant women, no matter how much technology we have and how modern we have become (Mauger, 2000). Women are afraid of birth; childbirth triggers old traumas and exacerbates the fear. Three of the interviewees requested cesarean sections in order to gain a sense of control over the circumstances. These women understood that they had special needs and asked their caretakers to honor that individuality. Only one of three requests for a c-section was granted: Z: I was scared of going back to the hospital, of seeing blood, of being cut. My fears were totally out of

control; most of them were unwarranted. Somehow the bombing attached itself to the birth and got stuck. In the ninth month the fears peaked. I was afraid of seeing green uniforms, of being at the mercy of others, of being dependent on their decisions and the touch of their hands. I was afraid of the green, the blood, the operating room, the anesthesia and the needles. I was scared to death. I was convinced that a c-section would be easier for me, it would hurt less and that there would be less blood than in a regular birth. Everything would be sterile; I would go in and come out with a baby. S: I wanted a c-section from the start. I knew what surgery is. I was familiar with the surgery routine. I was an expert in being operated on. I didn't know anything about birth and it scared me. No one understood me. They didn't understand why I wanted a c-section. Birth is a painful, highly arousing and life-threatening event. The women who were interviewed approached their births overcome with fear, and understood that as a result they had long and difficult labors. They felt lonely, some lost control and others felt that they really suffered. They were exhausted from dread and apprehension, their resources depleted from the outset. Even those who had given birth in the past doubted their own abilities to cope with this post-traumatic labor from the start. S: The birth was frightening. I didn't know what to expect. When the contractions got stronger, I was really scared. I had contractions for two days. I kept telling myself that I must find the strength to suffer through the contractions. I was alone with my pain and it was difficult for me. C: When the contractions started getting painful, I kept asking myself, "What are you doing? What are you dong here?" I wanted to get up and go away. I didn't want to be there. I wasn't like this before. I used to be calmer; I used to suffer by myself, quietly and not make a fuss. The bombing changed me. During the birth, the women were reminded of the terror incidents on both the conscious and unconscious levels. The reminders appeared in the form of objects, behaviors, sensations and emotions. The sight of blood was reported by several of the interviewees as an extremely difficult experience. O: It's not that I didn't want the baby. I wanted her. I had gotten used to the idea. She was a fact. When I gave birth they handed her to me. When I saw her covered with blood, it reminded me of the bombing and it all came back to me. She looked like a piece of meat. I was shocked by the sight of her, really shocked. I couldn't handle it. I pushed her away and told them to take her away. It was really hard for me. The traumatic memory of the terrorist incident emerged during the birth, in different forms for each woman. In the following narrative, reappearing unconscious materials from the incident combine with the biological experience to create a powerful and unforgettable birthing experience for the interviewee. She experienced the confrontation of birth and death together with a spiritual opening that created a transpersonal state of consciousness, a state of rebirthing (Grof, 2000). S: During the birth itself, I could see the whole scene with the terrorists before my eyes. When the time came to push the baby out, I suddenly saw before my eyes, like a photograph, everything that happened in the incident. With each contraction I heard myself yelling: "The window, the window, go to the window. " Everything was happening at once. Who will go to the window? When the baby was about to be born, I found myself right by the window, trying to jump out. The midwives were yelling at me that I'm not letting my baby come out, that I'm holding him inside and that I'm making him suffer. I heard the fire of the automatic rifles and the explosion of the grenades. In the end, I pushed, the baby came out and I jumped. Reenacting the role of the victim during the birth was an experience shared by several interviewees. They had learned the victim role during the incident, feeling self-pity, misery and vulnerability. These feelings reemerged during the birth. When this feeling of victimization is transferred unconsciously to the birth situation, blame too is transferred. The woman, who feels weak and helpless, not understanding why she feels this way, will blame herself for feeling the ways she does. She may lack the power and motivation to behave according to her own expectations and the expectations of those around her. She may allow others to make decisions for her (Reich, 2000). This behavior may cause dysfunctional labor and necessitate medical interventions. She will be disempowered by her birthing experience and will feel disconnected from her body. C: I was pushing and pushing, and at a certain stage I said, "Enough, I don't want to push anymore. Do a vacuum delivery." I lost the willpower to push, and I am certain that it was a result of the bombing. I felt like I couldn't go on, that I couldn't do more than I did. I couldn't handle the pain anymore. I felt

