

NOREEN ANNE CAULEY

Trauma and Mothering: An Autoethnography

Sexual violence and mothering are prevalent events in women's lives. However, they are not often studied together from a feminist perspective. This essay uses autoethnography to explore the parallels between sexual violence and mothering. Specifically, this essay examines the medical models of trauma and childbirth, Maushart's "mask of motherhood," rape myths, patriarchal mothering, and empowered mothering. I argue that more vigorous interrogations of the commonalities and differences of mothering and rape will open strategic avenues for female growth, learning, and empowerment.

Sexual violence and motherhood are at first glance strange bedfellows. However, given that for women the statistical probability of experiencing sexual violence and becoming a mother is high, their intersections warrant attention. Estimates indicate that one in three Canadian women will experience sexual assault in their adult life (Statistics Canada, *Measuring Violence* 24). Additionally, a 2017 report compiled by Statistics Canada calculated that in 2011, more than 9.8 million women in Canada were mothers ("Mother's Day"). Thus, trauma and mothering are potential, underresearched, allies. I believe more vigorous interrogations of the commonalities and differences between mothering and rape will open strategic avenues for female growth, learning, and empowerment. As I emphasize the relationship between mothering and sexual violence, my hopes are two-fold—that this article be a site of healing for sexual assault survivors and mothers and that this article encourage discussion and connection within the worlds of trauma, pregnancy, and childbirth

Trauma's medical model obfuscates the importance of community in the healing journey. Although society acknowledges that sexual abuse damages an individual, there is rarely an accompanying societal responsibility reflected in actual community support. Similarly, lip service is paid to the importance

of mothers, although medical models of pregnancy, by design, disempower mothers. Nor are mothers supported under patriarchal assertions of ideal motherhood. In fact, myths of motherhood resemble myths of the perfect rape victim. Both silence women.

Rape, sexual violence, and motherhood are feminized, even though not all survivors of rape and/or sexual abuse are women and not all women are mothers. I do not support the gender binary, nor do I support the essentialization of motherhood and femininity. However, as Donna Haraway suggests in her *Cyborg Manifesto*, I will speak of “affinity”. Haraway argued that feminists should create coalitions based on affinities rather than identity. As feminization enforces “extreme vulnerability” on people (Haraway 38), I argue both motherhood and rape render a person vulnerable. Thus, an association between motherhood and rape survivors need not be based solely in their gender categorization; rather, it can be based on a recognition—an affinity—of the similarities between these two life experiences and vulnerabilities creates possibilities for allyship.

Sara Ruddick argues against the essentialization of mothering and instead positions mothering as a disciplined, intellectually-driven endeavour (96-97). The essentialization of motherhood diminishes the labour that goes into mothering; it relegates this work to an instinct or to a “natural ability” that women inherently possess. This devalues mothering. Similarly, society often feminizes crimes such as rape and sexual abuse in order to dismiss and/or ignore them (Herman 30). The overlap between seemingly disparate topics—motherhood typically associated with joy and rape typically associated with terror—presents potential for healing through the creation of strong support systems. These are communities that seek to empower mothers and survivors and to dispute harmful myths surrounding motherhood and trauma.

Pregnancy and childbirth can be empowering, embodied experiences. Yet these experiences can also isolate women. The medicalization of childbirth, lack of agency, and myths of ideal mothers and the perfect childbirth enforce the social exclusion of mothers (Block; O’Reilly, “Labour Signs”). The absence of support systems, narratives of the “perfect” victim, and medical models of trauma can cause similar isolation and shame to a survivor of sexual trauma, and can severely limit the survivor’s ability to heal and thrive. Nevertheless, healing from sexual abuse as well as from pregnancy and childbirth are potentially transformative sources of strength.

1. Trauma

My abuse occurred throughout my early teenager years. As Judith Herman notes,

adolescent girls are particularly vulnerable to the trauma of rape. The experience of terror and disempowerment during adolescence effectively compromises the three normal adaptive tasks of this stage of life: the formation of identity, the gradual separation from the family of origin, and the exploration of a wider social world. (61)

Many of my symptoms—self-harm, an eating disorder, intrusive flashbacks, disruptions of consciousness, and nightmares—are typical of trauma survivors. Yet the plethora of medical professionals I saw through my later teen years and into my early-to-mid-twenties rarely broached trauma as a possibility for these symptoms. I was ignored when I mentioned suspicions of rape. Instead, an array of pharmaceuticals was prescribed.

