THE EXPERIENCE OF BIOLOGICAL MOTHERS WITH COMPLEX TRAUMA IN THE CHILD WELFARE SYSTEM

By

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ABSTRACT

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This phenomenological study used the human ecological model and family systems theory within a feminist lens to explore the experiences of biological mothers with complex trauma in the child welfare system. Five women with complex trauma whose children were in the child welfare system due to neglect were interviewed for this study. Using in-depth interviews, 10 themes emerged regarding their experiences with the child welfare system. The textual and structural descriptions of their experiences included the impact of complex trauma, concerns for their children, impact of family dynamics, and negative views from society. The women also discussed feelings of empowerment and provided advice for parents in the child welfare system.

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CHAPTER 1: INTRODUCTION

In 2008, more than 3.7 million children were the subjects of Child Protective Service (CPS) investigations (U.S. Department of Health and Human Services, 2010a). One-fifth of those children had substantiated cases of maltreatment. Of the 772,000 child victims of maltreatment in 2008, 71.1% were victims of neglect, 16.1% were victims of physical abuse, 9.1% were victims of sexual abuse, 7.3% were victims of psychological maltreatment, 2.2% were medically neglected, and 9% were victims of other maltreatment such as abandonment or threat of harm. In 2009, it is estimated that 1,770 children died from abuse and neglect in the United States (U.S. Department of Health and Human Services, 2010b). Despite these alarming statistics, little is known about the impact of intergenerational transmission of abuse for the biological mothers with complex trauma in the child welfare system. This study will focus on biological mothers who currently have a child in foster care due to neglect. It will explore their experiences and views regarding environmental factors (microsystem, mesosystem, and exosystem influences), feminist issues (age, culture, and gender), and abuse histories and complex traumas (intergenerational transmission).

Statement of the Problem

According to the U.S. Department of Health and Human Services (2009), 463,000 children were in foster care in 2008, with 47% of children in foster care in nonrelative homes. Nevertheless, 49% of the case goals of the children in foster care were to reunify with parent(s). Of the 285,000 children who exited foster care in 2008, 52% were reunified with their parent(s). Despite this, little is known about how biological parents perceive their situation regarding involvement in the child welfare system (Gockel, Russell, & Harris, 2008; Hojer, 2009). Additionally, neglect is a relatively understudied social issue (Slack, Holl, Altenbernd,

McDaniel, & Stevens, 2003) despite being the leading problem faced by the child welfare system (Chaffin, 2006). This gap in research is exacerbated by the number of studies done on foster parents, foster children, adoption, and other forms of child maltreatment. Parents with children in foster care often experience feelings of inferiority, guilt, and shame (Hojer, 2009). In particular, biological mothers who bear the burden of care and shame have little power and influence (Carolan, Burns-Jager, Bozek, & Escobar Chew, 2010)—thus the purpose of this phenomenological study is to describe the experiences of biological mothers in the child welfare system.

Theoretical Framework

This study focuses on Bronfenbrenner's human ecological theory and Bowen's family systems theory with a feminist theory lens. These combined theories and viewpoints are useful to explore intergenerational transmission of abuse in a mother's ecology in regards to complex trauma. In past research, the ecological–transaction model has been used to explain how the ecological factors influence child maltreatment (Cicchetti & Lynch, 1993). Questions focusing on the interaction of multiple environments, inequalities, and differentiation are intersected by these three theories. Belsky (1993) identified cultural and contextual factors of child maltreatment, which include parental characteristics, child characteristics, parent–child interactions, community and social support, and the societal–cultural context. Based on these factors, this research project will use the concepts from human ecology and family systems to explore perceptions and beliefs regarding the child welfare system from women with intergenerational transmission of abuse and environmental factors as informed by feminist concepts of gender and class. This study will be qualitative and will utilize the discussed theories

to construct research questions. The research questions will help generate areas of inquiry that will guide each interview.

Human Ecology

Human ecological theory is a framework for understanding interactions of individuals within multiple environments and has been suggested for use in understanding foster care (Whiting & Lee, 2003). In 1970, Giovannoni & Billingsley (p. 204) stated that "among low-income people, [child maltreatment] would seem to be a social problem that is as much a manifestation of social and community conditions as it is of any individual parent's pathology." Incorporating the ecological, contextual, and interactional factors between biological mothers and child maltreatment is necessary for an integrative concept of child neglect (Chaffin, 2006).

Bronfenbrenner's (1979) human ecological theory is the basis for this project, as it depicts the family as a system embedded in other systems. Human ecological theory views families within multiple, interrelated nested layers ranging from individual factors, to community structures, to broader social contexts (Bolen, McWey, & Schlee, 2008). These layers are described by Bronfenbrenner (1994) as the microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

The microsystem is described as the setting within which the individual is behaving at any given point in time (Lerner, 2005); occasionally described as the *biopsychosocial person.* For purposes of this study, the microsystem is be composed of biological mothers. Microsystem risk factors for child maltreatment include mental health or illness of parent, drug or alcohol use, marital conflict, age of child, and marital violence (McCloskey & Bailey, 2000). There is evidence to show that a history of maternal sexual abuse can increase the risk for child maltreatment among the women's children, which will be explored later.

The mesosystem is a set of systems that directly influence the individual, such as extended family, foster parents, and neighborhoods, and is defined as the interactions occurring between two or more microsystems (Bronfenbrenner, 1994). Family structure, such as family social isolation, maternal employment, and the presence of a live-in partner, is often related to child maltreatment (McCloskey & Bailey, 2000).

The exosystem comprises multiple systems not directly involving the individual that have an influence on the person's behavior and development (Bronfenbrenner, 1994). Furthermore, the exosystem encompasses the immediate settings in which the individual is influenced. Exosystems may include societal views of child welfare, community resources, and extended family support, as well as ethnicity and income.

The macrosystem is an overarching level that involves culture, institutions, and public policy. This level influences the interactions within all other levels of human ecology and includes poverty, ethnicity, cultural values, customs, as well as child welfare laws. The economic indicators of the macrosystem have been said to be a risk factor for child maltreatment (McCloskey & Bailey, 2000). The chronosystem involves multiple dimensions of time—family or historical—which moderates change across the life course.

Human ecological theory gives researchers tools to understand and study the differentiated but nested levels within the context of human development. Understanding how parents navigate these systems can uncover gaps in services and better clarify the needs of the parents and children. Human ecological theory provides a lens through which individuals reciprocally interact with and influence their environment (Bubolz & Sontag, 1993). Through this lens, parents involved in the child welfare system may feel isolated from family supports and may have lacked effective parenting role models.

Feminist Informed Research

The feminist paradigm focuses on the reduction of gender inequality, empowerment of marginalized groups through research and social advocacy, and understanding the link between the macrosystem and microsystem with critical reflection on the influence of the macrosystem (Wang & Heppner, 2011). Feminist theory is a fundamental way of looking at the world and recognizing the inequalities. Feminist research focuses on rethinking family concepts in new ways (Thompson, 1992). It places women at the heart of analysis and critically analyzes power relationships based on group membership (McDowell & Fang, 2007). Broadly defined, feminist informed researchers acknowledge the historical disparities of lived experiences of women across racial and/or cultural and socioeconomic groups.

This research project centers on the concerns of those who have been traditionally marginalized and oppressed in social contexts. At a minimum, the feminist researcher has the responsibility to give voice to those who experience oppression. This type of approach often exposes multiple truths and countertruths. Research for women is aimed at emancipating women and enhancing their lives (Thompson, 1992). Thompson (p. 4) stated that feminist researchers often collaborate with participants to decide how research will be carried out and share or discuss the results, thus promoting the well-being of the participants.

Research findings are often used to advocate for changes in policy and practices, which make a positive difference in the lives of those studied. Through the feminist lens, research is viewed as “an exercise of freedom and mutual responsibility of empowerment between the researcher and the participants” (McDowell & Fang, 2007, p. 560). Feminist researchers listen to and embrace the voices and concerns of women as mothers. Feminists look critically at the unrealistic expectations of maternal perfection regarding caring for and rearing children. Within

the child welfare system, biological mothers are often idealized and demonized at the same time. Few researchers have challenged popular assumptions about mothers who do not have custody of their children, detailing the complexity and diversity of their situations (Arditti & Madden-Derdich, 1993; Rosenblum, 1986). Furthermore, feminist scholars have been known to evoke negative responses as they are critical of privileged groups and highlight difficulties faced by less privileged groups (Grauerholz & Baker-Sperry, 2007).

Bowen's Family Systems Theory

Bowen's family systems theory lends a valuable framework for feminist researchers to integrate the female experience, as it places individual development in the context of interdependence and conceptualizes the family as an emotional unit that influences the function of each member (Knudson-Martin, 1994). Differentiation includes three interrelated systems: the emotional system, the feeling system, and the intellectual system. Most importantly, the emotional system regulates human behavior, whereas the intellectual system acknowledges emotional, feeling, and subjective states while controlling how to respond to these states. Bowen's theory focuses on two competing ideas: individuality and togetherness. Differentiation is the process by which individuality and togetherness are managed within a relationship (Kerr & Bowen, 1988).

Differentiation of self is a central developmental process of adulthood and is essential to the formation of healthy marital and parenting processes (Bowen, 1978). Differentiation of self is the ability of a system and its members to manage emotional reactivity, allow for both autonomy and intimacy in relationships, and engage in adaptive problem solving. Therefore, it is the capacity to think clearly during strong emotions and self-regulate strong emotions such as anxiety, fear, or anger. It is the ability to experience intimacy with others and preserve autonomy

in family relationships. Differentiation is separating the thinking from the feeling to control automatic behaviors driven by the emotional system.

Parents with higher levels of differentiation are often less emotionally reactive; more flexible and adaptive under stress; and better able to regulate emotions, think clearly under stress, and maintain a clear sense of self, such as connecting with their children while supporting their own autonomy (Bowen, 1978). The connection between chronic anxiety and differentiation is that those with low levels of differentiation have more anxiety about leaving their family of origin and assuming responsibility for themselves (Miller, Anderson, & Keala, 2004). Those with low differentiation and high chronic stress are less adaptable to stress and have constant worry about future stressful events.

Due to chronic stress, Bowen (1978) believed that people with lower differentiation were at a higher risk for psychological and physical health problems. Skowron, Kozlowski, and Pincus (2010) found that mothers at low risk for child maltreatment reported greater differentiation, including a greater ability to self-regulate their emotions and behaviors and a greater capacity for connection and autonomy in relationships. Therefore, the risk for child maltreatment was higher among mothers who were emotionally reactive and cut off from others under stress. Additionally, in 2005, Skowron and Platt found that those who self-scored lower levels of differentiation had a higher risk for child abuse in a sample of young, nonparent college students. Bowen's theory (1978) assumes that "multigenerational trends in functioning reflect an orderly and predictable relationship process that connects the functioning of family members across generations…multigenerational emotional process…includes emotions, feelings, and subjectivity determined by attitudes, values, and beliefs that are transmitted from one generation to the next" (p. 224).

Intergenerational Transmission and Complex Trauma

Researchers have found support for the notion that children who experienced harsh or abusive parenting are likely to become themselves harsh and abusive parents (Pears & Capaldi, 2001). Estimated rates of transmission vary from 18% (Hunter & Kilstrom, 1979) to 40% (Egeland, Jacobvitz, & Paptola, 1989). In 2001, Pears and Capaldi found that parents' own histories of abuse predicted abusive behaviors toward their children. This suggests a direct effect for the intergenerational transmission of abuse. Nevertheless, this research does not account for the influence of complex trauma and contextual factors, discussed later. Pears and Capaldi (2001) found a 23% rate of intergenerational transmission in their 10-year longitudinal study conducted with two generations of abuse reporters. In 1996, Zuravin, McMillen, DePanfilis, and Risley-Curtiss found that no one type of maltreatment (physical abuse, sexual abuse, neglect) has a greater effect on transmission than any other type. However, sexual abuse does increase the likelihood for transmission. More severe forms of sexual abuse (intercourse) also increase the probability for transmission, whereas less severe forms (molestation) do not. Nevertheless, those who reported one sexual abuse experience were more likely than those who reported multiple incidents to abuse their own children (Zuravin et al., 1996).

Past research on child maltreatment, as cited above, has been guided by the theory that maltreatment is caused by individual pathology (Stith et al., 2009). For this study, behavior is conceptualized as being determined by a variety of interactive factors (Cicchetti & Howes, 1991). Briere and Jordan (2009) theorize that childhood maltreatment occurs within a context of social, psychological, and biological factors that influence maltreatment as well as produce effects. Furthermore, the relationship between psychological dysfunction in adulthood and a history of child maltreatment is complex and reflect not only the maltreatment experience but

also contextual variables. Mental health difficulties associated with child maltreatment include, but are not limited to, posttraumatic stress, cognitive disturbance, mood disturbance, attachment injuries, affect regulation, chronic interpersonal difficulties, and emotional regulation disturbance (Briere & Jordan, 2009; Cook et al., 2005).

Cicchetti and Howes (1991) propose that the course of child maltreatment is defined as multifactorial such that children's developmental outcomes are not due to a single incident but rather complex, interrelated factors. An adequate conceptual model of child maltreatment must be complex and developmental, incorporating multiple factors for both adaptive and maladaptive outcomes (Cicchetti & Howes, 1991). Complex posttraumatic stress disorder (Herman, 1992) attempts to explain persistent and varied symptoms associated with child maltreatment; however, it is unlikely that a single label or concept fully incorporates the complexity of outcomes for traumatized individuals (Briere & Spinazzola, 2005). Complex trauma in adults often affects developmental, biological, sociocultural, and psychological functioning (Briere & Spinazzola, 2005). Complex traumas are often "associated with a life history of multiple interpersonal victimization experiences, often beginning with extended childhood abuse and neglect" (Briere & Spinazzola, 2005, p. 401).