sorry for myself; sorry for the fact that I was suffering. The suffering reminded me of the way I felt after the incident. It doesn't go away, the feeling that I am a terror victim, poor me. I felt it during the birth; it seems like an extension of the bombing, like one long experience of misery and suffering. Midwives and doctors accompanying women during labor play crucial roles in determining the quality of the birth experience. Women who have been traumatized clearly have special needs. The most important areas of concern in preventing retraumatization in post traumatic labors include: social support, trust, good communication, control, choice, preparation for procedures and adequate pain relief according to the preference of the woman (Reynolds, 1997; Garratt, 2002). Women whose needs were neglected felt lonely, rejected, and angry and mistreated by caretakers they described as insensitive, technological and abusive. Inadequate pain relief, lack of information sharing and inattention to emotional needs were common complaints. O: The midwife and the doctor were OK. I can't remember their names or their faces. They were very busy with the technical parts of the procedure. They didn't help me at all. I had needs, special needs, and no one took the time out to find out what they were. I should have had a psychologist with me throughout the labor. C: I don't think they even knew that I had been in a bombing incident. I didn't tell them; I didn't think that it was relevant at the time. Today I realize how important it is that they should know things like that. I had special fears and special needs. They really should have known. S: The second birth was really difficult for me. The midwife decided not to call the anesthesiologist for an epidural. She wanted me to feel the birth. I could have strangled her. What is the purpose of the epidural? Not to feel the pain. The experience of mothering can be difficult, and may even lead to unhappiness and depression. Women who have unresolved fears will carry those fears over to their mothering. Women marred by wounds before or during their maternity experiences may be filled with guilt, fear, anger and an injured capacity to bond (Mauger, 2000). The women interviewed expressed multifaceted difficulty with their mothering. They described themselves as fearful, over-protective, hysterical, depressed and angry. Some reported situations in which flashbacks of the trauma are triggered in association with their children's safety, causing instant panic. The fears reported by the women included: physical and emotional damage, leaving the house, damage suffered in the womb, the baby's safety, illness and consequences of their reactions triggered by reminders of their traumas. In posttraumatic stress the ability to distinguish between safety and danger is often blurred (Rothchild, 2000). Several expressed feelings of guilt for causing their children damage as a result of their over-protective mothering. There was a great deal of pain expressed in the mothering described by the interviewees, for both the mother and the child. Together with the pain, the interviewees described cherished and unique relationships created with the children born after the incidents. S: I was filled with fears. I was afraid of everything. I raised my son in an atmosphere of fear, protection, and over-protection. I limited him. Till this day he suffers from my fears. When he went to the army he wanted to be a fighter. Because of me he couldn't become an officer. He told them, "It's not me; it's my mother."It didn't help. He suffered a lot because of me, but we have a very special relationship. When he was a baby, if he heard me crying, he'd find me to make sure I was OK. He always worried about me, and he still does. C: I didn't go up the stairs because I was afraid that he would fall and something would happen to his head. Because of the things I saw in the bombing, I'm afraid he'll cut his head. I spend most of the time in the house with him. He never leaves my side. Z: I am hysterical when it comes to their safety. I can't handle it when they're sick. When they get sick, I'm sick. I actually get depressed. I get angry if my son falls and hurts himself at nursery school. I asked the teacher over and over to watch him. It turns out that during the bombing pieces of meat and flesh fell on me. It came up during a hypnosis session with my therapist. I can't stand the sight of blood or the smell of meat. We're all vegetarians now. O: My girls don't go to any after-school activities anymore, no public swimming pool, nothing. I close them inside the house together with me. When my husband takes them out it makes me angry. I can't stand to hear the baby cry. When I'm feeling bad I'm afraid to take care of her; I'm afraid of doing her harm just by being with her. Sometimes I imagine that I can create a bubble, and I can put her inside, and then she'll be protected, and no harm can come to her. I can't be inside there with her; I have my problems. She is pure good. The Empowerment of