Initially, medication kept me afloat. My first prescription helped me cope when I entered a hospital treatment program for eating disorders (ED). The prescription helped. It made eating more tolerable by decreasing obsessive thoughts around food. I benefitted from the hospital's cognitive-behavioural therapy (CBT). After nine weeks in the hospital, I re-entered the world. I had a strong support system. I recovered from ED with the help of my family, friends, therapy, and medication. All of these softened the emotional edge around food preparation and meal times.

Unfortunately, pharmaceuticals concurrently facilitated a disconnect with myself. My mind felt dull, swathed in cotton, and slow like molasses. I loved the first few weeks—a mind free from ED-associated thoughts—but I hated that as the initial relief faded away, my razor-sharp mental speed also vanished. Bessel Van Der Kolk noticed similar effects in military veterans “the powerful drugs we prescribed often left the men in such a fog that they could barely function” (19). Enmeshed in cyclical, inescapable struggle, I would take medication for weeks and months on end. I rode a roller-coaster of feeling better and feeling worse. Stop the medication, feel better then feel worse. Start, stop, ad nauseam.

All the while, as I continued recovering from ED, I noticed something lurking in the back of my mind. I voiced these concerns to my psychiatrist (who specialized in ED treatment), but he ignored me and instead redirected the focus to maintaining my weight gain. Flashbacks began to haunt me; my doctor ignored this and merely prescribed more medication.

Van Der Kolk suggests widespread prescription of pharmaceuticals to treat posttraumatic stress disorder may “in the end have done as much harm as good.... In many places drugs have displaced therapy and enabled patients to

suppress their problems without addressing the underlying issues” (36). I know from experience that posttraumatic stress does not exist “all in one’s head” and that “the symptoms have their origin in the entire body’s response to the original trauma” (11). Attempting to locate mental illness “primarily by chemical imbalances in the brain that can be corrected by specific drugs” (Van Der Kolk 35) has overshadowed fundamental aspects of trauma. Pharmaceuticals are helpful. However, when they mask, suppress, and silence trauma’s pain—absent the discussion of medication as a strategy for the survivor to navigate trauma—their prescription becomes complicit in the dismissal of sexual abuse.

Furthermore, Peter Levine asserts that posttraumatic stress is not a disease, and it is not a disorder; it is the way the body copes with overwhelm, with terror, with trauma. Levine argues that trauma is an injury to both body and mind. He further stipulates the posttraumatic stress injury is an emotional wound, amenable to healing (34). Both Levine and Herman argue for therapists and doctors to empower survivors, instead of traditional top-down relationships; not doing so creates further suffering for the survivor and is counterproductive to healing (Herman 133; Levine 34).

Unfortunately, as my eating disorder behaviours and symptoms decreased, I began to experience terror. My perception of surrounding sounds would increase, my vision would darken, and I would lose consciousness. Repeatedly, I awakened to the feeling of my body crumpled on the ground. Ethologists call this “tonic immobility”: “When any organism perceives overwhelming mortal danger (with little or no chance for escape) the *biological* response is a global one of paralysis and shutdown” (emphasis in original, Levine 23). According to Levine, humans experience this as a state of panic. It’s not meant to operate permanently. For survivors of chronic abuse, this tonic immobility—rather than as a last-ditch effort to flee an inescapable threat—becomes the default reaction to a variety of situations in which emotional states are highly aroused (Levine 24).

My family doctor ordered an electroencephalogram (EEG) to monitor the electrical activity in my brain—to check for epilepsy. Over the years, I wore halter monitors to measure the electrical activity of my heart over twenty-four-hour periods. Eventually, I was diagnosed with depression, with anxiety, and was given more medication. None of it helped.

One of the medications I was prescribed was a powerful antipsychotic. Before a flashback would begin, I’d take a pill and fall asleep for nearly twenty-four hours. Still, the flashbacks persisted. I tried alcohol. I tried marijuana. Nothing really helped. The prescription drugs, the legal drugs, the street drugs—they all kept me in a kind of fog, a numbness. After several sexual experiences that I now categorize as rape,¹ the flashbacks intensified. It was no longer possible to start and stop taking medication as I had done earlier. Given

the increased number of prescriptions, abrupt cessation caused withdrawal symptoms.

As my struggles with treatment escalated, I increasingly questioned the medication, but I was unsure how to proceed. Ultimately, someone else made the decision about my prescriptions for me. The administrator at my psychiatrist's office told me I could not get an appointment for three weeks. I explained that in three weeks my prescriptions would be gone; I was not sure what state of mind I would be in to make it to an appointment. I asked if I could come in briefly to renew my prescriptions. Although I don't remember their exact words, I do remember that their tone was shaming, and they implied I was a drug addict. These were prescriptions I did not want; if I was an addict, it was by their design.

