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# "She gave me hope and lightened my heart": The transition to motherhood among vulnerable (young) mothers

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ABSTRACT

The aim of the present study was to gain an understanding of how vulnerable mothers with adverse childhood experiences transition towards motherhood. Semi-structured interviews were conducted with a convenience sample of 15 vulnerable (young) mothers who were residing in a mother-baby home at the time of the study. By means of inductive thematic analyses, a number of themes were identified that characterized the transition to motherhood. The results showed that mothers experienced a number of adversities during childhood which made them aware early on what type of mother they wanted to be for their children. Because of medical complications or involvement of child protective services, the ability to take care and bond with the baby was sometimes delayed. Further, the arrival of the baby was often considered a turning point: to bring change to the life of the mother or a second chance to motherhood. Relationships with their own parents were generally strained and sometimes put on hold to protect oneself. The mothers also mentioned difficulties with accepting and asking for support, their outlook on social support was generally ambiguous. Clinical implications of the results are discussed in the light of traditional care and the theory on ambiguous loss.

## 1. Introduction

In the Netherlands, every year approximately 1700 children are born to vulnerable or young mothers. Although the Netherlands is one of the countries with the lowest number of pregnancies in adolescence, young and vulnerable motherhood remains an important public health concern (Picavet, Van Berlo, & Tonnon, 2014). Vulnerable and young motherhood (under age 24) is characterized by an accumulation of risk factors among which: lower level of education, lower income or welfare dependency, lack of social support, inadequate parenting skills, parental stress, and parental mental health problems (Figueiredo, Bifulco, Pacheco, Costa, & Magarinho, 2006; Oudhof, Zoon, & Van Der Steege, 2013; Van Vugt, Loeber, & Pardini, 2016). This myriad of risk factors has typically been associated with the development of psychosocial problems in children, child maltreatment and child protection measures such as out-of-home placement (Lavergne et al., 2011; Mejdoubi et al., 2013).

Although most young and vulnerable mothers want to be "good" parents for their children, this hope is often overshadowed by the fear of repeating the way their own parents interacted with them, often in a neglectful or abusive manner (Connolly, Heifetz, & Bohr, 2012; Herland, 2019; Maxwell, Proctor, & Hammond, 2011; Pryce & Samuels, 2010). Research has shown that on average 9 out of 10 vulnerable (young) mothers experienced adverse childhood events (Fliers & Peters, 2010). Of these, poverty, child maltreatment, divorce, mental health problems among parents, or the death of an important person were the most commonly reported events (Fliers & Peters, 2010; Quinlivan & Evans, 2005). As a result of these experiences, vulnerable mothers often report more difficulties to form warm and sensitive relations with their children (Levendosky, Leahy, Bogat, Davidson, & Von Eye, 2006; Postmus, Huang, & Mathisen-Stylianou, 2012). It has also been demonstrated that a high degree of parentification, because of dysfunctional family patterns, is associated with less responsive behavior towards the child and knowledge of child development (Nuttall, Valentino, Wang, Lefever, & Borkowski, 2015). Moreover, there is ample evidence that vulnerable (young) mothers, who have been maltreated themselves during childhood, have a three times greater chance of neglecting or abusing their own children (Assink et al., 2018).

Nevertheless, a significant number of vulnerable (young) mothers see motherhood as an opportunity to overcome the difficulties associated with adverse childhood experiences and positively improve their own and their children's lives (Easterbrooks, Chaudhuri, Bartlett, & Copeman, 2011; Watts, Liamputtong, & Mcmichael, 2015). In this light, motherhood is perceived as a rather restorative process (Pryce &

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Samuels, 2010). (Young) mothers with adverse childhood experiences often describe the birth of the baby as a welcoming event. It is often the lack of bonding with their own caregivers and feelings of rejection or abandonment that are generally mentioned as the primary reasons to continue the pregnancy. More specifically, the baby is thought to fill an emotional void and provide for an enduring relationship to create the longed-for family (Connolly et al., 2012). Further, motherhood tends to give vulnerable (young) females a new identity with newly defined roles that help them to move away from identities related to their own upbringing. Motherhood also helps the females to become aware of their inner strengths, in terms of perseverance, problem-solving and successful parenting (Haight, Finet, Bamba, & Helton, 2009). Connolly et al. (2012) in their *meta*-synthesis of qualitative research on young mothers involved with child protective services, showed that motherhood often gave the females a purpose in life. Motherhood was considered stabilizing in the sense that it helped mothers to desist from destructive behaviors such as substance dependency (Callahan, Rutman, Strega, & Dominelli, 2005; Chase, Warwick, Knight, & Aggleton, 2009).