Although researchers have attempted to establish a direct relationship between child maltreatment and specific outcomes, as stated previously, child maltreatment effects are multidetermined in etiology and multivariate in presentation (Briere & Jordan, 2009). Variables associated with maltreatment and long-term psychological and social difficulties often include the age of onset. Manly, Kim, Rogosch, and Cicchetti (2001) found that child maltreatment experienced early in life is often related to later maladaptive functioning; for example, children

maltreated during infancy and toddlerhood often externalize more symptoms and are perceived to be more aggressive and less cooperative by their peers.

Many abuse victims have experienced a multitude of incidents and types of maltreatment during childhood, only furthering the complexity of child maltreatment (Briere & Jordan, 2009). Hamiliton and Browne (1998) stated that physical neglect had the highest rate of repeat victimization, followed by emotional neglect, lack of supervision, physical abuse, and sexual abuse. Girls aged 1 to 6 are the most vulnerable for repeated victimization, whereas adolescents had the lowest rate of repeated victimization (Finkelhor, Hotaling, Lewis, & Smith, 1990; Fryer & Miyoshi, 1994). Boys and younger children, especially preschoolers, are most commonly subject to neglect (Chaffin, 2006). Additionally, incidents of neglect are more likely to be repeated than other forms of child maltreatment (Hamilton & Browne, 1998). Nevertheless, child neglect cases are often overrepresented in poor, marginalized groups with low education, low income, inadequate parenting skills, fewer resources, and social isolation (Chaffin, 2006).

The goal of this study is to give voice to biological mothers' unheard stories regarding involvement in the child welfare system and the intergenerational transmission of abuse within a feminist and ecological framework. In the United States, 80% of perpetrators of child maltreatment were parents (U.S. Department of Health and Human Services, 2008) and another 6.3% were other relatives (U.S. Department of Health and Human Services, 2010). Nearly one-third of parents who have personal histories of child maltreatment grow up to abuse or neglect their own children (Newcomb & Locke, 2001). Research on child neglect is limited, although child neglect has been show to be the most frequent type of child maltreatment (Stith et al., 2009). The purpose of this study is to explore, describe, and understand key dimensions of the personal experiences of biological parents with children in foster care, addressing ecological,

intergenerational, and feminist contexts. This research will contribute to child welfare policy and practice as well as provide a better understanding of this recurring social issue.

Adverse Effects of Child Maltreatment

Child maltreatment is a serious public health problem that has been shown to result in both short- and long-term consequences, including impaired brain development, self- and emotional regulation deficits, and slowed school readiness (Skowron et al., 2010). Child maltreatment affects the individual, family, and environmental contexts. Childhood maltreatment histories have shown higher rates of depression in adolescents and adults (Pears & Capaldi, 2001). One explanation could be that depressed parents may be more irritable and hostile and therefore more likely to react to child behaviors with abusive discipline. Although posttraumatic stress disorder (PTSD) is not directly linked to abusive parenting, it can lead to chaotic family functioning and parental irritability, which increases the likelihood of child maltreatment (Pears & Capaldi, 2001). Additionally, parents who experienced high levels of abuse and presented with high levels of depression and PTSD were less likely to be abusive themselves than parents who experienced high levels of abuse but low levels of depression and PTSD (Pears & Capaldi, 2001).

Variables in the abuse-outcome relationship include socially transmitted attitudes regarding child maltreatment and social and economical deprivation; such that these variables compound negative effects on parents and children and may intensify the effects of victimization and increase the likelihood of exposure (Briere & Jordan, 2009). Additionally, Chaffin (2009) reported that low-income families (annual incomes lower than $15,000) are 44 times more likely to be reported for child neglect, which is reflective of a major health disparity with multiple factors and multiple implications. Child maltreatment and complex trauma often vary on

"dimensions, such as age of onset, severity, frequency and duration, and extent of injury" (Briere & Jordan, 2009, p. 382). Therefore, complex trauma varies significantly from woman to woman.

Methodology and Research Questions

Recently, studies have shown roughly one-third (35.4%) of perpetrators were between the ages of 20 and 29 and more than one-half (53.8%) were women (U.S. Department of Health and Human Services, 2010a). Additionally, one-third of mothers with personal histories of maltreatment transmit maltreatment to their own children. Therefore, this study will focus on biological mothers between the ages of 20 and 29 who report intergenerational transmissions of child maltreatment and symptoms of complex trauma. Previous research concludes that children, specifically those under the age of 12, are more likely to experience victimization than adults or older children, as they are more dependent on others and have little choice regarding the people around them and their environments (Finkelhor & Dziuba-Leatherman, 1994). Therefore, this study will focus on biological mothers of children under 12 years of age who are currently in the child welfare system due to neglect.

Guided by the theoretical framework described above, this study used qualitative methods to give voice to biological mothers and their experiences in the child welfare system. A phenomenological approach was chosen to allow a marginalized, underresearched population to be heard. This study will initiate a deeper understanding of how these mothers understand their experiences in the child welfare system.

Some research questions guided by major theories include the following:

- Bowen Family Systems Theory: What are the past and present experiences of biological mothers with complex trauma in the child welfare system?

- Feminist Theory: How do gender, age, and culture influence experiences in the child welfare system?
- Bronfenbrenner Human Ecology Theory: How does environment influence experiences in the child welfare system?

CHAPTER 2: REVIEW OF LITERATURE

The research on child maltreatment regarding statistics, risk factors, and services offered and received is vast; however, little is known on the impact of these factors on biological mothers in the child welfare system. The human ecological model focuses on the family embedded within systems and therefore how the environment influences views of the child welfare system. This feminist study focuses on the interactions between intergenerational transmission of abuse and biological mothers' ecology in examining their experiences and views in the child welfare system. Through the feminist lens, past literature has geared researchers toward issues of race, class, and gender within the child welfare system. Additionally, research regarding the intergenerational transmission of abuse and subsequent quantitative findings has ultimately lost the qualitative voice of the victims and their views of the child welfare system.

Defining Child Maltreatment

In the United States, each state sets its own definition of child abuse and neglect based on federal guidelines. The minimum set of behaviors that define child abuse or neglect according to federal standards are

> any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or, an act or failure to act which presents an imminent risk of serious harm (Child Welfare Information Gateway, 2008, p. 2).

The major types of child abuse and neglect according to the federal guidelines are physical abuse, neglect (physical, medical, emotional, and educational), sexual abuse, emotional abuse, abandonment, and substance abuse. This study will focus on child neglect.

For the purposes of this study, child maltreatment will be used to refer to the various types of child abuse and neglect unless otherwise stated. In 2009, research showed that 53.8% of perpetrators were women and 83.2% of all perpetrators were between the ages of 20 and 49 (U.S. Department of Health and Human Services, 2010b). Additionally, nearly two-fifths of victims were maltreated by their mother acting alone and 18% of victims were maltreated by both parents.

Intergenerational Transmission

Intergenerational transmission of child maltreatment is a complex cycle of violence involving complicated relationships with numerous intervening factors. The probability of a parent with an abuse history becoming an abuser is dependent on many risk factors. Parents with a history of maltreatment are significantly more likely to be involved in social services if they have a history of mental illness, are of young parental age, reside with a violent adult, and demonstrate poor parenting practices (Dixon, Browne, & Hamilton-Giachritsis, 2009). Mothers who broke the cycle of transmission were more likely to be in a long-term stable relationship, have a secure home environment, and demonstrate greater emotional stability. They were also more likely to receive emotional support or mental health services and present with fewer symptoms of depression, stress, and anxiety. Maltreating families have been shown to isolate themselves from society, which reduces their access to emotional and financial support (Cicchetti & Lynch, 1993).

Families with intergenerational transmission of abuse can be categorized into one of four groups (Dixon et al., 2009). The first group were *maintainers,* or those continuing the cycle of abuse, meaning that the abusive parents themselves had been abused as children. The second group were *cycle breakers*, or parents who were abused as children but did not repeat such acts

on their own children. The third group, *initiators*, were the group of parents who did not report abuse as children but do abuse their own children. Lastly, parents who had no reported abuse history and did not abuse their own children are considered *controls*. This study will focus on the first group, the *maintainers.*

Risk Factors

Research has suggested that the severity of maltreatment experienced by a parent affects their likelihood of maltreatment (Pears & Capaldi, 2001)—the more severe the sexual abuse in the first generation, the greater the likelihood of abuse in the second generation. The potential for abuse is higher in young adults who have received injuries because of abuse than those who only experienced abusive acts without injury or no abusive acts. Therefore, this suggests that the experience of injury because of abuse may be an important variable in the transmission of abuse or neglect. Parents who reported greater severity of abuse were linked to higher levels of abusive behaviors toward the next generation. Furthermore, those who had experienced both multiple physically abusive acts and multiple injuries demonstrated higher levels of maltreatment toward their children. Therefore, higher levels of experienced abuse predicted higher levels of abuse toward the next generation (Pears & Capaldi, 2001).

Neglected children often deal with low academic performance, developmental delays, cognitive impairments, social and emotional withdrawal, lower self-esteem, and low assertiveness (Chaffin, 2006). Neglect is multidimensional and is associated with multiple types of behavioral and social problems. It has been proposed that inflexible social factors have caused neglect to become the most prominent type of child maltreatment (Chaffin, 2006). It is important in the treatment and prevention of child maltreatment that we help at-risk families reduce multiple risk factors.

Child maltreatment has been associated with the development of mental health problems such as PTSD, depression, anxiety, antisocial personality disorder, and substance abuse (Dixon et al., 2009). Research shows that both maternal drug use and maternal sexual abuse history significantly predict daughters' likelihood of sexual abuse (McCloskey & Bailey, 2000). Girls were at 3.6 times greater risk for sexual abuse than other girls in the study if maternal sexual abuse history was reported. Illicit drug use also increased this risk. Other risk factors confirmed by McCloskey and Bailey were frequent moves, drug use, psychopathology, and domestic violence. Nevertheless, merely 53% of child welfare agencies surveyed in 2004 had policies for screening and assessing domestic violence (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004). Additionally, children growing up in abusive families are unlikely to observe consistent and fair parenting.

Services Offered and Received

The programs utilized by CPS are often characterized as brief, low cost, and not requiring advanced degrees for trainers (Bolen et al., 2008). Most programs fail to address the reason for entry into CPS, have limited flexibility in program length, and lack an assessment of age-appropriate interventions (Bolen et al., 2008). Furthermore, parent education programs have little effect on high-risk families unless parents also receive services regarding the multiple risk factors the families face (Bolen et al., 2008). However, some parent education programs can be helpful (Chaffin & Friedrich, 2004).

In the past, research has shown that sexually and physically abused children receive more services than neglected children do (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996). Recently, child neglect has become known as one of the most complex social problems; however, it continues to receive less attention than other forms of maltreatment (Bundy-Fazioli,

Winokur, & DeLong-Hamilton, 2009). Parents of sexually abused children are more likely to receive some type of mental health service (Kolko et al., 1999). According to the U.S. Department of Health and Human Services (2010b), preventive services are provided to parents when children are at risk of child abuse and neglect. Examples of these services include family support, child daycare, education and training, employment, housing, and referrals. Post-response services, such as counseling and in-home services, address the safety of the child based on the assessment of the family's situation, including service needs and family strengths.

Family support services are primarily preventive and community-based programs designed to decrease parenting stress and increase parental caretaking abilities. Family support services include childcare, financial assistance, legal aid, emergency housing, dietary supplements, parenting education, support groups, transportation, job support, and mental health counseling (Rajendran & Chemtob, 2010). Family support services have been shown to improve parental functioning, reduce childhood delinquency, and improve other child and family issues (Rajendran & Chemtob, 2010). Regardless of the services offered or received, few researchers have explored biological mothers' views on the role in the intergenerational transmission of abuse (Carolan, Burns-Jager, Bozek, & Escobar Chew, 2010) or views on the impact of the child welfare system. Additionally, few services adequately address the parent's complex trauma.

CHAPTER 3: METHODOLOGY

Research is a shared awareness of freedom, responsibility, and empowerment between the researcher and the participant. Qualitative research is uniquely capable of focusing on issues of power that traditional social science research practices may silence by obscuring marginalized or oppressed groups from their inquiry. Denzin and Lincoln (2005) argue that qualitative researchers should be familiar with many methods of collecting and analyzing data. Feminist research assumes an understanding and attunement of oneself toward the power dynamics within the research relationship (Way, 1997). This phenomenological study will describe the lived experiences of biological mothers with complex trauma in the child welfare system and give voice to those experiences.

Phenomenological Research

Phenomenological research methods are scientific as they are methodical, systematic, critical, and potentially intersubjective (Wertz, 2005). Phenomenological research illuminates the specific, identifying phenomena through the voice of the participant (Lester, 1999). The main goal of phenomenological research is to record participants' subjective experiences and reveal the multiple meanings and similarities among experiences (Silverstein, Auerback, & Levant, 2006). Phenomenological research seeks to describe rather than to explain as it documents a rich description of both local context and individual experiences (Silverstein et al., 2006). Additionally, phenomenological research studies details in situations that do not lead to direct generalization of the larger population from which the participants were drawn.

Phenomenological research is based on the assumption that there is a structure and meaning inherent to shared experiences that can be narrated (Marshall & Rossman, 2006). These experiences are descriptions of phenomena, which do not rely on empirical evidence or logical

argument (Osborne, 1994). Personal experience is subjective and reflects the intentional and conscious thought (Hays & Wood, 2011) of individuals such that

> any gaze is always filtered through the lens of language, gender, social class, race, and ethnicity.…Subjects or individuals are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories, about what they did and why. (Denzin & Lincoln, 1998, p. 12)

Through a feminist lens, this research challenges structural or normative assumptions by adding an interpretative dimension to inform, support, or challenge policy and action.