I decided that I did not want any more medication. I was not sick. I was not depressed. I was not anxious. No, I was someone who had been raped—many times—and wanted, *needed*, to talk about rape, about trauma, about dissociation, about flashbacks. I looked up the half-life of my medications, and planned to wean myself off the medication. Not that the medications were addictive, but to stop taking any of the medications abruptly resulted in feelings and sensations I was not sure I could tolerate—heightened emotional arousal, greater suicidal ideation, and floating out-of-body detachedness. I also decided to seek a therapist willing to discuss rape. I grew determined to air the festering traumatic wound buried deep in my psyche, which increasingly burst from my subconscious. Despite feeling trepidation, I was ready to confront rather than ignore my traumatic past.

As I began to search for help, I remembered how previous doctors refused to countenance discussions of trauma. Visibly uncomfortable when I did so, they were perhaps unequipped to discuss sexual violence. I would tentatively broach the subject, asking if all these symptoms could be related to rape. But those entrusted with my healing would ignore, gloss over, and shut down these conversations. The harm this caused is incalculable, and reverberates in my life today.

When I went to Homewood Health Centre in Guelph, Ontario, for their posttraumatic stress recovery program, one of the program's psychiatrists wanted to prescribe an antianxiety medication that also caused drowsiness; the medication helped others with posttraumatic stress disorder sleep at night. Although it had been a year-and-a-half since I'd taken any medication, as the doctor told me, "you won't get very much benefit out of being here, if you're not sleeping at night." Thus, I agreed to trial the medication for a week, after which we would evaluate its usefulness.

A week later we met, I told him sleep remained elusive, and my mouth felt dry as dust. He said, "well you know what the solution is?" and at the same time I said "stop taking it," he said, "increase the dosage." We laughed. I told

him I'd been down the road of increasing medication dosages before, and I was not interested.

For me, medication as a strategy failed. A doctor respected my choice, and it felt great. We discussed different sleep routines. It was collaboration between two people, instead of a top-down relationship in which the power dynamic rested heavily with the doctor.

2. Pregnancy and Trauma

Discovering I was pregnant emboldened me to find an empowering, patient-centred medical team. Lorna Turnbull's concern that "the medical model removes the power of women with respect to their pregnancies and places it in the hands of doctors or, in some cases, the state" rang in my ears (129). Feeling respected, maintaining agency, and working with my birth team to support my health and the birth of my child were all necessities. Healing from trauma gave me the confidence to demand my place as an active participant in my pregnancy.

Emily Martin laments how "obstetrical literature ... describes the birthing woman as a machine, her labour as a form of factory production that must be supervised, managed, and controlled" (qtd. in O'Reilly, "Labour Signs" 219). Andrea O'Reilly argues the medical discourse erases birthing women as active subjects. Obstetrical policies and procedures are a tangible example of the objectification of labouring mothers: "the complex process of birth that interrelates physical, emotional, and mental experience is treated as if it could be broken down and managed like other forms of production" ("Labour Signs" 219). These policies articulate a top-down relationship. Furthermore, they deny mothers agency in their own birthing experience.

Trauma and birth are complex. In conceptualizing this, I acknowledge the manifest, tangible ways that Western medicine does help; medicalized interventions can be helpful in some circumstances.² Yet they become deeply harmful when misused to ignore trauma symptoms. The problem with medicalized interventions is when they are used to ignore and/or dismiss the real circumstances and agency of traumatized and/or pregnant woman.

I stipulate that societal shaming of survivors and pregnant and labouring mothers seeking medication and medical interventions is detrimental to their wellbeing. This societal shaming functions similarly to the medical model: they both attempt to limit women's choices. O'Reilly argues that for pregnancy, women must be allowed self-determination, access to information, economic resources, allegiances across race and class, and to participate in decision making about reproduction ("Labour Signs" 222). This is similar to Van Der Kolk's argument for trauma treatment. He urges his readers to remember what is forgotten in the brain-disease model: restoring community and

relationships is central to healing, self-determination, and creating social conditions where children and adults feel safe to thrive (38). Actively participating in healing trauma, in pregnancy, and in birthing a child instead of being simply a patient is profoundly empowering

Sexual abuse is a violation; there is no choice. During pregnancy—in a time when I was most vulnerable—I would again be subject to someone else’s will. I worried my agency would be lost. This was intensely frightening. I was particularly wary of childbirth with a stranger. My closest hospital has thirteen obstetricians on call, giving me a twelve in thirteen chance that my labour would be overseen by an unfamiliar doctor. I absolutely did not want some random obstetrician— regardless of their expertise—having authority over my body or my birth.