Stern (1995) suggested that the transition to motherhood has many more phases than just the delivery of the baby. This transition often already starts early in pregnancy and continues throughout the baby's first year of life. This psychological transition, also referred to as motherhood constellation, offsets several new tendencies, sensibilities, fantasies, fears, and wishes. The motherhood constellation concerns three related discourses and four themes which are thought to be vital to establish a nurturing relationship with the baby. The three discourses that need to be brought together by the mother are (1) the mother's discourse with her own mother (how the own mother acted as a caregiver to her child), (2) the mother's discourse with herself (especially with herself as a mother) and (3) the mother's discourse with her baby. More precisely, during pregnancy and after birth, it is expected that the focus of the new mother is more on her own mother and less on her father, more on her role as a mother-as-mother and less on her role as a mother-as-wife/woman and more with her baby than other things in life.

Of the four themes that play a role in the transition to motherhood, the first two themes reflect the mother's ability to protect the child. In the first theme, life-growth, the focus is on the physical care of the baby, to keep the baby alive. In contrast, the second theme, primary relatedness, concerns the mother's emotional care towards the baby, whether she can love and securely attach to the baby (Stern, 1995). All mothers experience different types of fears related to their babies survival and quality of parenting skills (Spinelli et al., 2016). The third theme, the supporting matrix, refers to the ability of the mother to create her own support network to fulfill her role as a mother. The main fear related to this theme is that the mother might be judged incompetent by her network or unable to create and maintain such a network. The last and fourth theme concerns the mother's identity reorganization. More precisely, whether or not a mother could accomplish the first three tasks is related to the reorganization of her self-identity. In sum, the eventual relationship between the mother and the baby is the result of a complex interaction between the mother's internal mental representations and her interpersonal exchanges with others (Stern, 1995).

Stern (1995) assumed that it is precisely in the present everyday interactions with the baby in which memories of the past are remembered. These memories do not only include the mother's own experience as a child while interacting with her mother, but also the way her mother interacted with her as a child. More specifically, the present interactions with the baby act as a remembering context for the mother. In case of adverse childhood experiences, these memories are also referred to as "ghosts in the nursery" (Fraiberg, Adelson, & Shapiro, 1975). This metaphor helps explain how a mother's past and early relationships with her own caregivers affect her understanding of and interactions with her baby (Malone, Levendosky, Dayton, & Bogat, 2010). Some parents reenact negative life experiences with their own children, where other parents are more attuned to the needs of their children and able to make a better life for the children (Lieberman, Padrón, Van Horn, & Harris, 2005). This may be due to so-called "angels in the nursery", which are memories and feelings of being loved and protected during childhood. This may help a parent with adverse childhood experiences to positively fulfill its caregiver role and buffer against the harmful effects of the "ghosts in the nursery" (Lieberman et al., 2005; Narayan, Rivera, Bernstein, Harris, & Lieberman, 2018).

To date, very few studies have examined how the transition to motherhood is made by vulnerable (young) mothers with adverse childhood experiences. By gaining insight into how mothers give meaning to their motherhood in light of their own experiences, services can be adapted to the risks and needs of these mothers (Maxwell et al., 2011). First, it provides new information about the extent to which young mothers are aware of how past experiences may potentially affect their day-to-day interaction with their children and how they deal with these experiences throughout their transition to motherhood. Second, health care professionals will gain a better understanding of how adverse childhood events impact the mother's image of herself as a mother and her parenting behavior, potentially breaking the cycle of child maltreatment across generations (Lanctôt & Turcotte, 2018; Rutman, Strega, Callahan, & Dominelli, 2002). Therefore, the aim of this study was to gain an understanding of how vulnerable mothers with adverse childhood experiences transition towards motherhood.

## 2. Method

### 2.1. Context of care

The Babyhome offers shelter, care and support to (expectant) vulnerable (young) mothers who are temporarily unable to provide the necessary care to promote the safety and development of their babies. The mothers generally presented a large number of risk factors and were referred to the Babyhome by other mental health organizations or were placed by child protective services. The intervention program, offered to mothers in the Babyhome, aims to establish a secure attachment relationship and positive mother-baby interaction by improving the parenting skills and psychological well-being of the mother (The Babyhome, n.d.). On average, mothers receive at least six months of intensive treatment before they move to a home of their own.

### 2.2. Participants

A convenience sample of 15 vulnerable (young) mothers was comprised following the guidelines of Guest, Bunce, and Johnson (2006) for estimating sample sizes of qualitative studies. Thematic exhaustion has shown to already occur after the analysis of twelve interviews (Guest et al., 2006) and in case of more homogenous samples, such as in the present study, to occur with an even smaller number of interviews (Kuzel, 1992; Morse, 1994). During the time of the study, in total 29 mothers were admitted to the Babyhome. The number of mothers who were interviewed could therefore be considered a good reflection of the total number of mothers admitted to care in that period, approximately 50%.