The focus of phenomenological research is what people have experienced and how they experienced it (Creswell, 2007). Rapport and empathy are essential in phenomenological research to gain in-depth information, particularly when participants are members of a marginalized population. Phenomenological research is necessary to make voices heard and provide a deep understanding of what it means to be human (McClelland, 1995).

The phenomenological researcher seeks to report an authentic telling of the experience and the meaning for the participant. Multiple realities and socially constructed meanings are identified through phenomenological research (McClelland, 1995). Research focused on personal meaning "gives voice to people who have been historically silenced or marginalized" (Brantlinger, Jimenez, Klingner, Pugach, & Richardson, 2005, p. 199). In qualitative phenomenological studies, the number of interviews is less important than the extent to which a phenomenon is explored in each interview; small sample size ensures common individual characteristics and similar life events (Parra-Cardona, Sharp, & Wampler, 2008).

Sample and Procedure

The purpose of this phenomenological study is to describe the experiences of biological mothers with complex trauma in the child welfare system. Criterion sampling strategies were utilized to increase quality assurance (Creswell, 2007). This type of sampling is appropriate when all participants have experienced the identified phenomenon. When using criterion sampling methods, participants meet a specific set of criteria.

Based on research statistics, previously reviewed, biological mothers between 20 and 29 years of age who have experienced intergenerational transmission of abuse and complex trauma were selected as participants for this study. The inclusion criteria was that the women would be mothers with a biological child under the age of 12 that was currently involved in the child welfare system due to neglect. Participation in this research study was voluntary and not contingent on other services currently being provided. It should be noted that all 5 participants were currently engaged in therapy services.

Participants were identified by recruitment letters sent to mental health counselors as well as social service agencies in a midwest metropolitan area. This method proved to be unsuccessful. After six months, no participants had contacted the primary researcher. The primary researcher then contacted fellow colleagues whose primary caseloads consisted of biological mothers involved in the child welfare system. These colleagues identified potential participants and assisted in scheduling the first interview.

Interested participants voluntarily contacted the researcher to discuss participation after they were approached by their therapist. The initial contact provided the opportunity for the primary researcher to ensure criterion sampling methods. Seven women volunteered for this study. All seven women completed the first interview. Only five women completed both interviews. Two women were unable to be contacted or were unwilling to schedule the second

interview. The criterion for study inclusion was completion of both interviews; therefore, this study only focused on the five women who completed both interviews to provide an in-depth understanding of their experiences in the child welfare system.

All of the mothers in this study were currently engaged in outpatient mental health therapy. It can be inferred that the participants in this study were more willing to discuss their lived experiences, as they were involved in a healthy, therapeutic relationship. Many of the women stated that they were willing to meet with primary researcher because their therapist discussed their participation in the present study. Women with complex trauma histories often have difficulties in understanding safety and interpreting relationships (Carolan et al., 2010) and therefore may have been more comfortable engaging in the research process when referred by their primary therapist. Research shows experiencing complex trauma can hinder the ability to trust, self-regulate, build meaningful relationships and boundaries, and assess safety of self and others (Briere, 1995; van der Kolk, McFarlane, & Van Der Hart, 1996). Additionally, the women who participated expressed gratitude over the gift card incentives, as they were low on resources.

The five mothers included in this study were all of Caucasian ethnicity; however, several of the children were biracial. Research shows that interracial families are more likely to experience risks that are associated with child maltreatment (Fusco & Rautkis, 2012). Additionally, Caucasian mothers of biracial children are at higher risk for physical, intellectual, and emotional problems (Fusco & Rautkis, 2012). One study found that families of biracial children were four times more likely to become involved with the child welfare system than either Caucasian or African American children (Fusco, Rauktis, McCrae, Cunningham, & Bradley-King, 2010). “Communities of color,” which have been historically overrepresented in

the child welfare system, have higher levels of mistrust and more generational experiences with the child welfare system (Kemp, Marcenko, Hoagwood, & Vesneski, 2009, p 106).

Interview Questions Based on Research Questions

In phenomenological research, the process of collecting data is primarily gathered through in-depth interviews (Creswell, 2007). This type of research allows a small number of individuals to describe their experiences in the child welfare system. Multiple in-depth interviews were conducted with each research participant (Creswell, 2007). Research questions "should be general enough to permit exploration but focused enough to delimit the study" (Marshall & Rossman, 2006, p. 39). The use of interviews is both a qualitative and a feminist research method (Whipple, 1996). Research questions serve as nonconstricting boundaries surrounding the research study.

An interview protocol (see Appendix A) was created to record information collected during the interviews. The interview protocol included the time of the interview, date, place, interviewer, and interviewee. A short description of the study and a reminder that the interviews would be recorded and transcribed verbatim was provided. Lastly, the interviewer thanked the participant for participating and assured confidentiality of their responses. Additional notes included future scheduled interviews. Open-ended questions allowed participants to express themselves freely and verbalize their own feelings, thoughts, and beliefs as well as decrease researchers' bias.

Several interview questions focused on understanding the culture of the child welfare system. The term *culture* takes into account "the knowledge of, attitudes toward, values understood, and skills used" in regards to "gender, race and ethnicity, sexual orientation, age, religion, education, social class, culture, family background, migration experiences, and legal

statuses" (Dettlaff & Fong, 2011, p. 53). Cultural awareness encompasses multiple identities and varied worldviews based on social experiences (Ortega & Faller, 2011).

Using interview methods, researchers attempt to understand the context of the participant and locate shared experience across participants (Hays & Wood, 2011). The purpose of this qualitative study is to explore the views of biological mothers with complex trauma in the child welfare system using an ecological framework, phenomenological research methods, and a feminist lens. Qualitative interviews were utilized to elicit participants' perceptions of their experiences in child welfare services and the intervention services they were offered and/or received. Due to the thoughts, feelings, beliefs, and values related to child welfare, the researcher must have face-to-face interactions with participants in order to gather a deeper understanding (Marshall & Rossman, 2006).

Semistructured, purposeful, and focused interviews were employed to provide opportunities for information to emerge spontaneously from each participant (Bogar & Hulse-Killacky, 2006). An interview protocol, including open-ended questions, follow-up probes, and opening and concluding comments were used to ensure the data gathered addressed all of the research questions. Active listening skills encouraged participants to elaborate on their answers and allowed the researcher to follow the interview protocol or deviate when necessary (Bogar & Hulse-Killacky, 2006).

Data Collection and Analysis

This research project followed the standards and guidelines set forth by the doctoral committee and the SIRB board at Michigan State University (IRB #12-188). All interviews were conducted by the same interviewer in the participant's homes or an agreed-upon outside location that ensured confidentiality and maintained a level of comfort for the participant. Research

participants completed an informed consent form prior to the first interview (see Appendix B). Two in-depth interviews were conducted with each research participant. A $20 gift card was awarded to each participant after the completion of each interview. The sample consisted of five completed sets of interviews. Phenomenological research intends to gather an in-depth understanding of the phenomenon such that saturation is not part of the methodological process.

Data analysis followed Creswell's (2007) simplified version of Moustakas' (1994) Stevick-Colaizzi-Keen phenomenological data analysis method, as it provided "the most practical, useful approach" (Creswell, 2007, p. 159). Creswell outlines the following steps in phenomenological data analysis. The first step is to describe the researcher's personal experience with the phenomenon being studied. This step involves bracketing preconceived assumptions regarding the research topic to refrain from adding personal judgment. The researcher's personal experience with the phenomenon or "epoche" is described in this chapter under the role of the researcher, as suggested by Creswell.

The second step involves finding significant statements regarding individual experience. During this stage, each transcription is coded for nonrepetitive and nonoverlapping statements in a process known as *horizontalization* (Hays & Wood, 2011). These statements are gathered in themes or clusters of meaning. The researcher then combines similar themes to provide thick descriptions and in-depth meaning of participants' experiences; this is referred to as *textural description.*

The next step is writing a structural description that reflects the setting and context (i.e., ecology) in which the phenomenon was experienced (Creswell, 2007). The last step is to combine the textural and structural descriptions to provide the "essence" of what the participants experienced and how they experienced it (Creswell, 2007).

Of the seven biological mothers who completed the first interview, two did not complete the second interview (unable to be contacted or unwilling to participate), which resulted in five complete interviews. Data analysis focused on the five women who completed both interviews as a requirement of full inclusion in the study. According to Creswell (2007), there are no concrete rules for sample size in qualitative research; however, Dukes (1984) suggested 3 to 10 participants that have experienced similar phenomenon.

During the first interview, a three-generation genogram was constructed with each participant (see Appendix B). First introduced in 1985 by Monica McGoldrick (1999), genograms are symbolic displays of family relationships that focus on family dynamics, repetitive patterns, and psychological factors. The genogram is constructed with simple figures that represent individuals and various lines that depict relationships. This study used genograms to gather information regarding the participants' family, emotional, and social relationships across three generations. During genogram construction, information was gathered regarding family relationships, intergenerational transmission of abuse, and complex trauma.

The second interview used two broad, general questions to focus attention on participants' experience in the child welfare system. This allowed the researcher to gather data that led to textural and structural descriptions of underlying structure and meaning ascribed to their experiences (Creswell, 2007). The two primary open-ended interview questions are as follows: What have you experienced in the child welfare system? What situations have influenced your experiences?

Phenomenological data analysis began with transcription of the audiorecorded interviews. The recordings were transcribed verbatim. The transcriptions were read several times to allow the researcher to become immersed in the participant's experiences during the interviews. The

audio recording was listened to while the transcripts were read to embrace the full experience of the interviews. Next, significant statements were highlighted, which provided an understanding of how participants experienced the child welfare system as biological mothers with complex trauma (Creswell, 2007). Moustakas (1994) referred to this step as *horizonalization* and emphasized that each statement is given equal weight of importance.

After horizonalization of the data, the significant statements were clustered into themes or "clusters of meaning" (Moustakas, 1994). All repetitive or overlapping statements were removed at this stage of data analysis. The significant statements and themes were used to write a description of what Moustakas describes as the findings of phenomenological research: textual description, structural description, and essence. The textual description includes what the participants have experienced. The structural description is what context has influenced their experience. The essence is the combination of the textual and the structural descriptions to describe an overall representation of the experience. Furthermore, the participants' names were changed to ensure confidentiality.

Standards of Validation and Quality

The purpose of qualitative phenomenological research is to understand a phenomenon by understanding another person's reality (Stenbacka, 2001). Therefore, validity is present when participants are part of the selected population and allowed to speak freely about their own experiences. Creswell (2007) identified eight strategies frequently employed in qualitative research. The current study utilized three validation strategies, which exceeds Creswell's recommendation of at least two of the eight strategies. First, information from participants was gathered using two different sources: the genogram and the semistructured interview. Second, the primary researcher engaged in peer debriefing, which involves "an individual who keeps the

researcher honest, asks hard questions about methods, meanings, and interpretations, and provides the researcher with the opportunity for catharsis" (Creswell, 2007, p. 208). Peer debriefing helps researchers explore their own perceptions and reactions as they carry out qualitative research (Barusch, Gringeri, & George, 2011). Lastly, thick, rich descriptions were used to allow for transferability. The author wrote each participant's experiences in detailed description to allow for transferability and provide a voice for each individual woman. In addition, the writing of rich descriptions of data analysis and methods used also ensure transferability. The study's reliability was increased by using a digital voice recorder and by detailed transcription. The researcher listed to the recordings while reading the transcriptions to increase reliability and "indicate the trivial, but often critical, pauses and overlaps" (Creswell, 2007, p. 209).

Lincoln (1995) outlined standards for quality of research, which include standards for judging quality, positionality, rubric of community, voice, critical subjectivity, reciprocity, sacredness, and sharing the perquisites of privilege. This research project followed the standards and guidelines set forth by the doctoral committee and the SIRB board at Michigan State University. Positionality was maintained by displaying honesty within the text and by the researcher admitting their stance: "detachment and author objectivity are barriers to quality, not insurance of having achieved it" (Lincoln, 1995, p. 280). Rubric of community addresses how research serves the purposes of the community, such as feminist thought using an ecological model, which was incorporated in this study. By providing rich, thick descriptions of the lived experiences of biological mothers with complex trauma in the child welfare system, this study provides voice to those often silenced. During this research study, the researcher gained a heightened self-awareness and recognized her passion and determination to provide a voice for

biological mothers with complex trauma. While this research was difficult and emotionally draining, it is vital to improve the lives of women and children. Reciprocity between the researcher and the participant was imperative to this study and was enabled by the researcher's ability to create open, trusting relationships. Sacredness developed in this research study from "a profound concern for human dignity, justice, and interpersonal respect" (Lincoln, 1995, p. 284). Lastly, the primary researcher shared the rewards of this work by providing participants with a small monetary gift for participation in the study, which does not begin to cover the endowment the researcher owes to these women for their participation. Lincoln described this concept perfectly:

> For the somewhat dark side of research hides the fact that most of our research is written for ourselves and our own consumption, and it earns us the dignity, respect, prestige, and economic power in our own worlds that those about whom we write frequently do not have. (p. 285)

Lincoln and Guba (1985) state that in qualitative research, trustworthiness and credibility replace reliability and validity, which is associated with traditional quantitative research. Morrow (2005) identifies trustworthiness as a core criterion for quality in qualitative research. Phenomenological researchers use bracketing, which describes the overt personal awareness of one's implicit assumptions and inclinations and sets them aside to avoid having them unjustifiably influence the research (Husserl, 1931).