Maternity in the Wake of Adversity The power of the mother lies in her potential to bear and nourish human life (Rich, 1995). Pregnancy and birth teach the woman to live with an ever changing and self-determining body. In posttraumatic pregnancy, women learn to understand deeply how their selves are indeed embodied; they begin to feel acceptance and gratitude for their imperfect bodies. Taking responsibility for their health empowers women (Kearney, 1999). The women who were interviewed told of feeling damaged and saw their inner selves as wounded after the incidents. Even though they were initially confused and ambivalent about their pregnancies, something about feeling their bodies fill up with the life and vitality of a growing fetus made them feel better about themselves. Z: I didn't believe that my body could sustain life. Something inside me had dissolved. After the initial shock wore off and my belly started to show, I realized that I was going to become a woman again, a mother. I have a fetus growing in my uterus; everything is normal and I am becoming feminine and round. I suddenly understood that if my body was strong enough to nurture a developing fetus, then my soul was strong enough to nurse itself back to mental health. A: I had one baby right after the other. My way of coping with my loss is to fill my life with sources of happiness, with the things that fill me up. Loss remains loss, but I try to fill the loss with happiness. O: I hoped something in me would change, something new, something good. I had hope and joy. I felt something good, something that wasn't a terrorist, and something that couldn't hurt me, something that is mine and that I need to protect. During labor women have the opportunity to experience their body's wisdom. Trusting the birth process and knowing how to tune in to the body are abilities that enhance labor and make it an experience with strong potential for empowerment (Northrup, 1998). A: All of a sudden I sobered up. I don't know why, maybe it was some kind of an instinct, but I bent my knees and squatted on the bed. The position helped me to get the baby out. I don't know what made me do it, but it was comfortable. I didn't care what anybody said or did. They were in the background for me. I was totally connected to myself. No one helped me during this birth. I helped myself. I was totally concentrated on what I was doing. I had no problem handling the pain. I ignored everything that was going on around me. I felt so powerful. It was amazing. I felt the head; no one believed me when I told them. Three minutes later the baby was born. When a birthing woman has control over her birth, uses her resources and abilities, and experiences a feeling of success she is empowered. She is aware of her rights and is able to exercise them in order to make decisions concerning herself and her baby. She is not subject to discrimination; she has adequate social support that ensures her physical and emotional wellbeing (Robertson, 1994). Birth contains the innate potential to heal old wounds. Even a cesarean section, a surgical intervention, can provide a woman with an empowering birth experience that heals old wounds if it is performed with compassion and the woman feels that she is in control. The behavior of the caretakers is crucial role in enabling the women to be empowered by her birth experience. Empowerment comes in different forms: Z: I said goodbye to my husband and my sister, I told them I'd be back soon and I went into the operating room. I sat on the bed by myself, I lay down by myself. My arms weren't tied, no one told me to be quiet, not to move, to be a good girl and to stop yelling. There was no uncertainty. There were smiles in the air, there was music, and my family was waiting outside for me. The anesthesiologist stroked my cheek. I was in control and nothing hurt. I didn't see a drop of blood. All of a sudden, the baby came out. She was perfect, healthy and simply amazing. I was elated and I wanted to tell them so, on the spot. "Do you know that you all are replacing my past, horrific experiences with a new positive and optimistic experience? You're talking with me, you're being kind to me, and you're laughing. I want to thank you all for this." Immediately after the birth, all of the women reported feelings of relief, happiness, hope, excitement, empowerment and courage to go on. This was in sharp contrast to feelings of hyperarousal, fear of death and injury, lack of control, extreme pain and suffering that some of the women reported during their births. The major element in this rather abrupt shift in emotions seems to stem from a reinterpretation of the event that is powerfully enhanced by the pure joy of the baby. Other positive factors that reduce stress and encourage well-being are emotional support, time to make sense of the events, information seeking and a gradual unloading of the tension that has accumulated in the body over time (Alien, 1998). The postpartum mother is in a volatile