At the time of the study, the mothers were between 16 and 39 years of age ($M$ = 25.80; $SD$ = 5.45). Nine mothers (60%) had a Dutch ethnicity and six mothers (40%) had a non-Dutch ethnicity, i.e. Caribbean and (North-)African. The highest level of completed education was reported for all mothers. Two mothers completed higher professional education (13.3%), nine mothers finished vocational education (60%), one mother fulfilled pre-vocational education (6.7%), one mother finished practical vocational training (6.7%), and two mothers completed primary school (13.3%). The age of the mothers varied between 11 and 33 years at time of their first pregnancy ($M$ = 21.9; $SD$ = 5.7). For nine (60%) of the fifteen mothers the pregnancy for

**Table 1**
Descriptives of mothers who reside in the Babyhome.

| ID | Age | Nationality | Education[1] | Employment[2] | Living situation[3] | First time mother | Planned pregnancy | Total n pregnancies | Age at first pregnancy | Age[4] baby | Gender baby |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 27 | Surinamese | Vocational education | Employed | Independently | Yes | No | 1 | 26 | 122 | Male |
| 2 | 16 | Dutch | Primary school | Student | With parents | Yes | No | 2 | 11 | 177 | Male |
| 3 | 23 | Dutch | Practical vocational training | Volunteering | Independently | Yes | No | 5 | 15 | 72 | Male |
| 4 | 25 | Dutch | Vocational education | Employed | Cohabiting | Yes | No | 1 | 24 | 180 | Male |
| 5 | 33 | Dutch | Higher professional education | Employed | Independently | Yes | No | 1 | 33 | 28 | Female |
| 6 | 28 | Dutch | Vocational education | Unfit for work | Independently | Yes | No | 1 | 27 | 91 | Female |
| 7 | 39 | Dutch | Vocational education | Unemployed | Cohabiting | No | No | 3 | 24 | 34 | Female |
| 8 | 27 | Dutch | Higher professional training | Employed | Independently | Yes | Yes | 1 | 27 | 84 | Female |
| 9 | 23 | Congolese | Vocational education | Student | Cohabiting | Yes | No | 1 | 23 | 48 | Female |
| 10 | 22 | Dutch | Pre-vocational education | Employed | Independently | Yes | Yes | 1 | 22 | 97 | Female |
| 11 | 24 | Antillean | Vocational education | Unemployed | Other | Yes | No | 1 | 24 | 105 | Male |
| 12 | 19 | Eritrean | Vocational education | Student | Independently | Yes | No | 1 | 18 | 168 | Male |
| 13 | 26 | Moroccan/ Surinamese | Primary school | Unemployed | With parents | No | No | 4 | 17 | 123 | Female |
| 14 | 28 | Dutch | Vocational education | Student | Cohabiting | No | Yes | 3 | 16 | 50 | Male |
| 15 | 27 | Moroccan | Vocational education | Unemployed | Independently | Yes | Yes | 2 | 21 | 183 | Male |

[1] Highest level of education.
[2] Employment before admission.
[3] Living situation before admission.
[4] Age in days.

which they were admitted to the Babyhome was their first pregnancy. The remaining six (40%) mothers had been pregnant between two and five times. Of these six, one mother had had multiple miscarriages and two mothers had had abortions. Three (20%) of the fifteen mothers had more than one child at the time of the interview. Eleven (73.3%) of the fifteen mothers indicated that the pregnancy with their youngest child, with whom they were residing in the Babyhome, was not planned. The age of the babies was between 0 and 6 months ($M$ = 2.87; $SD$ = 1.73). The gender of the babies was equally distributed: 46.7% of the babies were girls and 53.3% were boys (see also Table 1). On average, $M$ = 3.77 care organizations ($SD$ = 1.64) were involved at time of admission of the mothers.

### 2.3. Procedure

The data collection procedure was approved by the Ethics Review Board of the University of Amsterdam, the Netherlands. All participants were first approached by a member of the Babyhome and when interested to participate in our study, connected to the researcher. The researcher subsequently explained about the aims and procedures related to the interview. Consent was obtained from all the participants after explaining that participation was voluntarily and could be ended at all times during the study. The interviews were administered in the period between April 2017 and June 2018. At the time of the interview, all participants were living in the Babyhome. The average time participants had spent in the Babyhome at time of the interview was $M$ = 63.20 days ($SD$ = 45.46), approximately 2 months.

The interviews were held in a quiet office at the Babyhome. In this way the participants were able to see their baby in case it needed to be fed or changed. Before the start of the interview, participants completed a short questionnaire concerning demographics and information related to the pregnancy. Completion of the questionnaire took approximately 5–10 min. All participants were assigned a number to maintain their anonymity. Subsequently, the participants were interviewed by a trained researcher with a clinical background. The interview had an average duration of $M$ = 50.87 minutes ($SD$ = 20.59). After completing the interview, the participants received a gift card worth ten euros. The interviews were audio-taped, after which they were transcribed and analyzed by the authors of this article.

### 2.4. Measures

**Demographic background and pregnancy characteristics.** A questionnaire of 17 items was developed to collect information about the mother's demographics, family composition, pregnancy history, level of education and work. Example items are: "What is your ethnicity?", "Are you still in contact with the biological father of your baby?" and "How many times did you get pregnant?".