Diane Speier argues that the “biomedical model of childbirth can disempower a woman by reinforcing dependency and inadequacy at just the time when her responsibility to a helpless new person is activated” (11). As a survivor, the potential loss of choice, agency, and vulnerability to a stranger— particularly in circumstances where I’d be totally exposed and at the mercy of someone else’s decisions about my body—was frightening. Plus the horror stories I heard from friends, television, and movies about the difficulties of labour were terrifying—tales of forced episiotomies, botched epidurals, and mothers being denied access to their babies on delivery. Foremost in my mind was ensuring an empowering birth experience.

There is a particular insanity in forcing someone who has already experienced a violation and a loss of bodily autonomy to unwillingly cede control to anyone else. Speier’s essay “Becoming a Mother” reinforces the importance of past life experience in childbirth:

Modern maternity care, driven by obstetric discourse and focused on the medical aspects of childbirth, has failed to acknowledge the psychological component in our understandings of the complexity of childbirth.... Since women always give birth in accordance with the way they live the issues that are consonant with their life prior to delivery will surely play out during the drama of birth, a grand magnification of those issues. An awareness of the probability of these dramatic events, which obstetric discourse ignores as irrelevant, allows couples to recognize things that might interfere with the process. They can choose to work on them before they go into labour, or they can deal with them in the moment in order to release their hold on the labouring woman. Midwives tend to be more in tune with the matters, as their approach to birth is often holistic. (10-11)

Given my apprehension of birth in a hospital,³ my partner and I found a supportive midwifery practice sensitive to the issues I might face as a survivor

of childhood sexual abuse. In particular, my two primary midwives took care to empower me during my pregnancy and delivery. They offered emotional support as I grappled with the shifting internal landscape of hormones and a changing body.

Ultimately, when I voiced my concerns, my birthing team treated me with respect. This empowered me. Conversely, my initial disclosures of rape were dismissed and/or outright ignored by my healthcare providers. The effect of these strikingly different reactions highlights the supporting role connection with others plays in trauma and mothering.

In fact, a strong support network is integral to healing trauma. According to Herman,

A secure sense of connection with caring people is the foundation of personality development. When this connection is shattered, the traumatized person loses her basic sense of self ... because traumatic life events invariably cause damage to relationships, people in the survivor's social world have the power to influence the eventual outcome of the trauma. (52, 61)

It is, therefore, no surprise that absent this assistance, like many survivors of sexual trauma, I struggled with self-doubt, guilt, and shame. I coped with years of suppressing memories of rape through prescribed pharmaceuticals, self-medication, and dissociation.

Although I did not outright deny what happened, I suspended belief. My support system mirrored my glossing over of trauma. Those charged with caring for me ignored my attempts to discuss rape. For many years, I convinced myself that the flashbacks and the memories were powerful constructs of my imagination.

Yet, as I healed, I craved connection. Herman explains:

Sharing the traumatic experience with others is a precondition for the recitation of a sense of a meaningful world. In this process, the survivor seeks assistance not only from those close to her but also from the wider community. The response of the community has a powerful influence on the ultimate resolution of the trauma. (70)

The inability and/or unwillingness of my closest friends and family to support me throughout the turmoil of remembering isolated me further. My spirit and body felt as though they were filled with concrete after flashbacks. But my support system was noticeably absent. When after days and nights of flashbacks, all I wanted to do was sleep and watch Netflix, where was my community of people? I needed friends and family to express their love by bringing me food, giving me hugs, and quietly sitting nearby while I cried.

Yet when I became a mother, people did connect with me. They brought me

food and held my baby so I could nap. Simultaneously, others disappeared from my life. To put it another way: “mothering is not supposed to be a solo mission. The real mission involves pulling into your circle of life all those with something to willingly offer. You are the gatekeeper, but you were never meant to be the whole world to your child” (qtd. in Thomas 62). In the same way, the trauma part of me is like my baby—I need to be the gatekeeper—but healing never was (nor should it be) entirely on my shoulders. This realization that trauma, along the same lines as mothering, is not an individual responsibility helped me acknowledge the profound loss I felt as a result of the alienation from my community. The aloneness of bearing the full weight of my trauma nearly crushed me. There were times I did not think I would survive.