state of changing emotions, most of them transforming themselves in positive ways. Z: The pregnancy had been full of fears and anxieties. After the baby was born, the next morning, I felt that the fear was gone. I released the fear; I let it go, it was over. From the moment the baby was born I forgot about the bombing. My body will always remember giving birth. I succeeded; I passed the test. O: After they cleaned her I took her in my arms. She really was very beautiful. The birth left me with a good feeling. I felt a sense of relief, not physically, but in my heart, in my soul. She gives me hope, a reason to live. Maybe she'll help me out of this nightmare. I wanted to be with her all the time. S: I cried a lot after the birth. I couldn't believe it was over. I felt like a bit of a heroine. I pray to God that he will give me enough strength to have a baby every year. When you're giving birth you don't feel death, you feel only life. Mothers and newborn babies feed off each other in an exchange of physiological responses. The baby is innocent, helpless and dependant and in need of its parents' love. The mother responds by nurturing and protecting the infant and, in response to her successful actions, she develops feelings of serenity, competence and responsiveness. This symbiotic relationship creates an atmosphere of pleasure and security for both the mother and the infant. There is unambiguous potential in this symbiotic relationship for the transformation of trauma for the wounded mother (Mauger, 2000). The newborn infant can help heal his mother's wounds. O: The baby makes me feel good. When I'm feeling down, it's enough for me to just see her smile, to see her innocence and I feel better. For me she is something pure, something holy. Sometimes I simply watch her sleep and it fills me with tranquility. When she wakes up in the middle of the night and sees me, she smiles. She doesn't understand who I am, what has happened to me. Sometimes she laughs and I cry; then she smiles at me as if to ask me why I'm crying. I think that maybe she came into this world to help me get better. Z: I'm nursing her and my appetite is back. I enjoy food again and I have someone to eat for. When I pull out my breast, she's attached to me and I feed her, !know that she needs me. That means that I am needed, that I am useful and that I am self-sufficient. I am no longer broken; I have been repaired. She expanded my heart, my empathy, my softness and my motherhood. Transformational Processes "There is only one question which really matters: why do bad things happen to good people?" (Kushner, 1989, p. 6). Women who have experienced the unexpected trauma of terrorism ask themselves this question incessantly. Events that involve loss or fear for survival may be especially likely to provoke constant re-evaluation. Women may be transformed into kinder, gentler versions of themselves as a result of being traumatized. Finding ways to benefit from adversity can help a person to continue to believe that they are deserving of good things (McMillen, 1999). Each woman comes to the traumatic event with her own personal history and unique personality. Each woman has different resources at her disposal and each woman has developed a personal coping style that she uses when required to handle stressors in her life (Lahad, 1997). Each woman comes from a different social, economic, political, educational and religious background. Who she is will surely effect how she fares. The process of psychological adjustment is a process of change and women change within their social contexts. Women come to believe in their bodies when they learn from survival and adaptation that they can trust their inner strengths and resourcefulness. Women who have been injured need to mourn the losses of their body integrity before they can accept their damaged selves (Kearney, 1999). The interviewees told of a new acceptance and love of their bodies after experiencing a long period of shame and disgust with themselves. Some of them told of feeling almost invisible before regaining their power and taking back control of body and self. Today they are proud of their bodies; they love and appreciate themselves. They have learned to listen to the body's voices, to react to the body's signals and meet physical challenges presented by the body. They have reclaimed their bodies as their own. S: I used to cover up my scars. I always wore long clothes, even in the summer when it was really hot. I never let anyone see my stomach. I was so ashamed that I couldn't straighten my arm. Today it seems natural to me. I'm actually proud of my body. C: After the bombing I felt sorry for myself. But as a result of my pregnancy I learned to accept and appreciate my body. I'm a lot less critical of myself. Today I love my body more than ever. I didn't use to think so, but today I think my body is beautiful. E: Today I like my body more than ever. I think I'm both striking and beautiful. I like my