In emotion-laden, qualitative research, maintaining reflexivity, or self-reflection, is invaluable. For this study, the primary researcher kept a self-reflective journal from the inception to the completion of the research project. In this journal, the researcher recorded her experiences,

reactions, and emerging awareness of any assumptions or biases that become known (Morrow, 2005). The researcher's values, personal history, and characteristics such as gender, culture, class, and age are inevitable factors in qualitative research (Haverkamp, 2005).

During the interviews, the researcher worked to represent the participants' experiences accurately by asking for clarification, interpreting personal meanings, verifying responses, and maintaining the stance of naivety in order to demonstrate trustworthiness. Credibility is enhanced by data collection methods that are thorough and that focus on the participants' lived experiences to validate the findings. Trustworthiness is also based on the researcher's acknowledgment of participant vulnerability; the researcher holds a personal responsibility to promote participants' welfare and guard them against harm (Haverkamp, 2005).

To improve trustworthiness, the researcher wrote field notes after every interview. Field notes consist of nonjudgmental, concrete descriptions of what has been observed by the researcher (Marshall & Rossman, 2006). The researcher's field notes were formatted with the description in the left column and observer comments in the right column. The observer comments served as insights to behaviors or initial impressions as well as provided important questions for future interviews.

The Role of the Researcher

Qualitative researchers are intrigued by the complexity of social interactions of daily life and the how participants define and experience these relations. Rossman and Rallis (2003) suggest four characteristics of qualitative researchers: that researchers view social phenomena holistically, engage in systemic reflection, remain sensitive to their own social identities and how these shape the research process, and rely on complex reasoning that moves between deduction and induction. Knowledge is generated through "dialogue, listening and talking" (Thompson,

1992, p. 10). Reinharz (1992, p. 29) stated, “for a woman to be understood in a social research project, it may be necessary for her to be interviewed by a woman.”

The primary researcher for this study is a marriage and family therapist. Training and experience as a family therapist has provided her with interpersonal skills to build trust, to maintain good relations, to respect norms of reciprocity, and to acknowledge ethical issues. Therefore, she worked hard to be an active, patient, and thoughtful listener while maintaining empathy and respect for the perspectives of others. To protect the emotional and physical health and safety of the researcher and maintain balance when data collection became emotionally draining, the primary researcher used journal writing and peer debriefing.

Researchers cannot completely separate themselves or their interpretations from qualitative research (Creswell, 2007). The researcher acknowledges her own biases pertaining to this type of research. The researcher has never been involved in the foster care system personally, nor has her immediate family, but she has had significant experience working with women and families with related histories. She has never been confronted with the hardships most of these mothers have experienced. Furthermore, the researcher has unconditional positive regard from family and friends, which is a privilege these participants may not have experienced. Though the researcher acknowledges she is of privilege and carries an invisible knapsack (Macintosh, 1989), she is able to express empathy and compassion for the participants of this study. Lastly, the researcher assumes a fiduciary role (Haverkamp, 2005) based on trust, which assumes the one with greater power accepts responsibility to promote the welfare of others.

Ethical Considerations

Due to the sensitive circumstances of those involved in the child welfare system, informed consent procedures followed the requirements of the Michigan State University’s

Social Science/Behavioral/Education Institutional Review Board (SIRB). Research is not ethical based on design or procedures, but rather based on the researchers' decisions, actions, relationships, and commitments during the research study (Haverkamp, 2005). In advocating for a feminist perspective in qualitative research, Denzin (1997) reflects that "this framework presumes a researcher who builds collaborative, reciprocal, trusting, and friendly relations with those studied…would not work in a situation in which the need for compensation from injury could be created" (p. 275). Participants were assured that their individual responses were strictly confidential and participation was voluntary. Participants were made aware that there were no direct benefits for participating in this study; however, their contributions could be helpful in improving child welfare services.

The primary researcher who conducted all of the interviews was aware of the sensitive nature of the information sought in the interviews. Her clinical skills were an invaluable asset in both recognizing and responding to signs of distress during the interview process. Clinical training provided her with skills and experience to respond in a therapeutic manner and elicit a deepened level of disclosure. Provisions were made for follow-up services for any participants who might have been distressed by issues discussed in the interviews. The researcher encouraged the participants to connect with local mental health agencies in the area, which also provide therapy for noninsured persons, if necessary. A list of providers was provided, per request; however, all of the participants were already engaged in outpatient therapy services. Nevertheless, the researcher is a mandated reporter and responsible for reporting any acts of abuse or neglect, which is thoroughly discussed in the informed consent procedures.

Demographics

To ensure confidentiality, the participant's names have been replaced with pseudonyms. Five women completed both interviews for this phenomenological study. All of the women were under the age of 30, had experienced complex trauma, and had a child under the age of 12 in the child welfare system due to neglect. Their experiences are written each individually to provide a deeper understanding of their personal differences. The following summaries were compiled using information gathered during the genogram interview.

Interviews

Katie

Katie is the oldest of three children. She has the same mother as her youngest sister and the same father as her middle sister. Her parents divorced when she was four months old. Katie reports that there was domestic violence between her mother and her father. Her father remarried and had a daughter; he died when Katie was eight years old. Katie is cut off from her paternal side of the family, including her stepmother and half sister, as she does not get along with her stepmother. Her father died when she was 8 years old. Her father has brothers, but she is unaware how many. Her paternal grandfather abused drugs and alcohol and her paternal grandmother was an alcoholic. The middle sister is married and has one child. Katie is cut-off from her paternal side of the family.

Katie's maternal grandmother was in foster care as a child. Katie was very close to her maternal grandmother, who passed away recently. Her maternal grandmother was in foster care as a child. Her maternal grandparents had seven children; they divorced when the youngest child was in high school. Katie's grandmother remarried a man that Katie remembers fondly. Her maternal grandfather died several years ago and her stepgrandfather passed away when she was

10 years old. Katie reflected on the hardship of losing her father and her stepgrandfather within two years of one another.

When Katie was seven years old, she and her sister went to live with their maternal aunt and her husband as a result of her stepfather being physically and sexually abusive toward both girls. Katie describes her mother was a very narcissistic person who was verbally and emotionally abusive. Additionally, her aunt's husband raped her mother and molested her sister during this time. Katie is unclear why her mother would allow them to live with the man who raped her, except that they were the only family members who would take them.

Katie has been exposed to physical, sexual, and emotional abuse by her mother, her ex-stepfather, her babysitter, and her mom's ex-boyfriend's daughter. She recalls attending an in-home daycare that had a torture chamber in the basement. Katie was molested and physically abused between the ages of four and seven. She recalls being tied to a pool table in the basement and beaten while attending daycare.

Katie is now divorced and has four children. Katie became pregnant with her first child when she was 19 years old. She granted guardianship of her first child to her mother, as she was young and unable to care for him. Her oldest son and youngest daughter have different fathers. Katie is divorced from her oldest daughter and youngest son's father, who was physically abusive during their marriage. Her oldest daughter and youngest son currently live with her oldest daughter's biological father. Katie reports that her daughter's father does not understand how to be a dad. Katie has visitation with her children on a regular basis. Her oldest son and youngest daughter are currently living with Katie's mother and stepfather, whom she describes as a "gentle giant."

Katie is currently pregnant with her fifth child. She describes her current relationship as complicated. Her boyfriend is also a victim of child sexual abuse, which she reports causes conflict in their relationship. Katie admits to "pushing matches a couple of times" with her current boyfriend.

Asha

Asha and her brother were adopted when she was five years old and her brother was three years old. Asha was sexually abused by their biological father. She knows very little about her adoptive mother's family. Asha's adoptive maternal grandmother died five years ago, but she was not informed about the death for six months. She has not had contact with her adoptive father's family in 12 years and has not seen her adoptive paternal grandparents in over 15 years. Asha does not know anything about her biological family.

She reports being cut off from her adoptive family due to her drug and alcohol abuse. Her brother, who has been married twice and does not have any children, also suffers from alcoholism. She attempted to contact her brother a year ago, but he told her never to call him again. Asha was kicked out when she was 18 years old and did not have contact with her adoptive family for six years. She reports that her adoptive father is a preacher and they were unhappy about her having a child outside of marriage.

Asha has three children. She had her first child when she was 18 years old. She reports that she was "young and stupid" and gave her parents guardianship of her first child. Asha reports that she started using drugs when she was 20 years old. She was physically abused by her youngest child's father; the other two fathers are currently in prison. Her two youngest children are currently in foster care. She has unsupervised visits three times a week.

Asha was raped when she was 20 years old and diagnosed with HIV when she was 21 years old. She stopped taking medication to control her HIV, as she was unable to "hide three bottles" of medication. She reports fearing for her life if others found out what she did while she was abusing drugs. Asha was also "jumped twice" by her youngest child's father. She reports that he once attempted to kill her because she asked for money to pay for an abortion. Her son was present during this incident.

Erika

Erika's parents were married and got divorced before her birth. She has one full brother, three half brothers, and a half sister. Her father has a girlfriend and a child on the way. Erika has never talked to her father's girlfriend nor met her. Her mother was remarried. Erika's stepfather sexually abused her, as well as physically abused her brother as he was trying to protect her. Her mother and stepfather divorced after the abuse occurred; her stepfather is now deceased. Her full brother is engaged and has three daughters. She is not close to her half siblings. Erika stated that two of her half brothers recently lost their mother and that her father is trying to gain custody of them.

Erika is unclear how many siblings her father has. Both her paternal grandparents are deceased. Erika is close to her mother. Her maternal grandmother recently passed away from cancer. Her maternal grandfather, whom she was very close to, committed suicide when Erika was eight years old.

Erika has six children. Three of Erika's children have the same father and the other two share a different father. Her oldest son was her only child by her ex-husband, who served a prison sentence for drug trafficking. Her rights were terminated for the oldest five children and her sixth child is currently in foster care. Her oldest four children were adopted by the same

family. Her oldest son would be 14 years old but was murdered by his adoptive parents when he was seven. His three siblings were also abused by the same adoptive parents. The three siblings have since been adopted by other families. Both Erika and her mother suffered from depression after her son was murdered. Her oldest son was by her ex-husband, who served a prison sentence for drug trafficking. Erika's rights to her oldest five children were terminated and those children were adopted out of foster care. Erika reports that her youngest child was removed due to prior terminations and lack of housing. She and her husband have been together for seven years and are hoping to reunify with their youngest child.

Erika has survived several violent relationships. She stated that she had to pry her ex-boyfriend's fingers off her oldest son during one incident. After threatening to hurt her ex-boyfriend if he ever put his hands on her son again, her ex-boyfriend picked her up by her throat and slammed her down on concrete. Her ex-boyfriend was sent to jail. A different ex-boyfriend was mentally abusive.

Emily

Emily has two children and is pregnant with her third. Her oldest daughter lives with her biological father, who was granted full custody after Emily had two DUIs and was on probation. Her youngest daughter is in foster care.

Emily's parents got divorced when she was seven years old. She asked to live with her father, who remarried after the divorce. Her mother never remarried but had twins with another man. Emily has three stepsiblings and two half brothers. Emily stated that her mother was active in her life until she was 12 years old. She stated that her mother fought for her for four-and-a-half years and then "she stopped fighting."

When Emily was 14 years old, she got into an argument with her stepmother and went to live with her mother for two weeks. Emily does not have a healthy relationship with her stepmother, who she states "was a really big stoner." She stated that she returned to her father's house after her brother had to be admitted to the hospital for seizures. Her stepmother would frequently drug test Emily while she lived with them, which she reports always came back negative.

When Emily was 14 years old, she was raped by 12 people. She remembers not being able to move her body, while her best friend sat nearby and laughed. At 15, Emily got pregnant and had an abortion. She reports that her parents made her abort the child or they were going to kick her out of the house. A few weeks later, Emily's father was drunk and became violent; she "jumped out the window to get away from him." As a result, she had to have tendon surgery and several stitches. She has not lived "at home officially since then." Emily reports that she used to self-harm as a teenager.

Emily's father has five siblings. Her uncle committed suicide. Her paternal grandmother is deceased. Her paternal grandfather is supportive. Emily's mother has two sisters. Her maternal aunt has eight children that are regularly involved with CPS. Her maternal grandmother is still living but does not approve of Emily living with her current boyfriend, as they are not married. Her maternal grandfather is deceased.

During an argument with her child's father, she was drunk and stabbed herself in the leg with a knife. She was on probation for DUIs at the time and was on suicide watch at the hospital for 24 hours. Emily believes that CPS has used the incident against her, saying that she is "mentally unstable."

Jennifer

Jennifer has two half siblings. Jennifer does not know her biological father except that he is married and has children. Jennifer's mother was 19 years old when she gave birth. Her mother has two sisters. Her aunt has two children; however, her son is Jennifer's brother. Her aunt was unable to have more children and because her mother was pregnant, had two children, and was not married, Jennifer's mother decided to allow her sister to adopt the baby. Her other maternal aunt is a single parent who has two boys and a deceased daughter, who died of a heart condition. Her maternal grandparents were divorced and grandmother was remarried. Both her grandfathers are deceased.

Jennifer stated that CPS was called once growing up, but that a case was never opened. She remembers being hit repeatedly with a spoon. Her sister reports being raped by a boyfriend but no charges were made.

When Jennifer was in seventh grade, her parents divorced. "And then we found out that he wasn't our real father, so that was traumatic." She reports that she moved out of his home after she found out "because he never treated us the way he treated his real daughter." Jennifer stated that since she and her sister did not have a father's name on their birth certificates, their stepfather was able to adopt them. Their relationship suffered after she moved out of his house until he had guardianship of Jennifer's daughter for several months.