3. Masks and Myths

Admittedly, patriarchal motherhood is also soul crushing. Just as trauma causes sequestration, patriarchal motherhood similarly attempts to disempower women. Patriarchal motherhood isolates mothers and enforces the belief they must raise their children alone (O’Reilly, *Matricentric Feminism* 19). Motherhood and healing from trauma, as sites of potential empowerment, rely on strong support systems. Compounding the difficulties in healing from trauma are the profound silences surrounding sexual violence. The disappearance of many close friends as I navigated the world of sexual trauma and litigation further damaged my wellbeing. Yet motherhood is Janus-faced: providing experiences of isolation and empowerment.

The isolation of motherhood is corroborated in Susan Maushart’s idea of the mask of motherhood. Like the dissociation and tonic immobility of trauma, the mask of motherhood ultimately “diminish[es] our knowledge, our power, our spirit as women...we no longer *make* a life—we *fake* a life” (emphasis in original, Maushart 463). Maushart’s work has clear applications to trauma and mothering. According to Maushart, motherhood’s mask exists to suppress the complexity of women’s lives; the mask silences women and keeps them from trusting themselves (460–61). Other scholars, including Trudelle Thomas, build on Maushart’s theories of masks and motherhood. Thomas deplores the divide the mask of motherhood creates between mothers and their communities. Thomas argues that the mask “prevents our society from realistically preparing prospective mothers ... [for the] huge trauma of re-organization” involved in becoming a mother (63).

Similarly, we do not realistically prepare women and girls for the possibility of sexual violence. This lack of preparation reinforces silence around sexual abuse. For years, I struggled to communicate my truth, much less find someone willing to listen. Society is uncomfortable when a woman names her experience of rape:

Husbands, lovers, friends, and family all have preconceived notions of what constitutes rape and how victims ought to respond. The issue of doubt becomes central for many survivors because of the immense gulf between their actual experience and the commonly held beliefs regarding rape. (Herman 67)

Like the mask of motherhood, society holds unrealistic, preconceived notions of rape and victims. The assumptions around so-called proper victimhood resemble society's misconstruction of mothering. Both misunderstandings produce harmful consequences that leave trauma survivors and mothers to cope in silence.

Thomas critiques the isolation many American mothers face as they assume full responsibility for domestic and childcare responsibilities. Furthermore, Thomas warns "the lack of fit between the expectations and realities of mothering may be experienced as a personal crisis, but it is ultimately a social tragedy" (63). A greater effort to prepare mothers for the realities of motherhood is needed. Communities cannot afford to support the mask of motherhood. The cost to mothers' mental health is too high.

The parallels between motherhood and trauma are further emphasized when I consider masks and dissociation. In terms of trauma, my capacity to dissociate saved my life. But years later, it cursed me and prevented me from confronting the violence I had endured. For mothers, masks impose a similar outcome. Maushart's evaluation of masks could replace my description of dissociation. Maushart acknowledges "the capacity for emotional make-believe, for pretense, for the construction of situationally appropriate masks, is perhaps our most enduring evolutionary advantage. It is also our greatest curse" (460). I maintain the silences mothers and trauma survivors face cause debilitating loneliness. The curse is the isolation from community. Society's lack of acknowledgment of women's lived experiences leads to the inability to share a common reality.

Society also enforces women's silence through the myths surrounding rape and motherhood. The parallels between the idealization of the perfect rape victim and the myth of the ideal mother are striking. Claire L'Heureux-Dubé, former justice of the Supreme Court of Canada, outlines the rape myths and stereotypes that political, social, and economic leaders use to uphold the status quo:

Sexually experienced women and those who transgress stereotypes of appropriate female behaviour by their sexual orientation, choice of occupation, ethnicity, poverty, intoxication, mental health, previous sexual assault complaints, by walking alone at night or accepting a ride home, fail to qualify as deserving victims and seldom have their cases processed through the criminal justice system. (Johnson and Dawson 104)

Another prevalent myth is that of the “good” rape victim. A good rape victim is a woman who is attacked and raped by a stranger in a dark alley. The perfect victim is sober, white, heterosexual, and able-bodied; she takes her rapist to court, she is a credible witness, and she clearly articulates “no” (Johnson and Dawson 105). According to Herman, the legal system only recognizes a crime as rape if the perpetrator uses extreme force, which is even more disturbing, “since most rapes are in fact committed by acquaintances or intimates, most rapes are not recognized in law” (Herman 72). The criminal justice system and the wider community rarely acknowledge the lived experiences of rape survivors. Rape myths effectively work to silence survivors from seeking any type of legal recourse—thus, masking the realities of rape.