uniqueness, my individuality. I feel that I'm different from everyone else in the world and that makes me feel good. It gives me strength. I believe in myself, in my own power. I believe that people will love me and my daughter, especially after what we've been through. I am a prize. Both my daughter and I are really special. One of the basic elements in the process of recovering from a traumatic experience is gaining perspective. This process entails changing priorities, learning to appreciate love; life suddenly seems like a gift. There is a new appreciation for living and a deep thankfulness for surviving the ordeal. Some discover their capacity to give; others find out that learning to receive help from others is a blessing. The interviewees discovered a new appreciation for themselves, their loved ones and life itself. They are glad to be alive and are determined to make the most of the time they have been given. They are more assertive about taking care of their personal needs and maintaining protective boundaries. They are aware that life cannot be taken for granted, that bad things can happen to good people. They discover their own strengths and weaknesses and accept themselves as they are. S: Waking up in the morning is no longer an assumption. I see things differently today. My priorities have changed. I see the yellow of the sun in my window. I see the challenge in crises; I've learned from my difficulties and distress. A: I no longer feel the need to judge myself or prove to myself that I'm good enough. We're all good enough; no one is any better than anyone else. I'm simply glad to be alive. It's very basic. Z: I'm a different person. I learned that I'm strong and that I love life. Things that I used to see as tragedies make me laugh today, and the opposite. Things that were inconsequential have become high priority. I've matured since the bombing. I now understand that what really matters in life is my family, what I can give them and what I can receive from them. I had to be blown to pieces in order to understand these things. Having come to terms with the traumatic past, the survivor faces the tasks of creating a future. She must develop a new self; she must develop new relationships or accommodate to changes in existing relationships. She must find a new sustaining faith. In accomplishing these tasks she can then reclaim her world (Herman, 1992). Women who give birth subsequent to their traumas have additional tasks. They also have to come to terms with their changing identity resulting from their passage into motherhood. A new self is created twice. If motherhood occurs during the posttraumatic period, the two changes of self may be integrated into one more complex change that may take longer to negotiate. The women interviewed who accomplished both of these tasks felt empowered by the process. They learned to view difficulties as challenges. They learned to expand their own potentials and search for their own resources. They discovered new means of expression and creativity. They set new goals for themselves; their priorities and behaviors changed. A: Good things came out of what happened to me. It's become a powerful element in many different parts of my life: how I view pain, how I see my career, how I raise my children, how I handle my relationships. S: My father used to say to me, "Do you have goals in life? If you do, then paint them with plenty of colors. Paint your objectives. There will always be obstacles, difficulties that will challenge you." When !encounter a difficulty, I see it as a challenge. I can't sit in one place. I'm always asking what's next. I believe that each of us should take advantage of her potential to do what ever she can, to search all the time for more. I have spheres of influence in my life; everyone does. I believe that we can change the world if each of us does her best in her part of God's little acre. Wherever I discover that I have the power to influence others, I do my best to help. Ifl save one soul in this world, for me it's as if I've saved the entire planet. But I still have fears, just like any normal person, maybe more than others. The fear is no longer inside of me; it's somewhere above my head I'm more aware of the possibilities. If a normal person says, "It won't happen", I say, "It could happen again." Intra-Gestational Trauma: Voices from the Womb Pregnancy offers the woman a unique opportunity to tune in to her inner body. It is changing daily in order to accommodate to the growth and development of the fetus. These changes generate signals to the woman concerning her physical and emotional state. Her instincts are sharpened and exercised. Three of the interviewees experienced the unique and mystifying juxtaposition of life and death within the confines of their own bodies. They were pregnant at the time of the bombing; in addition, two of the three lost family members in the incident. These women, when examining their behaviors during the incident, discovered, in retrospect, that their reactions were governed by