**Possible Selves.** A structured interview protocol was developed for the purpose of the study (Lanctôt & Turcotte, 2018) based on the Possible Selves Mapping Interview of Shepard and Marshall (1997). The interview focused specifically on the future 'self' of the (young) mothers, taking into account the hoped, expected and feared for future selves (Shepard & Marshall, 1999). Although this adaptation of the possible self-interview (Lanctôt & Turcotte, 2018) does not directly focus on adverse life events, information was collected through the mother's stories about her own childhood. Example questions where major life events have been discussed are: "How were you as a child?" and "How did you feel within your family?". For the aim of the present study, the possible selves interview focused on the transition to motherhood by means of the following questions: "What type of mother are you?", "Can you tell me what you are most proud of as a mother?", "How do you experience being a mother with your baby?", "If we think about the future, let's say in five more years, what type of mother do you want to become?", "What motivates you to become this type of mother?" and "What do you need, to become this type of mother?".

### 2.5. Data analysis strategy

Both quantitative and qualitative research strategies have been used in the present study. Descriptive analyses were performed on the data concerning demographics and pregnancy information, using the Statistical Package for the Social Sciences (SPSS) version 25. These results were included in the method section of this article.

In addition, qualitative analyses were carried out on the interviews. After literal transcription of the recordings, two researchers performed thematic analyses through an inductive research approach (Boeije, 2014; Braun & Clarke, 2006). In an inductive approach the identified themes are closely linked to the data set (Patton, 1990). This means that the coding of the data is performed without a pre-existing coding scheme. Initial coding was performed through careful reading of the interviews. Subsequently, classifications were made by means of axial coding, in which overlapping codes were merged and overarching themes were formed. A theme captures important information in relation to the research question and is considered a patterned response within the interviews (Boeije, 2014; Braun & Clarke, 2006). The inter reliability of the coding process was constantly verified by the discussing and comparing of the themes between the two researchers. Ultimately, the significant themes with their accompanying text fragments formed the results of this study (Boeije, 2014; Braun & Clarke, 2006; Tong, Sainsbury, & Craig, 2007).

## 3. Results

All of the mothers who were interviewed were placed in the Babyhome as the result of a number of risk factors that could potentially jeopardize the development and safety of their babies. One baby was directly placed out-of-home after birth in the hospital and the mother was reunited with the baby at the Babyhome. Five mothers reported (previous) involvement of child protective services. Further, a number of mothers in our sample were homeless due to financial problems and/or domestic violence, or were residing in the Babyhome because of mental health problems such as postnatal depression. Almost all of the babies were unplanned but very much wanted. Some of the mothers in this sample experienced complications during pregnancy or birth which delayed their bonding experience. There was very little contact with the mother's own family, bonds were often (temporarily) cut off due to accumulating problems that were experienced over the course of life. In addition to this, the mothers mentioned that there was little to no contact with their (half) siblings as well as with the biological father of the baby. Despite the fact that they received care at time of the interview, all mothers in this sample were highly motivated to provide a better future for their baby. The mothers could often very well express what type of mother they wanted to be. The majority of the mothers in our sample were very driven to become this type of mother as a result of their own upbringing and generally described that they wanted to show the opposite behavior of their own mothers. The arrival of the baby was described as a new start to do better as a mother. Even though the mothers mentioned the importance of material circumstances, including housing and employment, to make a fresh start happen, they had difficulties describing the necessary steps to reach these circumstances. From the interviews, a number of related themes emerged which contributed to the transition to motherhood among which: making amends with one's own adverse childhood experiences, the ability to give love and life to the baby, the birth of the baby as a turning point, re-evaluation of family and partner relationships, and ambiguous feelings towards support.

### 3.1. Theme 1: Making amends with one's own adverse childhood experiences

The mothers' discourses were strongly characterized by their own childhood and upbringing. More specifically, the mothers told about their own, often traumatic, childhood which was dominated by domestic violence, child abuse and neglect, parental mental health problems and substance abuse. Further, a number of the mothers in our sample described the decease of a parent or sibling and how this impacted their family life. As a result of these adversities some mothers had to take care of their siblings as parents were not psychologically available or not physically present. Some mothers were for these reasons raised by their grandparents.

*"I was preparing the food for my siblings, and brought them to day care and school and was making sure their backpacks were ready. I often had to pull my mother out of bed in the morning when she had been drinking."*.

Further these experiences had made mothers aware, often already during childhood, of the type of woman and mother they wanted to become in the future. These representations that they had made for their own motherhood were generally the opposite of the behavior their mothers had showed. This was specifically true when the mother's own mother had left or not protected her. The mothers often had very detailed recollections of specific (violent) events or gave examples of situations in which they did not feel supported or heard by their own mothers.

*"We often needed to run away from home and then I stayed in a shelter together with my mother and sister. I think I have been in a shelter at least 8 or 9 times, and then after a few months we would go back home again to my father. I remember asking my mother: "why would you do this again?". I wanted to stay and not go back and forth between the shelter and home each time."*.