Jennifer has one daughter and is pregnant with twins. She is currently in a relationship with her twins' father. Her boyfriend is in the military and they are planning to relocate out of state after her daughter is returned. Her daughter has a cleft palate and recently had surgery. Additional surgeries are necessary to correct the deformities.

CHAPTER 4: FINDINGS

The purpose of this study was to provide a deeper understanding of the lived experiences of biological mothers with complex trauma in the child welfare system. This feminist informed study used Bronfenbrenner's human ecological theory and Bowen's family systems theory. The primary interview questions asked were "What have you experienced in the child welfare system?" and "What situations have influenced your experiences?" Genogram questions gathered information regarding family dynamics, intergenerational transmission of abuse, complex trauma, and mental health and substance abuse concerns. Transcriptions of both interviews were compiled and significant statements were extracted. After the significant statements were consolidated into nonrepetitive and nonoverlapping statements, they were then gathered into clusters of meaning, out of which 10 themes emerged.

Of the 10 themes that emerged, five reflected *what* the women with complex trauma experienced in the child welfare system. Mental health problems, substance use problems, and the effects of complex trauma described what the women have experienced in the past and present. The women experienced lack of trust with the child welfare system and concerns regarding their children involved in the system. However, the women also experienced feelings of empowerment because of being involved in the child welfare system.

The other five themes depicted *how* the women with complex trauma experienced involvement with the child welfare system. Family dynamics and interpersonal relationships described the environment that the women experienced. They also had trouble with the removal of their children and the involvement of child welfare. The women discussed what services they were offered or, more appropriately, what services they asked for or engaged on their own. The

women experienced negative views from society, which allowed them to give advice to other mothers or families involved in the child welfare system.

The following textual and structural descriptions provide a better understanding of how and what women with complex trauma experience in the child welfare system. Utilizing the feminist lens, each woman is identified individually, empowering their voices and providing a better understanding of their experiences. Pseudonyms are used to protect the identity of participants. First-person descriptions allow for more in-depth summarizations of their experiences.

Textual Description

Five of the themes spoke to the textual description of what the women experienced regarding the phenomenon. These included presence of mental health, substance abuse, and recovery issues; impact of complex trauma; visitation and concerns for children; lack of trust in the system; and feelings of empowerment.

The first theme, mental health problems, substance use concerns, and recovery issues, revealed commonalities such as mental health diagnoses, repeated drug use, and involvement with the legal system. One mother denied any mental health or substance abuse issues and resented the fact that CPS treated her as “the same type of person that they always deal with.”

The second theme, impact of complex trauma, gave insight to the mothers’ repeated physical, sexual, and emotional abuse; domestic violence; and difficult family situations. Many of the women discussed traumas that they experienced as children. Three of the women experienced sexual abuse as children, which research shows increases the likelihood of intergenerational transmission of abuse (Zuravin et al., 1996).

Visitation and concerns for children were combined into the third theme as they spoke to the difficulties that children have experienced in the child welfare system. Three of the women had their children placed with family members. One of the women discussed her discontent with how often her children were moved in foster care because of a medical diagnosis. The last woman was unsure of the location of her children as they were adopted out of foster care. The women expressed concerns regarding their children's well-being and mental health. They also spoke about the hardships their children have experienced as a result of being in the child welfare system, such as missed birthdays and inconsistent caseworkers.

All of the women expressed difficulties trusting the child welfare system, which encompasses the fourth theme. The women described lack of consistency, professionalism, and communication on part of their caseworkers, which precipitated their lack of trust in the system. Most importantly, the women expressed how their lack of trust in the system originated with how they and their children were treated.

The fifth and last theme was feelings of empowerment. The women discussed trying to be positive in light of their current situation as well as the choices they have made and how they are fighting for their children. Self-advocacy was evident by the experiences they described, the choices they made, and the battles they were fighting.

Theme 1: Mental Health Problems, Substance Use Concerns, and Recovery Issues

Parents with mental health issues are more likely to be investigated by child welfare (Westad & McConnell, 2012). Furthermore, mothers with a mental health diagnosis are three times more likely to be involved with the child welfare system. The biological mothers that participated in this study voluntarily shared their struggles with mental health concerns, diagnoses, and recovery.

Several of the women were forthcoming about their struggles with mental illness, diagnosed or otherwise. Some of the women denied mental health issues, but as their stories unraveled, it was evident that mental health or substance abuse concerns were present. For example, one had several charges of driving under the influence, but still denied any mental health or substance abuse issues. Additionally, one woman resented that she was viewed as someone with issues. Most of the women also discussed their recovery and progress made in therapy and other services.

Katie

> There was several times that I wanted to commit suicide. I really wanted to kill myself at one point. I needed help. I knew I needed to go to the psych ward because I had already attempted to overdose on Xanax and everything I had in the house was in my system. I have been diagnosed with Bipolar, BPD, PTSD, ADD, OCD, and the list goes on. I was diagnosed with depression after the birth of my son. I remember telling the doctor that I cannot stop crying and I do not know why.
>
> I was absent from doing cocaine for two years but I was never clean and sober because I didn't get the therapy and the help that I needed but I just quit doing it. I struggled to get into a rehabilitation center because I had been sober for 30 days. I went to the National Council on Alcoholism and went through their program but was kicked out because I could not afford the bill. When it came to having the energy to clean the house, do the dishes, do the laundry, chase my kids, the only way I knew how to get through that difficult time was to pick up the crack pipe again.
>
> I had let go of 25 years of hate that I walked around with that is what fueled my addiction. I knew I needed help with my thinking and trying to figure out why, what my

problem was why I kept falling back on drugs. I started attending therapy, going to Narcotic Anonymous meetings, and I was able to let go of all that hate, anger, animosity, everything that I was pissed over what had happened to me in my childhood. I just let go a lot of that hate and figured out why I was an addict.

Asha

I used drugs while pregnant with my children; I used three times when I was pregnant with my daughter and my son came back positive for cocaine when he was born. I [was] caught up in my own drug and alcohol stuff. I have been using drugs since I was 20 years old and I just could not put them down. Now I am in recovery and doing it for my kids and for me. I did not have any friends anyways so what else did I have left but drugs. I do not have any mental health concerns, but when I found out I was HIV positive that caused me to take drugs.

Erika

I had depression after everything that happened with my son being murdered and then my doctor put me on antidepressants the same day that they took my youngest son from the hospital. My doctor did not want me to get to the point that I went crazy. My emotions about my son being murdered will always be there. Therapy has helped me talk about everything in my past. My therapist has helped me with that.

Emily

I had two driving under the influence charges and was on probation, but I do not do drugs, I do not have an alcohol problem, but CPS keeps using that against me.

Jennifer

I do not have any mental health or substance problems. I always got the feeling that CPS treated me as if I was the same type of person that they always deal with, but I am not on drugs, I do not smoke, I do not drink, and I do not have any bad habits like that. When I attended parenting classes, I was with the kind of people you would expect to see in CPS, like the people on drugs, who have drinking problems, or have tattoos all over the place; but, just because they are those types of people, they are still people.

Theme 2: Impact of Complex Trauma

Inclusion criteria for this study included the experience of complex trauma. Complex trauma can be defined as "a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships or contexts" (Courtois, 2008, p. 86). Those who experience trauma rarely experience only a single, traumatic event; rather, it is typical to experience several episodes of traumatic events (Kessler, 2000). The term *complex posttraumatic stress disorder* (CPTSD) has been used to identify criteria such as alterations in regulation of affective impulses, attention and consciousness, self-perception, perception of the perpetrator, relationship with others, somatization and/or medical problems, and systems of meaning (Courtois, 2008, p. 88).

The lived experiences of biological mothers regarding complex trauma are described below. The women were candid regarding the complex trauma they have endured, including sexual, physical, verbal, and mental abuse; self-injurious behaviors; adoption; HIV diagnosis; domestic violence; and murder.

Katie

> I am a survivor of sexual abuse, physical abuse, verbal abuse, emotional abuse, substance abuse, and have a lot of psychiatric disorders that go along with it. I was molested and

physically abused by my mother's ex-husband. My mother sent my sister and me to live with our aunt, whose husband raped my mother and molested my sister. I also suffered physical abuse at the babysitters'. They had a torture chamber in their basement. They ran an in-home daycare and [the] woman's husband and sons tortured little girls and boys. I tried to keep a lot of the abuse from my family (who also attended the daycare) and other kids. I would push them out of the way because I would rather get hurt than see them tied down to a pool table and beat. It started when I was four years old and lasted until I was about seven years old. Think of the worst horror movie you have ever seen. It was 100 times worse.

I also was physically abused by my ex-husband. I had head trauma due to horseback riding accidents as a child, and blunt force head trauma from a bad car accident a couple years ago. I [have] severe scar tissue on my brain because of the head trauma. I used to be a cutter but found an easier way to do it with piercing and tattoos. When I was a teenager, I would self-harm by burning myself with lighters and cutting on my arms. I learned the self-harm behaviors from my mother; my sister and I would watch her beat herself up, like pulling out her hair, punching herself in the face, and we would ask why are you hurting yourself? I have also experienced several deaths in my family. My dad passed away when I was 10. Two years later my grandfather died, so that was hard. I remember a lot of domestic violence between them [parents]; my dad was an alcoholic and hid his drug problem from my mom.

Asha

I was placed in foster care because my biological father was sexually abusive. It was when I was five years old. I became pregnant when I was 18 years old. My adoptive

father, a preacher, kicked me out of his home. I was raped when I was 20 years old and contracted HIV. I got sick and almost died in the hospital. I mean being raped was what caused the infection, which caused me to take drugs. I am no longer taking medication to control the HIV as that is a part of my life I hide from people and I cannot hide my medicine so I just quit getting it. I have been jumped by my child's father twice but that was my own doing. He really tried to kill me because I did not want another baby so I asked him for the money for an abortion. He only did it like three or four times and I never went back after that. I do not have friends because everybody I know always moves away, or they leave, or I move, so why have friends?

Erika

I was sexually abused by my stepfather when I was nine years old. My stepfather abused my brother because he was trying to protect me. When I was eight years old, my uncle was struggling with pain and he shot himself. Before my first child was removed my ex-boyfriend put his hands on my son, I pried his fingers off my child and went after my ex-boyfriend and told him if he ever put his hands on my son again I was going to hurt him severely. He then picked me up by my throat and body slammed me down onto concrete. I have had several ex-boyfriends as being that were physically, emotionally, verbally, and mentally abusive. My oldest son was murdered after being adopted out of foster care. My other three children were in the same household when my son was murdered.

Emily

I had a bad childhood. My parents divorced when I was seven years old and I asked to live with my dad. I remember my mom being around until I was 12; she fought for me for four-and-a-half years and then after that she stopped fighting. I got pregnant when I was

15 but had an abortion. My parents made me do that one because they told me they were going to kick me out if I did not have the abortion. When I was 15, I jumped out of a window because my dad came in one night and he was drinking and got violent. He went to go at me and I jumped out the window to get away from him. I had to get tendon surgery. I did not lose my virginity appropriately. I was taken advantage of by 12 people when I was 14 years old and the girl that was supposed to be my best friend sat there and laughed. I began cutting when I was 12 years old. Recently, I was drunk and fighting with my kid's father; he took a knife towards me, and my stupid drunk butt took the knife and stabbed my leg. I was not trying to kill myself but the hospital watched me for a day. I have had several past relationships that included several abusive and controlling men.

Jennifer

I was spanked with a spoon as a child. I remember my sister being raped but nothing became of that. The person that I call my father is not my real father; he is my adoptive father. When my parents got divorced, my sister and I found out that he was not our real father. My relationship with my stepfather suffered because after I found out that we were adopted, I moved out of his house, because he never treated us the way he treated his real daughter. I only know my biological father's first name and that the Navy helped him cover up the paternity.

Theme 3: Visitation and Concerns for Children

An estimated 26% of children in the United States will experience or witness a traumatic event before the age of four (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). Children in the child welfare system have typically experienced multiple traumatic events, including but not limited to removal from their homes, parents, and loved ones. Children with

complex trauma are more likely to have behavior problems, posttraumatic stress, and at least one clinical diagnosis (Greeson et al., 2011). Nevertheless, only half of all children in the child welfare system receive services that are consistent with national standards (Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010).

Visitation between biological parents and children provides an opportunity to engage parents and build relationships (Gerring, Kemp, & Marcenko, 2008); however, the mothers in this study discussed their challenges with visitation. The women described their concerns for their children such as multiple placements, missed birthdays, inconsistencies such as missed visits.

Katie

> My ex-husband was granted guardianship of my oldest daughter and my youngest son because he was able to take care of them. I granted guardianship of my oldest son to my mother because he is experiencing many behavioral issues. I did not feel that I could support and help him because of my current circumstances. My son has been through a lot in his 10 years, which has been very difficult for him. When he was still living with me, I had to call the police to help restrain him. My son is extremely angry, which I do not blame him because he has every right to be with what he has experienced. My oldest son also has attachment issues because of what he witnessed between my and my ex-husband. He witnessed a lot of domestic violence and would often try to protect me. He was so little he did not understand. He was trying to protect his mom.
>
> It was difficult for my children and me after they were removed. It was two days before my youngest daughter's first birthday. I could not see my children. I was not allowed to see my daughter for her first birthday. I also missed my oldest son's birthday

and my oldest daughter's birthday. Now, I get to visit my oldest son and youngest daughter throughout the week and every weekend. I am allowed to visit them anytime I want to because my parents have guardianship. My oldest daughter and youngest son live with their father and I get to visit them every weekend but not through the week.