voices from the womb that dictated their actions according to clear personal priorities. Their initial reactions were governed by their bodies; only afterwards could they gain cognitive understanding of their behaviors. M: It was pure egoism, survival. It was as if my genes and the whole process of evolution itself were speaking to me. I received instructions from my belly to get off the bus as quickly and as carefully as possible. I then broke out in a sprint and didn't stop running until I felt safe. My only concern was the content of my womb. Maybe I would have behaved differently if I hadn't been pregnant. C: It seems natural that I lost consciousness. It was too much for me to handle; fainting was a kind of escape. It seemed best to just sit and not risk falling because of the baby. I reminded myself that I was pregnant, that I'm allowed to sit, and that I shouldn't exert myself. When I was first brought to the hospital, my thoughts were focused on the baby. I needed to know that he was OK. An intriguing observation made concerning these three women who were pregnant at the time of the incidents was that none of them developed PTSD. The question raised by this finding is whether or not pregnancy serves as an intrinsic defense mechanism against traumatic stress. We know that high levels of oxytocin, endorphins and estrogen provide a physiological resource for stress management in women (Taylor, 2002). Women who are pregnant have high physiological levels of these hormones; they enjoy the benefits of supplementary amounts produced by the placenta and the fetus. These hormones are known to promote the female survival behaviors of nurturing and affiliation in times of stress. These hormones are significantly higher than in non-pregnant states and may provide a possible physiological explanation for this phenomenon. M: I went to a therapist six years after the incident. It was hard for me to believe that I didn't have any traumatic stress reactions to the bombing, so I decided to go find out where my trauma was hiding. After three or four meetings, I finally understood. You idiot, girl, you were pregnant. You were taking care of your baby. When I got out of the bus, I was taking care of the baby, and I succeeded even though people were on the floor, crawling in between my legs. CONCLUSIONS The Israeli woman who has experienced a terrorist attack is, first and foremost, still a woman. Fate brought this incident upon her and changed her forever, but she still maintains a life that is hers alone. She has a history, a personality, an identity, a self and a body that is uniquely hers. Although at times it may not seem possible, but after the incident passes, her life somehow does go on. The quality of her subsequent existence is dependent upon her ability to grow, learn, develop and find meaning from the events of her life. Maternity is a significant part of women's lives. Mothering is a common denominator of women across cultures and time. Most Israeli women define themselves through their pregnancies, births and the mothering of their children. It is what the female body knows best; mothering is what women do. In the eyes of women, losses that involve the ability to mother are losses that are critical, irreplaceable and unbearable. The woman who is wounded physically and emotionally is anxious about maintaining her ability to procreate and care for her children. The woman who has been traumatized fears that she may never be the same and that she may never properly fulfill her role as mother. Women who have survived terrorist incidents feel that they are different from other women. They have fears, insecurities, and doubts that set them apart. They yearn to regain normalcy, social acceptance and optimism; often they turn to maternity in hope of achieving these goals. The maternity experiences of terror survivors are different from those of other women. Posttraumatic pregnancy is an experience filled with extreme ambivalence, fear, self-doubt and anxiety. The contradictions are enormous. Although she is hopeful for a new beginning, she is also deeply aware of the dangers that life entails. She experiences the power of her body as it creates and nourishes life. Fetal movements remind her that she is about to become a mother, and that her life is moving forward. She is afraid of losing control, being hurt and being surrounded by strangers. Her brush with death has damaged her sense of basic trust. As labor begins, the pain of the contractions reminds her of other pain and trauma that she has felt in the past. She has special needs; she has unique fears that no one can anticipate. She may lose the ability to cope with the challenge of labor because memories of her trauma intertwine with the sensory experiences of pain and create an intensely confusing and difficult experience. If communication with caregivers is effective, the unique needs of the posttraumatic woman will be identified before, during and after labor. If she receives care that answers her