Most mothers in our sample mentioned that already since they discovered that they were pregnant, they actively thought about their role as a mother and how to ensure that their family history was not passed on to their child.

One mother said: *"During pregnancy I felt very anxious and thought what kind of mother do I want to be, what do I want to pass on and what not and how am I going to do that? What do you exactly do as a mother?"*.

The mothers had an active wish to break with family patterns that they had experienced themselves and were still dealing with their past. Examples of the type of mother, the mothers wished to be was: loving, caring, protective, independent, and attentive to the needs of their child. As said, these descriptions often resulted from their own (adverse) childhood experiences and were opposite to what they themselves had experienced.

*"I lived together with my father after my parents divorced when I was still a baby. I did not like living with my father but I had to accept it. As a child you do not have any choice. He sometimes had a girlfriend and I felt like the third wheel. I do not want to become a mother who does not have any attention for her child because she is in a relationship and forgets about her child. I know how it feels, as I experienced it myself: not getting any attention from your parent."*.

Two mothers in our sample mentioned in regard to these adverse childhood events that they should have stood up for themselves or should have left the situation even though they were still children. Two other mothers reported how they did everything to not come back home or to convince child protective services to place them out-of-home. This shows how the mothers still tried to make amends with their past experiences even as an adult. A mother said: *"I think I should talk a bit more about my past. I know that my past keeps coming up during the daily things I do and I kind of panic about whether it made me who I am today."*.

### 3.2. Theme 2: The ability to give love and life to the baby

In the majority of the cases, the baby was not planned and some mothers in our sample found out late that they were pregnant. Two mothers described that they discovered that they were pregnant after being brought to the hospital for severe abdominal pains. Four mothers expressed openly their mental health problems and how this affected their ability to take care of the baby. *"From the moment she was born, I did not feel anything towards the baby, and I felt very guilty about that. I*

*didn't have that mother feeling, I could not look at the baby and say I love you so much. I hardly was able to kiss the baby. Later, it was discovered I had a postnatal depression.".* One baby was placed out-of-home directly after birth and was reunited with the mother at the Babyhome. Some mothers in our sample experienced complications during or after birth or children were born prematurely which left the mothers feeling overwhelmed and this hampered them to fully adapt to their role as a mother. These mothers had to readjust the internal dialogues they had with themselves. One mother said: "*If you become a mother you think it will be great and nice but there is so much more to it. And your dream is to of course have the perfect baby and family and no fights with each other, but that is not the reality.".* One mother who because of an illness did not expect to become pregnant and suffered from many complications during pregnancy and birth said: "*I was thinking that this baby would not survive and that I should not attach to it. For a long time I blocked everything that had to do with babies because I thought I would never hold this baby in my arms.".* The first weeks after birth this mother described that she gave the baby as much as possible to professional caretakers at the Babyhome. She described that she did not know what to do and if she was able to care for the baby. Later, she explained that she was so proud of herself that she was able to give birth to a baby after all the things that happened in her life. "*I became independent and was able to give all the sadness in my life a place and grabbed everything together to continue my life.*".

### 3.3. Theme 3: The birth of baby as a turning point in life

Despite the fact that the majority of the babies in our sample were not planned, the mothers generally described that the baby was very much wanted. Some mothers in our sample mentioned the birth of the baby as a miracle and turning point in their lives. One mother who had lost custody over her two other children, mentioned: "*This baby gives me hope and lightened my heart. The baby fills the empty spot left behind by her siblings. I have always walked around with an empty heart. I felt empty, misunderstood, I felt worthless, like the earth moved away under my feet.".*

Another mother described that the birth of the baby took a number of days. She had lost her father unexpectedly, whom she had been very close with, when she was young. Over the years, she also lost contact with her mother and siblings. Eventually, this mother gave birth on her father's death day: *"It am not religious but I do feel that this was meant to be. The hospital did everything to get the baby out but the baby waited until that day: a new beginning on the day that my father passed away. How beautiful can it be.".*

The birth of the baby (or the fact that they knew they were pregnant) had put some of the mothers in our sample on a different life path. These mothers felt supported by the fact that they had the opportunity to stay together and take care of the baby at the Babyhome after intervention of child protective services. They talked lovingly about their baby and indicated that they were often one with the baby, the baby gave them hope and meant everything to them. Three mothers specifically mentioned promises that they made to their baby, themselves or family members.