I want more help for my children. I will do whatever it takes to help my children. I do not want my children to get lost in the system. I am serious about getting help that I need to fix my life and get my children returned. I am going to finish this because it is about my children and me. If I do not take care of myself, I am no good for my children or anyone else.

Asha

After my children were removed, they were in an emergency placement for a month and then moved. The second family could not deal with them because they were so young and they already had two high-risk foster children in their home. They were moved a third time but after the family found out I was HIV positive, even though the children have been cleared, they no longer wanted my children. Now they are with a good family. I probably could not ask for a better family. CPS told the families that my children had a communicable disease. Both my children had been tested and cleared. They do not have HIV. My children were discriminated against because of my disease. That hurts me because they are just little children. They do not deserve that because they had no control over what I did.

My oldest child lives with my adoptive parents. I do not worry about him because I know he is safe and stable. He has been with my parents since he was two years old. I am not his mom anymore; I am more of a friend. I have accepted that he is never coming

home because I was not there when he needed me. My main priority right now is my two children. They are not going to be in foster care much longer. They are coming home to their real mom.

My son has behavior problems but I cannot blame him because I used drugs during my pregnancy. He is currently involved in early childhood services. He is going to start play therapy soon. When he comes home, I realize that I will have a lot to deal with, but I did it to him, it is my fault. My children are my life.

Erika

I have had six healthy children. All of them have been removed and adopted except the youngest. I have not seen any of my other children since they were babies. I had my daughter for three months, my son for one week and they took my other two children directly from the hospital. I was with my youngest son at the hospital for two days before CPS came and took him. They never gave me a chance with any of my children.

My oldest son was adopted by his foster parents. His adoptive mother was physically abusive and murdered him. Three of my children were adopted by the same family but I do not have contact with them. My other daughter is adopted but I do not know by who or where she is living. My children did not deserve any of this.

My husband and I are currently fighting for custody of my youngest. We have visitation with my youngest son twice a week. It is for 90 minutes one day and two hours the other day.

Emily

I have two children and am pregnant with my third. My oldest daughter lives with her father and his family. My youngest daughter is in foster care. I fear that to my children, I

seem inconsistent due to the circumstances, but I am not. When I visit with my oldest daughter she will often cry, plead, and beg not to go back with her father. I feel like I am fighting a losing battle because my daughters' fathers gang up on me. Both fathers have tried to get me to sign away my parental rights, but I refuse. I do not want to give up on my children.

Jennifer

I have a daughter who is currently in the care of my grandmother and am pregnant with my second and third children. My daughter has been through a lot in her life. She had a cleft palate and had to have surgery. When she had unexplained bruises, she had blood in her urine and had a seizure. That was traumatic for both of us. I still do not have any confirmed diagnosis for her bruises on her back, blood in her urine, or the seizure. Her father's rights are going to be terminated. I feel bad because I do not know my father and I wanted my daughter to know her father.

Theme 4: Lack of Trust in the System

Altman (2008) found that parents in the child welfare system often ask for what the workers seem unwilling or unable to provide, such as assertive, honest, clear communication and a caring but firm parent–worker relationship. Similarly, the women in this study reported a lack of trust in the system, including concerns regarding communication and failures on part of the caseworkers. They also reported lack of clear expectations. Many of the women were concerned about the safety of their children due to their experiences with the child welfare system; some discussed how being involved in the system makes parents become more protective of their children. Not only do the mothers not trust the system, they do not trust the caseworkers to do their jobs appropriately and protect the children involved in the system.

Katie

Being involved in the child welfare system has made me more protective of my children. I admit that it took something extreme to get my attention and realize that I needed help. However, the child welfare system was not helping me as a parent. They were not giving me referrals or any information on places that could help me. I believe that the system lies and manipulates. They do not consider all the factors. When the goal is reunification, that means they are supposed to support the parents by providing services. They did not do that for me. I feel that they try to break apart families instead of learning how to help the parents get better.

Asha

I have missed several visits with my children because there is no communication between the caseworker, the foster parents, and me. I am always the last one to find out about things and they move on their own timeline. In addition, CPS had no right to disclose my HIV status to the foster parents. I wish I could sue the Department of Human Services over how they have treated my children. I do not think that if I was in the foster care system, instead of drug court, that I would get my children back. The first time I met my foster care worker, she told me it would be six to nine months before I even got unsupervised visits. I believe that drug court actually wants parents to have their children returned whereas foster care does not.

Erika

There is not many foster care workers or CPS workers that I trust. I do not trust the system. I worry about my children and their safety. I worry that if they terminate my rights to my youngest son that he will be adopted into a family like my oldest son and the

nightmare will happen all over again. When my son was murdered, his caseworker was not paying attention to any of the reports she was getting. I think that it took my son being murdered for the system to realize it had to change. I will not trust any of them. Have faith in your child, love your child, and do your best in everything they tell you to do to get your child back.

Emily

My experience with CPS has been hit or miss. My current cases are so complicated that legal aid refuses to take me on as a client. I remember the foster care worker telling me that I did not have time to be a full-time parent when I was going to substance abuse classes daily and was on probation. CPS does not listen to my concerns. I think that I am treated differently because I am fighting against CPS and want my children back.

Jennifer

From all the stories I have heard, my case has actually been good, except our caseworker is not professional. Even though I was doing everything they asked, the judge still wanted to terminate my rights. I did not understand why he wanted to terminate my rights. I do not feel that they are honest about what I am supposed to be doing to get my daughter back.

Theme 5: Feelings of Empowerment

Despite the trauma these women have experienced, all of them spoke about feelings of empowerment or a sense of faith as they have overcome and conquered their difficulties, including mental illness and substance use. They spoke about educating themselves and becoming knowledgeable of how the child welfare system operates as a form of self-advocacy. All five of the women interviewed firmly believed that their children would be returned. Their

stories of empowerment and faith are truly inspiring after understanding the horrific tragedies they have endured in their lives.

Katie

> I finally figured out what my problem was and let go of all that hate and anger. I am able to move past what happened to me. Everyone has a choice in every situation. They may not like the choices they have, but they always have a choice. I am strong and I fight for my children and myself. I will not give into the darkness and let Satan take me. I have my head on straight and my priorities in check. I am going to be in control of my emotions. I am a lot better than I was before now. I am stable. I am a survivor. Educate yourself and take care of yourself because unless you take care of yourself, you are no good to anyone.

Asha

> I had a choice. I want to be clean and sober so I can keep my children. I am doing this for my children and for me. I want my children back. I want to be there for my children. You have to join the game, not just play the game.

Erika

> I have a very calm attitude. I have faith that we are doing our best and are going to get our child back. I will have faith until the judge says yes or no. However, I will never have faith in this state again.

Emily

> I refuse to give up on my children. I will not sign my rights over. I am still fighting.

Jennifer

I do not expect anyone to do things for me. I am doing this for myself. I will overcome this and will be a fine parent. During the psychological evaluation, they said that I smiled too much. I refuse to be somber all of the time. I am trying to be positive.

Structural Description

Of the 10 themes, five themes identified how the women experienced the phenomenon, which provide the structural description of the phenomenon. These themes included family dynamics and interpersonal relationships, child welfare involvement and reason for removal, services, views held by society, and advice.

The sixth theme, family dynamics and interpersonal relationships, identified how the impact of the women's families affected their experiences. They spoke about how their immediate and extended family situations, including adultery, divorce, and adoption, affected them both as children and as adults.

The seventh theme, child welfare involvement and removal, allow the women to be candid regarding how they experienced the removal of their children. They discussed what precipitated the removal and how child welfare has been involved in their lives since the removal. It should be noted two women discussed their substance use as grounds for the removal of their children.

The eighth theme, services, describes the women's frustration over how services were initiated or provided. Several of the women discussed how they went months without services, which they had been asking for the entire time.

The ninth theme shows how the women experienced the negative views society held about them, including judgment, which prevented one woman from following her dream of teaching children. Other women discussed becoming "another statistic" and her feelings of

resentment for being treated like “those other people.” One mother stated that she has been told by people that she should never have any more children after her son was murdered.

The last theme, advice, was uplifting for these women. The women gave advice for other parents involved in the child welfare system. There was a sense of altruism in their words. These women wanted their voices heard to help others understand how they and their children survived the child welfare system.

Theme 6: Family Dynamics and Interpersonal Relationships

Bowen (1978) theorized that differentiation of self, in which individuality and togetherness are managed within a relationship, as a central developmental process of adulthood and is necessary to become a healthy parent. Although it was measured in this study, the women experienced several similar difficulties as those with lower differentiation. This concurs with research done by Skowron, Kozlowski, and Pincus (2010), as they found that mothers who were more emotionally reactive and cut off from others, interpreted as lower levels of differentiation, were at higher risk for child maltreatment. All of the women interviewed described difficult family dynamics and interpersonal relationships. These difficulties included having limited or no contact with family members, divorce and remarriage, family deaths, domestic violence, and judgment or lack of support. This is how the women experienced their family and interpersonal relationships.

Katie

> My mother left my father when I was four months old and he never made it a point to be a part of my life. My father remarried and had a daughter but I never had a relationship with them. My stepmother judged me for having a child outside of marriage, which is pretty funny because technically my dad was still married to my mom when she got

pregnant with my sister…that's adultery, that's way worse. I had no contact with my father after her parents divorced. When I was eight years old, I got a phone call from somebody telling me that my dad died. When my grandma was dying just be able to tell her that I am clean, I am sober, and that things is not going to happen again.

I was married to my oldest daughter and youngest son's father but we divorced. Now for the sake of our kids, we put all our past behind us and just moved forward. My boyfriend and I had a couple pushing matches but that was more when I was having a bad day and acted out violently and he was trying to restrain me. My ex-boyfriend was in jail because things were insane between us.

When I asked my mom for help she looked at me and said, "I have a life too and I cannot be here everyday to help you and hold your hand." I wish she would have been my mom and been there to help me. After I got help, I went from having no relationship with my mom to her feeling as if she has her daughter back. I think my mom has been helpful and hurtful at times. I did not want to be rescued. I wanted to be able to be let go and make my own mistakes but every step in my life I had somebody in my family trying to come rescue me.

Asha

I was adopted when I was five years old and I do not have contact with my biological family. After my adoptive parents kicked me out when I was 18, I did not see them for six years. I just did not want anything to do with them. My grandmother died five years ago and my mom did not even tell me for six months. My parents shunned me due to my life choices. I tried to repair the relationship with my brother. I tried calling him a couple

years ago and he told me never to call him. Two of my ex-boyfriends are in prison. My child's father is an alcoholic and when he gets drunk, he likes to hit people.

Erika

My parents got divorced just before I was born. When my mother divorced my stepfather, I did not really care because he was abusive towards me. I have limited contact with my father and typically only send him a text message when we find out good news. He has a new girlfriend that I have never met.

I was with an abusive ex-boyfriend when my child was removed. Another ex-boyfriend was not physically abusive but he was mentally and emotionally abusive. I am sure I have had a few other abusive ex-boyfriends, but I did not have kids with them. My family does not understand because they all have their kids and I do not have any of mine, so they think they are better than I am. Certain family members hardly ever talk to me. I am the black sheep of the family. I am pretty much on my own.

Emily

I asked to live with my dad when my parents got divorced. I was seven years old. I do not get along with my stepmother because she was a big stoner. My stepmother used to take me in to get drug tested all the time but they always came back negative.

Both my kids' fathers were abusive and controlling and both went to jail. One had trust issues and he put in video cameras all over so he could watch me. My oldest child's father actually hit me in the stomach when I was pregnant.

Jennifer

When my parents divorced, I found out that the man that I call my dad was not my real father, and he is my adoptive father. Everyone has been positive in my family and I get plenty of support if I ask for it; I just do not ask.

Theme 7: Child Welfare Involvement and Removal

The relational dynamics between parents and child welfare workers often include feelings of fear, shame, guilt, and anger (Gerring et al., 2008). The following are the women's personal experiences with removal of their children from their custody. The women discussed the impact of violence, drug use, deception, and medical problems on their children's removal. Additionally, child welfare workers often fail to communicate clearly to parents about treatment expectations and consequences of noncompliance, which may lead to parental denial and confusion (Azzi-Lessing & Olsen, 1996). Lack of trust in the child welfare system was reflected several times during their interviews. The women describe how they experienced their children's removal as well as how the child welfare system has been involved since that time.

Katie

I was working long hours and leaving my children with my sister. I started having seizures and the side effects of the medication were horrible. I was having difficulty taking care of my children and keeping the house clean. My mother helped around the house for a couple weeks but then the help faded. The only way I knew how to get through this difficult time was to pick up the crack pipe again. I have a history of cocaine and marijuana use but had been clean for two years. After my boyfriend was released from jail, he contacted my mother about the drug use. CPS showed up at the house after my mother made a report and my children were placed with their maternal grandmother.

Asha

My children were removed because their mother is a crack head. I was unable to put the drug down long enough to keep my children. My son tested positive for cocaine when he was born. I also used three times when I was pregnant with my daughter. I am currently working towards reunification through the drug court.

Erika

After I left an abusive relationship, I went to the state for help and was told the only way they could help is to put my son in foster care and to make a petition saying that he was being abused and neglected. He was in foster care for a year before my rights were terminated and he was adopted. The longest I have had custody any of my children after my son was murdered was three months. One of my sons I only had custody of for one week. Two of my other children were taken at birth and my youngest son I had for two days before the state took custody. I did not have my own place to live and did not have a steady job. Since they terminated my rights to my oldest son, the state has used that against me.