specific needs, she may have a positive and empowering birth experience. The significance of a good birth experience could be far-reaching by boosting her confidence, reaffirming her belief in herself and helping her to reconnect with the wisdom and power of her body. This could be the time when healing begins for her. If her needs are ignored, missed or wrongly identified, or she is treated coldly and insensitively by midwives or doctors, she may suffer a disempowering and retraumatizing birth experience. She may suffer further losses concerning her body's abilities to perform its basic female functions of pregnancy, labor, birth and lactation. She may come away from birth with new traumatic memories that will make mothering a newborn baby a complex task. Even though she succeeds in achieving maternity, normalcy remains unattainable for her. Women who have suffered numerous losses as a result of trauma approach the task of mothering from a perspective of apprehension and weakness. Posttraumatic mothering is filled with fears and anxieties concerning basic safety. Fortunately, newborn babies are sources of hope, light, optimism and innocence; they represent the goodness in human nature and the renewal of life. Women are reborn as mothers when they give birth to their babies. Young children force their mothers forward into the reality of the here and now and prevent them from dwelling on their dark pasts. They help heal their mothers from their traumas and pay the price of being overprotected by them. When given the opportunity to evaluate the overall outcome of the posttraumatic maternity experience, the majority of the interviewees reported that they had undergone positive changes. They felt gratitude and acceptance for the vitality and wisdom of their imperfect bodies. Pregnancy filled up their empty spaces; birth gave them a feeling of victory and accomplishment; breastfeeding and mothering made them feel needed and connected. The interviewees felt that they had become more honest, communicative and empathetic. They learned to recognize and deal with their fears by employing a variety of coping mechanisms. They reclaimed their individuality by recognizing their strengths and weakness. Life took on new meaning for them; each day seemed like a gift. They asked questions about the meaning of their lives and reevaluated their relationships with their loved ones. These changed women reported evolving into improved versions of their old selves. LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH The most obvious limitation of this research is the narrow nature of the target population. Women from other sectors of Israeli society need to tell their stories: Arab women, Orthodox religious women, women with strong political stands, women from different geographical areas. Palestinian women suffer no less than Israeli women from the violent nature of the ongoing conflict between two nations. An extended area of exploration to be pursued as an extension of this research is the effects of other forms of trauma on maternity experiences, and visa versa. Extensive work has been done on the ramifications of childhood sexual abuse on pregnancy and birth (Simkin &Klaus, 2004). Other causes of trauma in women's lives deserve equal attention, as does the effect of maternity on women who have suffered traumatic experiences in their lives. The significance of birth in women's lives needs to be further explored. If birth has the potential both to heal and to wound women, then midwives, obstetricians and other caregivers need to become more aware of the consequences of their words and actions. Birth is so much more than just getting the baby out. It has far-reaching implications for women, babies and society at large. References REFERENCES Abrams, M. (1999). Intergenerational transmission of trauma: Recent contributions from the literature of family systems approaches to treatment. American Journal of Psychotherapy, S3, 225-232. Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic birth. Journal of Reproductive and Infant Psychology, 16, 107-131. Attias, R. &Goodwin, J. (1999). Splintered reflections: Images of the body in trauma. New York: Basic Books. Ayalon, O. (2002). Living with terror, working with trauma: A clinical handbook. Pre-publication draft. Bleich, A., Gelkopf, M. &Solomon, Z. (2003). Exposure to terrorism, stress-related mental health symptoms and coping behaviors among a nationally representative sample in Israel. JAMA, 290, 612-620. Garratt, L. (2002). Maternity care of survivors of sexual abuse. MIDIRS Midwifery Digest, 12, 26-28. Gidron, Y. (2002). Posttraumatic stress disorder after terrorist attacks: A review. Journal of Nervous &Mental Disease, 190, 118-121. Grof, S. (2000). Psychology of the future: Lessons from modern consciousness. New York: State University of New York Press. Hassett, A. &Sigal, L. (2002).