*"I was not sure if I wanted or could be a mother…from the moment I saw the baby…I was standing next to the baby's crib and I just knew that I would do everything for my child. Then I also knew what kind of mother I wanted to be. I also promised the baby that I would really try to make the best of it.".*

### 3.4. Theme 4: Re-evaluation of familial and partner relationships

The majority of the mothers in our sample expressed that because of the adverse (childhood) events they experienced, they were generally no longer in contact with their own parents and siblings. The relationship with their own parents was sometimes put on hold to be able to take care of themselves and their babies. One mother mentioned: *"It may sound harsh, but I decided to stop having contact with my mother. My mother is still having her own problems and involved me too much in her problems and that is neither good for me nor the baby".* Another mother said: "*That is also the reason why I am not in touch with them (parents) anymore. They are too negative and I cannot use negativity in my life, because if I have negativity in life, my children will also have negativity in their life.".*

In some cases the birth of the baby helped to renew the relationship with mostly the mother's own mother. The mothers were sometimes able to make peace with the past, as they better understood what their own mother went through or expressed their loyalty towards their own parents. One mother said: "*And now, because the baby is born, I try to keep my head up high because my baby is entitled to see his grandmother and she is entitled to see her grandchild. Now she can show she is a grandmother. She shows that by asking: "how can I help and support you?" and then I let her. In the past (with my previous child) she did not, and now she does and I let her.".*

The mothers in our sample rarely mentioned their relationship with their own fathers. For most mothers, their own father was not involved in their upbringing and some fathers passed away or moved to other countries. The biological fathers of the babies were also generally absent in the daily care of the baby. These mothers often stated things such as: "*men come and go, but your children always stay.*". Some mothers in our sample, however, indicated that they did feel supported by their partner relationship. These partners, in most cases also the biological father of the baby, were reported to have a positive contribution to the mother's well-being. Other mothers in our sample who were not in a relationship anymore with the biological father of the baby, did emphasize the importance of the presence of the biological father in the life of the baby, and still tried to maintain a positive relationship whenever possible.

### 3.5. Theme 5: Ambiguous feelings towards support

In the interviews, the mothers mainly mentioned the importance of material circumstances such as housing, a job, or a diploma in creating the life they envisioned for themselves and their baby. However, they had difficulties explaining which steps to take or which resources to allocate to realize these material circumstances. In contrast, very few mothers mentioned emotional or social support as important factors that could help them realize their future living situation. The mother's social support network was generally small, due to the fact that the majority of the mothers lost touch with their close family. One mother said: "*At this time I am really all alone. I do not attach to people: they can walk in the door today and walk out tomorrow and it doesn't really matter to me. I only attach myself to my baby.*". Another mother said: "*My parents will always be in my heart but not in a loving way. Just like, ok you are my parents, and you will always be, but sometimes I am better off without.".* Especially in the case of domestic violence, child maltreatment, parental psychopathology or substance abuse, the mothers tended to name their children as the most important persons in their lives, followed by the mother's partner, extended family members, people of the church, friends and even a deceased person. A number of mothers in our sample also expressed difficulties in depending on others, and frequently mentioned that they themselves were best able to provide for their children's needs. In particular, in the cases where child protective services were involved the mothers felt they had to prove themselves and show that they were able to independently care for their own children. One mother said: "*There are some mothers who give their babies to the volunteers, but not me. I want to do everything alone. Maybe I am a bit more independent in that regard. The reason is also that I am under aged and evaluated by the child protection services whether I can take care of my child independently.".* At the same time some mothers in our sample also learned that asking for help is not a weakness but also a strength. One mother said: *"Because I looked for help, while I am always the type of person that says: "I will do it alone…", I think that is already a sort of path to autonomy and strength. To ask for help and not wanting to do everything alone.*".

## 4. Discussion

The present qualitative study was conducted among 15 vulnerable (young) mothers who were residing at the Babyhome at the time of the study. The aim of this study was to gain insight into the psychological transition to motherhood, also referred to as motherhood constellation, of vulnerable females with adverse childhood experiences. Our analysis of the interviews showed a number of central themes, i.e. making amends with one's own adverse childhood experiences, the ability to give love and life to the baby, the birth of the baby as a turning point, re-evaluation of family and partner relationships, and ambiguous feelings towards support. Our findings will be discussed in relation to the four themes that are central in the mental reorganization towards motherhood respectively: life growth, primary relatedness, supporting matrix, and identity reorganization (Stern, 1995).

The present study showed that the transition to motherhood among vulnerable mothers who experienced adverse life events during childhood is still very much determined by their past experiences. In sum, it was found that the mothers experienced a number of hardships during their own upbringing which made them aware early on what type of mother they wanted to be for their children. The mothers generally gave examples and descriptions of behaviors and characteristics that were opposite to what their own mothers had been showing. The context of giving life and love and the ability to adapt to their new role as a mother was often determined by their experiences with their own mother and family at large. In addition to this, medical complications or involvement of child protective services sometimes delayed the ability to take care of and bond with the babies. Further, despite the hardships these mothers experienced in their past and present life, the arrival of the baby was often seen as a turning point, thought to bring change to the life of the mother, and considered a second chance to motherhood. The building of and dependency on a supporting matrix was not always achieved. Relationships with their own parents were generally strained and sometimes literately put on hold to protect oneself. The mothers also mentioned difficulties with accepting and asking for support, their outlook on support was generally ambiguous. The mothers mainly wanted to care for the baby alone and demonstrate that they did not need anybody. Self-reliance was seen as a strength to preserve the well-being of their small family.