Emily

My youngest child's father was mentally abusive and added his name to the birth certificate without my knowledge. My youngest daughter was removed from my care when she was four days old. CPS and the police arrived and took my daughter while I was breastfeeding. Her father had called CPS. I had several of my family members offer to take guardianship of my daughter, but the judge granted it to the father.

Jennifer

I found bruises on my daughter's back that could not be explained. I discussed the bruises with my boyfriend, my daughter's father, but he could not explain how it happened. He

did not want me to take our daughter to the hospital. My daughter did not seem to be in pain so I was not worried. A few days later, my daughter had blood in her urine. I took her to the hospital and showed them the pictures of the bruises but nothing was reported and my daughter was discharged. Later that year, my daughter had a seizure. Again, I showed the doctors the pictures of the bruises and CPS was called. The charges were made against my boyfriend, the child's father. His rights are being terminated. My daughter is currently in foster care with her great-grandmother.

I am in the process of getting my child back. At one point, the judge wanted to terminate my rights. I was completely surprised because I thought I was doing great. Now the court is only terminating her father's parental rights. The entire time I have been involved with the child welfare system, they keep saying that I am not being honest, which is rather annoying.

Towards the beginning, they made a big deal about how old I was and that I did not have the maturity level to take care of a child. The person that completed the psychological evaluation said that I was not a fit parent because I smiled too much. I was surprised when I told my caseworker that I was pregnant that she did not criticize me.

Theme 8: Services

Complex trauma is rarely addressed in the child welfare system. The child welfare system does not routinely screen for exposure to trauma or symptoms related to trauma other at than the initial assessment at the time of removal (Greeson et al., 2011). However, a comprehensive assessment of past traumas, including emotional and behavioral symptoms, is necessary to determine appropriate services in the child welfare system. Staudt and Cherry (2009) found that nearly 78% of caregivers with mental health concerns who were involved in the child welfare

system were offered outpatient mental health services; however, only 84% of services were provided. They reported higher utilization of services for parents in the child welfare system than for the general population; caseworkers served as "gatekeepers" of services. Many of the women in the present study stated that when they asked for help or assistance, they were often turned away or not provided with answers. Several of them stated that they connected with services independently, rather than waiting on the child welfare workers to "do their jobs." Overall, the women did not feel supported by the child welfare system.

Katie

> When I asked for help, I hit roadblocks. The caseworkers were telling me I had to go to rehab, but they were not helping me get into one. I was doing my job; they were not. I felt that the male caseworker I had had a personal vendetta against women. He was sexist and very biased against me. He consistently treated me as if I was dog shit under his shoe.
>
> They keep trying to use my psychiatric issues against me but I have been stable for years. I kept asking for therapy. I asked for help for nine months before they were willing to pay for services. I believe that if parents are asking for help, they need to go out of their way to help them. After I started substance abuse counseling, I was able figure out how to get better. I would recommend substance abuse counseling to everyone, even if you do not abuse substances.

Asha

> Being involved in drug court is far better than having a foster care worker. I have reviews every three months instead of every six months. All the system has given me is visitation with my children. They have not provided me with any services. I did not take parenting classes. I feel that the drug court wants me to get my children back.

I would have liked services to include my children. I believe that children should go to therapy and hear your experiences so that they learn how to prevent themselves from making the same mistakes. It is helpful to hear other people's stories. Services need to be more hands on.

Erika

The worker we have now, different from the ones with my other children, has been helpful. She has offered me services, provided me with bus passes, and helps me locate the mobile food pantry. She has been much better than other workers have. She is much nicer. She was trying to get us engaged in parenting classes, but we had already taken it upon ourselves to go. My husband and I started attending the classes before we ever met our caseworker. She also got both my husband and me into therapy, which has been a huge support.

Emily

I do not feel that CPS has ever listened to my side. They consider me the bad person. They are not meeting my needs as a parent. At one point, they were not letting me see my daughter enough, I became so stressed that I stopped lactating. My doctor had to give me medication to induce lactation. My caseworker finally arranged for me to have a therapist, which has helped me a lot.

Jennifer

After CPS became involved; I went four or five months without help. My first caseworker disappeared. I had no idea what was happening. I attended a parenting class, which was helpful, but I wanted CPR training or a class on what to do if your child gets hurt. All I received as a psychological evaluation, parenting classes, and therapy. Overall,

I have been happy with my caseworker but I have not received all the services that I requested.

Theme 9: As Viewed by Society

The women in this study were biological mothers with complex trauma in the child welfare system. Previous research has not focused on biological mothers; therefore research does not address how society has influenced their experiences. These women have lived through many traumas, including having their children removed by the child welfare system; nevertheless, society dictates that it is the mother's role to protect children from harm (Shivas, 2002). The following describes how the women have experienced society's views of them, including their own families. Many negative views include not having their children, being in the system, and being "bad parents."

Katie

My first caseworker did not believe people could be rehabilitated. I felt like she viewed me as a bad parent because I did drugs. Many people have said that parents cannot change. Outsiders do not know my story. They only hear one side of it. Women from my mother's church are very judgmental and refuse to speak to me or acknowledge me in public.

Asha

My parents shunned me when I found out I had HIV. I admit that I have done many wrong things when I was doing drugs that I should not have done. Honestly, if the wrong person found out about my diagnosis, I would be dead within the hour. I know that my children were discriminated against due to me being HIV positive. That was hurtful because they are just little children; they did not deserve that. The strongest message that

I receive from society is that I am a crackhead who lost her children because she was not able to stay clean and sober long enough to keep her children. Now, I am just another statistic.

Erika

Many people have told me directly that I should never have had children because of what has happened and that my son was murdered. It is as if they are blaming me for him being murdered. I am not the one who murdered him. It was not my fault. I was not in the same state when it happened. I asked for help for my son and me and the state screwed up. Other people have said that I deserve a chance that it was not my fault. I read a comment that said that parents with children involved in the child welfare system should not be allowed to have more children; they should be sterilized. That is difficult to hear and makes me feel like a bad parent. I am continuously looked down on because I do not have any of my children.

Emily

There is many things that I want to do with my life that society will not allow. I would love to open a hip-hop dance studio for little children but I am too scared to try because of society. I am a dancer and people look down on me for that as well. My child's father has ruined my reputation. It is hard to go into shops in my town because of the way people look at me. So many people look at me as if I am different.

Jennifer

I need the benefit of the doubt. I felt like they were treating us as if we were less. People treat you based on your type. I wish it had been acknowledged that we are only involved with CPS because something unfortunate happened. We have jobs, we have money, and I

am not the same type of person that CPS typically deals with. I am not like those other people.

Theme 10: Advice

During the interview process, many of the women had advice for other parents involved in the child welfare system. The women also expressed concern over other parents and other children involved in the system. All of the women expressed interest in helping others or, at the very least, having their voices heard. They wanted others to understand how they experienced being biological mothers in the child welfare system. The following is their advice to other parents based on how they experienced the child welfare system.

Katie

> Parents need to be serious about getting help for themselves and for their children. If parents cannot take care of themselves, they cannot take care of their children. CPS tries to make you look like a fool. The best way to fight them is with education and knowledge.

Asha

> People have to want to be clean. People have to want their kids. People have to want to deserve their children. What happened in the past is in the past. Just because you were abused does not mean that your children deserved to be abused.

Erika

> I believe that it took my son being murdered for the system to realize it had to do things differently. Have faith in your child. Love your child. Do everything in your power to get your child back.

Emily

CPS can tell someone to go to therapy, but it is up to that person to go and benefit. Do not give up. I do not want to give up on my children.

Jennifer

If a parent can overcome this; they will be a fine parent. Do not expect anyone to do anything for you. Ask questions. Ask for services. If you do not ask, they will not give you answers. You have to advocate for yourself.

Essence

The essence of phenomenological research is bringing together what the participants experienced and how they experienced it. Biological mothers with complex trauma in the child welfare system have experienced mental health, substance abuse, and recovery issues. The difficulties included difficulty engaging in supportive services and lack of services that addressed complex trauma. The women described incidents of trauma, including physical, sexual, and emotional abuse and domestic violence. The abuse they were subjected to as children was transmitted to the next generation—their own children.

The mothers struggled with inconsistent visitation with their children; several of the women experienced gaps between visitation with their children, often weeks or months. Their experiences with caseworkers during and after the removal of their children were also problematic. They often described lack of professionalism, consistency, and communication on part of the caseworkers. Due to these difficulties, the women experienced a justifiable lack of trust in the system.

However, in spite of the obstacles they faced, these women experienced feelings of empowerment and self-advocacy. They described feelings of hopefulness for their own and their

children's futures. They also experienced feelings of personal power by advocating for themselves within the child welfare system.

These biological mothers often asked for services for themselves and for their children. They also requested help identifying resources for their families, without much follow-through by their caseworkers. The mothers lacked many services despite their requests. Several of the women engaged in services before being referred by the child welfare system. The biological mothers also dealt with negative views from society, such as being told they should not have had children or being called a bad parent. Nevertheless, the women wanted their experiences known and voices heard to help other families involved in the child welfare system.

CHAPTER 5: DISCUSSION

It has been stated that childhood trauma is the single most important public health concern in the United States (van der Kolk, 2005). Research shows that one-third of mothers with personal histories of trauma maltreat their own children and two-fifths of children were maltreated by their mothers acting alone (U.S. Department of Health and Human Services, 2010a). Transmission of abuse depends on several intervening factors. Parents who are young, reside with a violent adult, or have a history of trauma or mental illness are more likely to become involved in the child welfare system (Dixon et al., 2009). The impact of trauma depends on several factors, including (but not limited to) developmental stage, temperament, intensity, injury, family stress, family stability, and social supports (Rice & Groves, 2005). Complex trauma is defined as "the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature and early-life onset" (van der Kolk, 2005, p. 402).

This study explored the experience of biological mothers with complex trauma in the child welfare system, a topic that has been historically overlooked. Using qualitative phenomenological research methods, it provides critical insight into understanding these experiences. Genograms and semistructured interviews were collected from five women who had a child under the age of 12 currently involved in the child welfare system due to neglect. Key findings included what and how they experienced being a mother with complex trauma in the child welfare system.

Discussion of Research Questions and Key Findings

This qualitative research study focused on three primary research questions: What are the past and present experiences of biological mothers with complex trauma in the child welfare

system? How do gender, age, and culture influence experiences in the child welfare system? How does environment influence experiences in the child welfare system? Each research question will be discussed within the theoretical framework, as described in Chapter 1.

What Are the Past and Present Experiences of Biological Mothers with Complex Trauma in the Child Welfare System?

Within Bowen's family system theoretical framework, biological mothers with complex trauma were asked to describe their experiences in the child welfare system. This study focused on complex trauma, which is when traumatic events happen repeatedly over time. In 2011 Chemtob, Griffing, Tullberg, Roberts, and Ellis reported that 91% of mothers in the child welfare system had experienced at least one traumatic event and 73% reported multiple exposures to trauma; 18% of mothers reported exposure to five or more traumatic events, with 70% experiencing interpersonal violence. Sexual abuse increases the likelihood for intergenerational transmission of abuse (Zuravin et al., 1996); in the current study, three women reported that their sexual abuse began between the ages of four and nine. The two other women did not report sexual abuse as children, but did report that their interpersonal traumas, including physical abuse and parental divorce, started as early as age seven.

Pears and Capaldi (2001) reported that children who experience harsh parenting are likely to become harsh parents, which defines intergenerational transmission of abuse. The rates of intergenerational transmission of abuse vary from 18% to 40% (Egeland et al., 1989; Hunter & Kilstrom, 1979). The two other women did not report sexual abused as children, but did report their interpersonal traumas, including physical abuse and parental divorce, started as early as age seven. Researchers warn not to underestimate the impact of contextual variables and complex, interrelated factors in child maltreatment (Briere & Jordan, 2009; Cicchetti & Howes, 1991).

Researchers have found that child maltreatment experienced at a younger age is often related to later maladaptive functioning (Manly et al., 2001). All five women in this study, now in adulthood, continue to experience traumas, including domestic violence and drug exposure. Research has shown that the presence of domestic violence decreases the likelihood of children returning home and increases unsuccessful reunification (Renner, 2011). Trauma has been continually present in the women's lives from a very young age.

Research has shown that parents with higher levels of differentiation are more flexible, adaptive, and regulated than parents with lower levels of differentiation (Bowen, 1978). Although differentiation was not directly measured in the current study, the biological mothers discussed high levels of chronic stress, which is associated with lower levels of differentiation (Miller et al., 2004). Lower levels of differentiation are correlated with higher risk of child abuse (Skowron & Platt, 2005). The women discussed how their families influenced their current situation. One mother stated that she wanted her child's father involved, regardless of abuse, because she grew up with an absent father herself.

The negative impact of parental divorce and the difficulties of living with blended families and stepparents were evident for the biological mothers in this study. Four of the five women experienced parental divorce. Amato and Keith (1991) concluded that parental divorce experienced in childhood often leads to lower quality of life, including difficulties with depression, family well-being, and physical health. It is noted that the other woman was adopted when she was five years old and had no contact with her biological family; however, her adoptive parents were still married.

Concerns for their children were also experienced by the mothers. A 2011 study showed that 92% of children reported at least one traumatic event and 86% reported multiple traumatic

events (Chemtob et al., 2011). The most common traumas children experienced were domestic violence (54%) and separation from a primary caregiver (47%) (Chemtob et al., 2011). This concurs with the fears and concerns the mothers had for their children in this current study. Several of the women discussed how their children have been affected because of their decisions and involvement of child welfare system.