Unforeseen consequences of terrorism: Medically unexplained symptoms in a time of fear. Archives of Internal Medicine, 162, 1809-1814. Herman, J. (1992). Trauma and Recovery: The Aftermath of Violence- from Domestic Abuse to Political Terror. New York: Basic Books. Kearney, M. (1999). Understanding Women's Recovery from Illness and Trauma. Thousand Oaks, Calif.: Sage Publications. Kushner, H. (1989). When Bad Things Happen to Good People. New York: Avon Books. Lahad, M. (1997). BASIC Ph: The story of coping resources. Community Stress Prevention, 1 &2, 117-145. Levine, P. (1997). Waking the Tiger: Healing Trauma. Berkeley: North Atlantic Books. McMillen, J. (1999). Better for it: Benefit from Adversity, Social Work, 44, 455-468. Mauger, B. (2000). Reclaiming the Spirituality of Birth: Healing for Mothers and Babies. Rochester, Vermont: Healing Arts Press. Moustakas, C. (1994). Phenomenological Research Methods. Thousand Oaks: Sage Publications. Northrup, C. (1998). Women's Bodies, Women's Wisdom: Creating Physical and Emotional Health and Healing. USA: Bantam Books. Portney, C. (2003). Intergenerational transmission of trauma: An introduction for the clinician. Psychiatric Times, 20, 38-40. Raphael-Leff, J. (1993). Pregnancy: The Inside Story. London: Karnac Books. Reich, N. (2002). Towards a rearticulation of women-as-victims: a thematic analysis of the construction of women's identities surrounding gendered violence. Communication Quarterly, 50, 292-312. Reynolds, J. (1997). Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth. Canadian Medical Association Journal, 156, 831-835. Rich, Adrienne (1994). Of Woman Born. New York: W.W. Norton and Comp. Robertson, A. (1994). Empowering Women. Australia: Ace Graphics. Rothchild, B. (2000). The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment. New York: W. W. Norton &Company. Saban, S. (1990). To Live Again, Tel Aviv: Ministry of Defense, Israel. Simkin, P. &Klaus, P. (2004). When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women. Seattle, Washington: Classic Day Publishing. Taylor, S. (2002). The Tending Instinct: Women, Men and the Biology of our Relationships. New York: Times Books. Tong, R. (1998). Feminist Thought: A More Comprehensive Introduction. Boulder, Colorado: Westview Press. Voges, M. &Romney, D. (2003). Risk and resiliency factors in posttraumatic stress disorder. Annals of General Hospital Psychiatry, 2, 1-9. Wagner, M. (1994). Pursuing the Birth Machine: The Search for Appropriate Birth Technology. Australia: Ace Graphics. www.idf.il/daily_statistics/english Retrieved Jan. 4, 2004. AuthorAffiliation Mindy Levy, CNM, MA AuthorAffiliation Mindy Levy CNM, MA, is a Homebirth Midwife, Childbirth Educator, and Midwifery Educator. Send correspondence to: Moshav Belt Lechem Haglilit, Israel 36007. E-mail: mindylevy@yahoo.com. Phone: 011 9724 9835920.

Publication title: Journal of Prenatal&Perinatal Psychology&Health

Volume: 20

Issue: 3

Pages: 221-248

Number of pages: 28

Publication year: 2006

Publication date: Spring 2006

Year: 2006

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: Forestville

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 10978003

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198787818

Document URL: http://search.proquest.com/docview/198787818?accountid=36557

Last updated: 2010-06-06

Database: ProQuest Public Health