The majority of the pregnancies of the mothers who participated in this study were unplanned and later very much wanted. However, none of the mothers spoke during the interviews about having had the intention to terminate the pregnancy or giving the baby up for adoption. In a qualitative study by Spierling and Shreffler (2018), on the motives of women who had an unplanned pregnancy, those who chose to terminate their pregnancy felt that the necessary circumstances to bring up a baby were missing. For instance, these women believed that, before they were ready to have a baby, they had to complete their education, establish a career, get a home, and find a suitable and supportive life partner. In addition to this, the women described that they made the decision in the best interest of the future child or other children that were already present. Generally, these women also had smaller support networks and resources to depend on.

In contrast to the study of Spierling and Shreffler (2018), the majority of the mothers in our study experienced the birth of the baby as a turning point in their lives. Although most mothers did not have the necessary circumstances as described by the women in the study of Spierling and Shreffler (2018), the baby was thought to fill a void, contribute to feelings of hope and healing, and provide for a relationship that the mothers were not able to establish before. Possibly, the decision to continue the pregnancy and keep the child had to do with the mother's own upbringing which was often characterized by a number of childhood adversities including maltreatment, domestic violence and substance abuse among parents. It appeared that the vulnerabilities the mothers had experienced had a lifelong impact and became again an important theme during pregnancy and birth (Lanctôt & Turcotte, 2018). For instance, Buchbinder (2004) describes that as a result of an internal conflict to correct one's own past experiences, mothers tend to materialize their ideal family through their baby. Additionally, for many mothers becoming a parent is a chance to set right the wrong past (Pryce & Samuels, 2010). A *meta*-review by Connolly et al. (2012) showed that motherhood, among women with a child protection history, was often viewed as positive and stabilizing. Motherhood was discussed by the authors in terms of resilience as it also gave mothers a sense of direction and purpose in their lives. Additionally, mothers expressed feelings of pride that they persisted as parents. Similar observations were made in our study, especially when child protection was involved, in which mothers expressed their gratitude for being given the chance to care for the baby (life growth/primary relatedness).

Especially in case of adverse experiences but also in case of benevolent experiences (Narayan et al., 2018), mothers actively discussed with themselves what type of mother they wanted to become (identity reorganization) and which aspects of their own upbringing they wanted to transfer to their child. Mothers expressed that they wanted to give their baby a better life than they experienced themselves (life growth and primary relatedness) and be good mothers (Herland, 2019). Buchbinder (2004) concluded that even though many mothers try to free themselves from the past, the determination to show opposite behavior of their own mother can cause a lot of distress and result in a constant fight against her own mother domineering aspects of her identity. This constant internal conflict was also observed among the mothers in the present study. Mothers often struggled maintaining a normal and healthy relationship with their parents, mainly with their own mothers. Some mothers therefore temporarily cut off contact with family members to be able to take care of themselves and their babies. This may also be the reason why mothers mostly mentioned practical needs, such as housing, employment and (the continuance of) education and much less social support (supporting matrix) to realize a fresh start for themselves and their babies. As completion of education and career adaptability have been associated with higher levels of resilience among vulnerable mothers, these may be important intervention goals to include in programs for vulnerable mothers (Barto, Lambert, & Brott, 2015; Clarke, 2015).

In line with findings from other studies (Connolly et al., 2012; Lanctôt & Turcotte, 2018; Muzik et al., 2013), the mothers in our study tended to show ambiguous feelings towards social support. This was both the case for informal support through family and friends and formal support by professionals. Some mothers in our study expressed that they had to prove that they could take care of the baby independently because of (prior) involvement of child protective services. Lanctôt and Turcotte (2018) interviewing a group of mothers with a history of residential placement reported that mothers' self-reliance appeared to be mainly based on mistrust as a result of negative experiences with e.g. child protective services. Broadhurst et al. (2015, 2018) showed that these feelings of mistrust might actually be legitimate as mothers who had a child removed for child protection reasons are at increased risk of losing subsequently born children. In a follow-up study by Broadhurst and Mason (2020), mothers who had experienced repeated removal described that their past court records continued to impact their current lives and that judgments made by professionals were not based on their present behaviors. In addition, child removal had been a gateway to further adversities such as the loss of a romantic partner, family, and housing, and increased psychosocial problems leaving the women often isolated and afraid to ask for support.

The beneficial effects of social support have frequently been documented (Bartlett & Easterbrooks, 2015; Dixon, Brown, & Hamilton-Giachritsis, 2005a; Dixon, Hamilton-Giachritsis, & Brown, 2005b). For instance, a study by Bartlett and Easterbrooks (2015) showed that among young mothers with neglect experiences an heightened frequency of contact with members of their social support network (e.g. partners, neighbors, friends, therapists, doctors, social service

agencies), and not the dependability on the network, was associated with better parenting. Possibly, social support acts differently in high-risk groups such as the sample that was included in our study and may be more about access to instrumental and practical support from external or professional networks. For instance, a study by Easterbrooks et al. (2011) on young motherhood showed that mothers classified as "resilient" tended to live much less with their family of origin and relied less on their own mothers as a source of emotional and caregiving support.