Traumatic events happened before, during, and after the women were involved with the child welfare system. Each woman talked about how stressful and traumatic it was to have their children removed from their care, including one mother who stated that she had to stop breastfeeding so that they could take her infant into custody. Two women discussed how their drug use led to the removal of their children. Two other mothers discussed how their children's father played a role in the removal. One mother reported being told to sign a petition that stated her son was being abused and neglected after asking the state for help when leaving an abusive relationship. This mother, without any other options, signed the petition and her son was removed from her care. Later, he was adopted out of foster care and murdered by his adoptive parents.

Studies show that parents in the child welfare system who have experienced trauma are associated with higher rates of substance abuse and mental health disorders (Marcenko, Lyons, & Courtney, 2011). Several of the women in the current study described their mental health concerns and their effects on their lives. In congruence with the present study, researchers have stated that women with mental health concerns are often referred to the child welfare system due to neglect (Westad & McConnell, 2012). Other women alluded to self-medicating with illegal substances. Those who had substance abuse concerns believed treatment positively changed their lives, as they were able to understand why they were self-medicating and how to understand their

behaviors. Researchers have stated that drug use is a "chronic condition complicated by other serious psychological, systemic, and environmental factors" (Twomey, Miller-Loncar, Hinckley, & Lester, 2010, p. 24). Additionally, one mother stated that she did not have any mental health or substance use concerns and resented being lumped into the same category with other parents.

How Do Gender, Age, and Culture Influence Experiences in the Child Welfare System?

Few studies have examined how gender, age, and culture influence experiences in the child welfare system. Using a feminist lens, this study sought to understand the experiences of biological mothers with complex trauma in the child welfare system. Only one mother directly discussed how her gender has influenced her experience in the child welfare system; stating that the male caseworker treated her disrespectfully based on her gender. Although the mothers in this study were relatively young, only one mother felt that she was discriminated against due to her young age. Another mother was angry that the person who completed her psychological evaluation reported that she did not have the maturity level to take care of a child because she "smiled too much."

The other two women answered the question, "Have you had any sense that you are being treated differently in regards to age, gender, or ethnicity?" by simply stating, "No." They were unwilling to elaborate during the interview.

How Does Environment Influence Experiences in the Child Welfare System?

Ecological theory provided the framework to understand the interactions between individuals within multiple environments. Azzi-Lessing and Olsen (1996) stated that the ecological model addresses the multicausality of risk in the child welfare system. Microsystem risk factors include parental mental health, drug and alcohol use, age of child, and marital violence (McCloskey & Bailey, 2000). The microsystem is often referred to as the

biopsychosocial person. In this regard, research has shown that complex trauma often affects biological, psychological, and sociocultural functioning (Briere & Jordan, 2009; Briere & Spinazzola, 2005).

The mesosystem, or the set of systems that directly influences the individual, was experienced as a continuum from supportive to distant. The mesosystem includes extended family and foster parents. One mother stated that she could not have asked for better foster parents, which resonated with other participants. Other mothers were concerned, as their children had been placed in multiple foster homes. Unfortunately, it is common for children in the child welfare system to change foster homes frequently. A recent study showed that nearly 50% of boys and 64% of girls have been placed in three or more foster homes (Dowdell & Cavanaugh, 2009). Furthermore, children who experienced frequent moves and changes in caregivers often have difficulty developing secure attachments.

All five women provided examples of how they feel they are viewed by society. In addition to the trauma of their children being removed, these women also struggle with the stigma of being involved in the child welfare system (Kemp et al., 2009). The mother of the murdered child discussed how strangers approach her and often say derogatory things. She has been told she should never have had or not be allowed to have more children. She stated that it is difficult to hear and that she felt like a bad parent, even though what happened with her son was entirely out of her control. She also believed that the child welfare system has used prior removals against her; it has subsequently removed all six of her children. Another mother believed that being involved with the child welfare system has ruined her reputation and derailed her career opportunities.

Discrimination due to HIV status was described as "hurtful" by one mother because it was used against her children and resulted in them being placed in several different foster homes. Mothers with HIV/AIDS are often stigmatized and fear that their children may face "stigma by association"; therefore, many choose not to disclose their status (Murphy, Roberts, & Hoffman, 2002, p. 197). She stated that the strongest message she receives from society is that she is "just another statistic." All the women agreed that society does not understand what they have experienced in the child welfare system. Society does not acknowledge the traumas they have experienced, the adversity they have overcome, or the challenges they continue to face.

Overall Experience

This study examined the lived experiences of biological mothers with complex trauma in the child welfare system in order to give voice to an otherwise underrepresented population. The women in this study have experienced horrific traumas, including sexual abuse, domestic violence, and removal of their children by the child welfare system. The negative impact of mental health, substance use, and complex trauma was undeniable. This research concurs with Cohen, Hien, and Batchelder (2008), who found that parents who have experienced complex trauma are more likely to be associated with lower levels of parenting satisfaction and a higher frequency of involvement with the child welfare system. The mothers in the present study experienced a lack of trust in the child welfare system and described their concerns for their children who were currently in foster care. Lack of trust was exacerbated by the lack of consistency, lack of professionalism, and lack of communication from their caseworkers. Often the symptoms associated with complex trauma, such as personality issues, emotional regulation, and difficulty with trust (Briere, Hodges, & Godbout, 2010), can influence the interactions with caseworkers and other professionals.

Some of the women had family relationships that were disconnected and confrontational at times, though others found their families supportive. They also lacked the services to address complex trauma and the intergenerational transmission of abuse. The services that could be beneficial were often inaccessible. Several of the women sought services on their own, without waiting for their caseworkers.

The women also often internalized the negative views of society. They were confronted with judgment from relatives, peers, and strangers. Nevertheless, the women who experienced complex trauma continued to articulate feelings of empowerment and offer words of advice for other parents in the child welfare system.

Limitations

This project was a small, qualitative study that focused on the lived experiences of biological mothers with complex trauma in the child welfare system. A doctoral committee was engaged in the planning and the approval of this study; however, only one primary researcher conducted the interviews, analyzed the data, and disseminated the findings. Although the primary researcher attempted to bracket her preconceived assumptions regarding this research, her personal values, history, and characteristics are inevitable factors in qualitative research (Haverkamp, 2005).

Biological mothers with complex trauma voluntarily participated in this study. Notwithstanding, self-selection may affect the results, as those willing to participate may be systemically different from those who did not participate (Sun, 2000). Although the participants were pleased with the small monetary gift, several noted that they simply wanted their experience heard. As the participants were recruited by local mental health therapists, they may

have valued the goals of this study due to the therapeutic relationship with their therapist. Additionally, due to the sensitive nature of this topic, many mothers may have been hesitant to be interviewed (Sun, 2000). Nevertheless, the women were willing participants and forthcoming with information regarding their experiences.

A semistructured interview protocol was utilized; however, no two interviews were the same. The semistructured interview outline made it possible for the researcher to have participants elaborate on certain questions as she found necessary. Although all participants were asked the same questions, each woman interpreted them differently and therefore provided individualized answers. Follow-up questions focused more directly on how age, gender, and culture influenced their experiences in the child welfare system, although many women found these questions particularly difficult to answer.

The genogram activity also used a semistructured interview protocol, during which information was gathered regarding family dynamics, intergenerational transmission of abuse, and complex trauma. Participants may have withheld information regarding their families or past traumas, as it was uncomfortable. However, all participants in this study were found to be open and candid in their responses. Although participants were asked about complex trauma during the genogram interview and provided examples, if necessary, a more structured protocol could have been beneficial for some participants. Several of the traumatic events were not discussed until the second interview, which focused on their experiences in the child welfare system.

Implications

This study finally provides a voice to the experiences of biological mothers. It has been argued that the primary role of the child welfare system is the well-being of children (Sun, 2000); however, that cannot be accomplished without addressing the needs of parents. The

impact of complex trauma on parents involved in the child welfare system has received little attention (Chemtob et al., 2011), but the present research provides a clearer understanding of their experiences. It provides insight regarding their struggles, concerns, and strengths. With this information, treatment options may begin to focus on complex trauma and supporting parents in the child welfare system. Additionally, it has been suggested that providers be trained to identify and to treat parental trauma to improve the outcomes in the child welfare system (Chemtob et al., 2011).

Marriage and family therapists (MFTs) have the potential to play an intricate role in treating those with complex trauma in the child welfare system. MFTs are commonly overlooked to work in the child welfare system (Weir, Fife, Whiting, & Blazewick, 2008). The systemic knowledge of MFTs can provide a deeper understanding of biological mothers with complex trauma in the child welfare system. They can also provide a unique understanding of family dynamics and intergenerational transmission of abuse. Lee and Lynch (1998) stated that the child welfare system is multilevel, complex, and requires someone who is well versed in systems and ecological theory.

The information provided in this study is useful for MFTs, as it provides a deeper understanding of the lived experience of biological mothers. These qualitative findings provide insight for assessment and treatment goals. One-fifth of MFTs graduating from a COAMFTE-accredited program provide services involving adoption and foster care; however, fewer than 5% of programs offer specific coursework related to these issues (Weir et al., 2008). With proper education and practicum experience, MFTs can serve as advocates for mothers and children in the child welfare system.

Many MFTs that work with this population are invested in collaborating with both the parents and the child welfare system. Due to their understanding of ecological and systems theories, MFTs understand the importance of family relationships and can help advocate for biological parents to maintain healthy, appropriate relationships with their children in the child welfare system. Other responsibilities include collaborating with the child welfare system to support the parents, the children, and the caseworkers effectively. MFTs are currently underutilized in the child welfare system even though they can help provide a better understanding of children, couples, and families.

Future Research

The results of this study are unable to be generalized to the broader population; however, that is not the primary goal of qualitative research. Further studies using both qualitative and quantitative research methods are recommended to investigate the experiences of biological mothers with complex trauma in the child welfare system. The current study contributes to research on child welfare, as it focuses on biological mothers. Research focusing on caseworkers, foster parents, and children in the child welfare system is well represented in published research. However, the experience of biological mothers with complex trauma in the child welfare system has been underrepresented.

This study is imperative, as current services do not address or are unable to address the needs of biological parents with complex trauma. Child welfare policies are often enacted without exploring the impact on biological parents. Future research needs to focus on evidence-based treatment models that specifically focus on parents with complex trauma.

The biological mothers in this study experienced their child welfare workers as untrustworthy, unresponsive, and uncommunicative. Although research has examined this

relationship previously, changes have yet to be made. Nevertheless, promising approaches have surfaced in literature. One approach focuses on strong a parent–worker relationship, as described by Gerring, Kemp, and Marcenko (2008). They found that positive outcomes for families are evident when special attention is given to both the needs of parents and their children. This relates to the mothers in the current study as they expressed concerns regarding services for themselves as well as for their children. Therefore, future research should identify how to cost-effectively implement these types of programs nationally.

Researcher Reflections

This research project has been humbling. The stories of these biological mothers were both traumatic and empowering. They were difficult to comprehend and challenging to conceptualize. The primary researcher acknowledges the privilege she holds to be able to present the experiences of biological mothers and hopes she has done justice in elucidating their experiences.

She was surprised by the candid openness of the biological mothers and humbled by their experiences. Although the primary researcher has been serving this population for several years, the stories of human suffering continue to astonish and exhaust. These stories will be carried in her heart for years to come.

APPENDICES

Appendix A: Interview Protocol

Research Study: *The experience of biological mothers in the child welfare system that have experienced trauma.*

Time of interview:
Date:
Place:
Interviewer:
Interviewee:

Description of study: This study will describe the experiences of biological mothers in the child welfare system that have experienced trauma.

Reminder: Individual interviews will be audio taped and transcribed verbatim.

Sample Script: The purpose of this one-on-one interview is to gain an understanding of your experiences as a biological parent within the child welfare system. I will be asking an array of questions and remember that at anytime you may take a break, request to skip a question, or even stop the interview all together.

Questions:

1. Please describe your experiences in the child welfare system.
2. What do you think has influenced your experience? Prompts: mental or physical illness, substance use, relationship conflict, age of child
3. How has your own family affected your experiences in the child welfare system?
4. How has society influenced your experiences in the child welfare system?
5. Have you had any sense that you are being treated differently? Prompts: gender, age, ethnicity
6. What situations (i.e. complex trauma) have influenced your experiences with the child welfare system?
7. Do you think that people who have experienced abuse in their past may have more difficulty caring for their own children? Has this been true for you?
8. How are child welfare services providers meeting your needs as a biological parent?
9. Do you feel that the child welfare responds to specific needs of parents with complex trauma? Why?
10. Is there anything else you would like to share about your experiences that have not been shared thus far?

Reminder: Thank the individual for participating in the interview. Assure her regarding confidentiality of responses and potential future interviews.

Additional Notes/Memos:

Appendix B: Genogram Activity

Genogram Activity will occur during the first individual interviews.

Interviewers Script: This first interview will be used to complete your genogram. Genograms are symbolic displays of family relationships that focus on family dynamics, repetitive patterns, and psychological factors of your family tree. In this study, genograms will be used as another way for me to collect data and get a better understanding of your family, social and emotional relationships. I would like your help to fill out the genogram with the first names, nicknames or initials of family members as well as other important information. For the purpose of this study, we will focus on three generations (i.e. you, your parents, and your grandparents). Essentially, I am looking for information regarding the intergenerational transmission of abuse, complex trauma, and family dynamics.

1. Tell me about your parents.
1. Tell me about your grandparents.
2. Who is your family has struggled with drugs and alcohol?
3. Who in your family has dealt with a medical illness? Mental illness?
4. Who in your family has experienced neglect? Physical abuse? Sexual abuse? Emotional abuse?
5. Tell me about the traumas you have experienced. (provide list of examples, if necessary)
6. What types of traumas have your children experienced?
7. How would you describe your experience with completing this genogram?

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