Similarly, O’Reilly distinguishes between the oppressive patriarchal institution of motherhood and the act of mothering. Mothering is rooted in women’s actual lived experiences of mothering children, and has the potential to act as a source of empowerment (O’Reilly, “Feminist Mothering” 794). To that end, O’Reilly defines the “ten ideological assumptions of patriarchal motherhood,” one of which is the idealization of mothers (*Matricentric Feminism* 14). Under this assumption, only a “white, heterosexual, able-bodied, married” woman who is also middle-class and a full-time mother is bestowed the title of good mother (O’Reilly, *Matricentric Feminism* 12-13, “Feminist Mothering” 802).

Since women are not prepared for the realities of motherhood or of rape, both events, if or when they occur, do not align with the ideals and myths society espouses. Initially, the survivor of rape and the mother are mired in guilt—guilt for not meeting unreal ideals. In the case of rape, these myths interfere with healing. In the case of motherhood, they disrupt the empowering aspects of being a mother. Both survivors and mothers are forced to wear masks. Through its ability to define and challenge these myths, feminism unmask the realities of rape and motherhood.

4. Empowered Intersections

Many women, including mothers, are survivors of sexual abuse. The literature urgently needs additional discussion on the intersection of motherhood and surviving sexual abuse. Existing references to this intersection tend to reference the damage an abused mother will supposedly cause her child (Cannon et al.; Carolan et al.; Cross). However, Herman reassures survivors that:

Contrary to the popular notion of a “generational cycle of abuse,” however, the great majority of survivors neither abuse nor neglect their children. Many survivors are terribly afraid that their children will suffer a fate similar to their own, and they go to great lengths to

prevent this from happening. For the sake of their children, survivors are often able to mobilize caring and protective capacities that they have never been able to extend to themselves. (Herman 114)

The birth of my child reaffirmed my commitment to life. This is not to say that having a child is the answer to healing sexual trauma. However, after years of hard work, the place that remained the most fragile and fragmented in me—the place where my connection to humanity was frayed—is the place that is filled by the love I feel for my child. To be clear, this is not my baby filling an emptiness or a wound to my soul and psyche. Rather, the love I feel for my baby spurs me to choose aliveness. Whereas once there was listlessness, tiredness, and ambivalence toward humanity, now there is a fierce desire and dedication to change.

My experience powerfully demonstrates motherhood's empowering potential. Raising my child outside "the dictates of patriarchal motherhood" (O'Reilly, "Feminist Mothering" 798) encourages me to value the knowledge I carry in my body. Before my baby, I desperately wished for acceptance from a community that often failed to recognize and support me in the ways I needed. Mothering freed me from this longing and emboldened me to stand outside the norms of healing and mothering. Most importantly, mothering emboldened me to accept myself.

Trauma is complex, as is pregnancy. The trauma of childhood sexual abuse stems from its pernicious nature. Injuring the body, mind, and soul of a person leaves a gaping, invisible wound. Pregnancy is the growth of a new life within another living person. A chemical imbalance in the brain and a mechanical process do not adequately convey the realities of trauma and pregnancy. Trauma and mothering are potential, though underresearched, allies. I believe through more nuanced explorations, survivors, mothers, and their communities can shed false premises surrounding trauma, pregnancy, and mothering. They can disambiguate the realities of rape and motherhood. They can unmask false myths and ideals of trauma and birth. This may also lessen the occurrences of rape, as we mother our children with the full knowledge of our bodies, minds, and hearts.

Endnotes

- ¹ I knew that if you said no, someone shouldn't force you to have sex. What wasn't clear was that the absence of consent does not equal consent. I had a tremendous capacity to dissociate.
- ² Pharmaceuticals can be helpful for traumatized people, especially when overwhelmed by their emotions (Van Der Kolk 36). Caesarean sections and epidurals save labouring women's lives.

³ I knew that despite planning for my ideal childbirth, I should have contingency plans. My partner and I visited the hospital to assuage some of my fears, lest our home birth plans go awry. Later, I spent six hours at the hospital, at week thirty-seven of my pregnancy, when I started having contractions that did not progress to labour. I am grateful for experiencing a quiet hospital with my midwife and partner nearby. It was rehearsal for my actual labour and lessened my fear of hospitals.

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