Some limitations of this study should be mentioned. First of all, at time of the interview all mothers were receiving care focusing on the mother's mental health and parenting skills which may have made mothers more aware of their own adverse experiences in relationship to their motherhood transition. Nevertheless, the average time spent at the residential care facility at the time of the interview was two months. The first period at the Babyhome is considered the stabilization phase of treatment as most mothers were admitted while in their last weeks of pregnancy. Subsequently, the average treatment duration of mothers admitted to the Babyhome is six months and thus if treatment could have affected the responses of the mothers we expect this impact to be relatively small. Second, the original focus of the interview was on possible selves and this may have limited the information we received from the mothers to fully comprehend their transition towards motherhood (motherhood constellation). Third, the current study was conducted among a sample of vulnerable mothers admitted to a residential treatment program and therefore caution is warranted with generalizing these findings to mothers in other treatment settings.

Last, the age and ethnic background of the mothers was diverse which could have impacted the way in which mothers experienced the transition to motherhood. For instance, one of the mothers gave birth to her baby when still an adolescent. Research has shown that the transition to motherhood for adolescent mothers could be challenged by a number of developmental tasks that need to be achieved in a relatively short time period, including individuation from parental figures and learning how to care for a newborn (Erfina, Widyawati, McKenna, Reisenhofer, & Ismail, 2019). Further, in contrast to adult mothers, adolescent mothers report the increased responsibility as one of their main challenges to overcome, besides the physical exhaustion, lack of time for oneself and others, and lack of (financial) resources (Erfina et al., 2019; Mangeli, Rayyani, Cheraghi, & Tirgari, 2017).

Additionally, six mothers belonged to a ethnic minority group. For mothers who came from countries situated in or around the Caribbean, matrifocality (female headed families) is much more common (Brunod & Cook-Darzens, 2002). Possibly, single parenthood or raising a child outside a marriage context has less impact on these women's transition towards motherhood when compared to women from countries with a patrifocal (male headed families) view on the family (e.g. Morocco). Nevertheless, both traditionally matrifocal and patrifocal families have in common that the care and education of children tends to fall in the hands of the mother (Badagliacco, 1999; Pels, 2000). It is important for professionals working with (vulnerable) mothers to be aware of cultural differences and how these could potentially impact the transition to motherhood (Ippen, 2018).

Traditional care for vulnerable mothers generally aims to reduce the risk for child maltreatment by targeting parenting skills such as sensitive and responsive behavior as well as more practical care skills. Although the effects of these interventions have been established (Bouwmeester-Landweer, 2017; Crijnen, Van den Heijkant, Struijf, & Timmermans, 2015; Van der Steege, 2013), they tend to be generally small and short-lived. A number of researchers have pointed out that interventions targeting vulnerable women should include the internal representations mothers formed of themselves based on earlier adverse life experiences. Maxwell et al. (2011) state: "Rather than focusing exclusively on imparting skills, parenting work, if required, it might be better aimed at supporting the mothers to develop their mentalizing capacity and emotional understanding of their child, and learning to tolerate their own, often overwhelming internal experiences evoked by the experience of being a mother" (p. 39). In relation to the often strained family relations, experiences of ambiguous loss should also be mentioned. Ambiguous loss is different from ordinary loss as the person is either still physical present but psychologically unavailable (e.g. parents with mental health or substance abuse problems) or physically absent but psychologically present (parental disappearance or unexpected decease). As a result of some sort of presence, there has not been closure and the process of bereavement was therefore frozen or blocked (Boss, 2010). The ambiguity felt by a mother, who can never (fully) rely emotionally on her own parents who are still physically present, can lead to mental health problems such as depression, anxiety, and feelings of hopelessness and despair (Boss, 2004). To be able to resolve this loss, Boss (2010) suggested that individuals need to be able to make sense of the situation, through meaning-making of the past. Mothers could learn and accept that the situation will not change, and that they have to create new hopes and dreams for the future. Possibly, the birth of the baby and creation of one's own family is one of the ways mothers cope with previous ambiguous loss.

## CRediT authorship contribution statement

**Eveline van Vugt:** Conceptualization, Methodology, Validation, Formal analysis, Writing - original draft, Supervision, Project administration, Conceptualization, Methodology, Validation, Formal analysis, Writing - original draft, Supervision, Project administration. **Pleuntje Versteegh:** Software, Validation, Writing - original draft, Investigation, Formal analysis, Resources, Data curation, Visualization, Software, Validation, Writing - original draft, Investigation, Formal analysis, Resources, Data curation.

## Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2020.105318.

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