HOW CHILD WELFARE INVOLVED MOTHERS' TRAUMA HISTORY INFLUENCES PARENTING: A GROUNDED THEORY STUDY

By

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ABSTRACT

HOW CHILD WELFARE INVOLVED MOTHERS' TRAUMA HISTORY INFLUENCES PARENTING: A GROUNDED THEORY STUDY

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The goal of this qualitative study was to investigate the ways in which trauma has impacted the life experiences of a group of mothers involved in the child welfare system. A special emphasis was given to study how cumulative trauma and trauma symptoms have influenced the participants' parenting experiences. Twelve participants were recruited through therapists who provide services to parents involved with the child welfare system. Mothers participated in structured interviews and completed assessments on trauma symptoms and parenting. According to the data, women were exposed to intense adversity and cumulative trauma throughout their lives. In addition, mothers reported extraordinary testimonies of resilience. By developing a grounded theory framework, the author proposes an integrated model on trauma and parenting. Study strengths and limitations, as well as implications for practice and research are discussed.

DEDICATION

This paper is dedicated to the participants and the other resilient women who continue surviving despite life's challenges.

ACKNOWLEDGEMENTS

Firstly, I am indebted to my clients and participants from whom I have learned so much. Their ability to be resilient against all odds is inspiring. I am forever thankful for them allowing me to share in their experiences.

This study would not be what it is without the support of my doctoral committee. Each of them has helped me develop as a scholar and individual in a unique way. I want to give a special thanks to Dr. Rubén Parra-Cardona for the immense amount of time and effort he put into helping shape this study. His supportive feedback throughout this process has guided me in developing the necessary skills to be a successful academic. Without Dr. Kathleen Burns- Jager this study would not have happened. I not only want to thank her for her recruitment efforts, but also for her support as a supervisor, mentor and friend. Dr. Marsha Carolan has helped me further solidify myself as a feminist researcher and therapist. I admire her un-wavering commitment to challenging power imbalances and dedication to advocacy. Finally, Dr. Sheryl Kubiak‘s commitment to social justice for trauma survivors has also helped guide this study, as well as her thoughtful insight when interpreting complex social issues.

It is no secret that moving several states from my home town was initially an emotionally taxing experience, however I quickly found a family of wonderful colleagues and friends who would help make East Lansing, Michigan home. Thanks to the FIT team who shaped me as a therapist. You are the most empowering group of people I know! Thank you for challenging me to challenge myself and my worldview. You truly are AKTS! Thank you to other dear friends who supported me throughout the years. Whether it was a Saturday tailgate, breakfast at Sawyer’s , or many panicked phone calls, you helped me feel like I was not alone in this process that few can really understand.

When I moved into my first apartment in East Lansing I was sure my parents were not going to leave and were going to try to convince me to move immediately back to Missouri. The fact that they did not proved their unwavering belief in me that I could handle any challenge. Throughout my life they have always believed that I can do anything I choose. Finally, I have to acknowledge Zach who has stuck with me throughout this entire process. Thank you for trusting me to follow my own path. I can't thank you enough for your unhesitating patience and understanding over the past 7 years. I can't wait for our next set of adventures and I feel so lucky to have you as a partner to share in whatever the future holds.

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Chapter 1: Introduction

Background of the Problem

More than 3 million reports of child maltreatment are received by state and local agencies in the United States each year (Center for Disease Control [CDC], 2012). At least 740,000 children and youth are treated in hospital emergency departments as a result of violence by caregivers on an annual basis (CDC, 2012). It is estimated that the annual cost of child maltreatment in the U.S. is approximately $104 billion (Wang & Holton, 2007). Children who suffer maltreatment are more likely to have behavioral, emotional, and physical health issues (CDC, 2011). Parents with a history of childhood maltreatment are more likely to maltreat their children than parents without a history of childhood maltreatment (Dixon, Browne, & Hamilton-Giachritsis, 2005; Hunter & Kilstrom, 1979; Newcomb & Locke, 2001). Estimates show that one third of individuals with a history of child maltreatment will go on to abuse their own children (United States Department of Health and Human Services [USDHHS], 2006). Additionally, women with complex trauma history and symptoms are especially at risk for perpetuating child abuse and neglect as well as intimate partner violence (IPV), putting their children at a heightened risk for maltreatment. Due to these life experiences, related mental health problems and lack of resources, female survivors of chronic interpersonal trauma who have children often find themselves involved in child welfare systems (Schirmer, Nellis, & Mauer, 2009). This system is difficult to navigate if women have difficulty managing affect regulation and effective interpersonal skills (Briere & Jordan, 2009).

Often times, parents who enter the child welfare system are referred to parenting programs. However, trauma symptoms can make it extremely difficult for parents to trust and engage in such services. In addition to the immediate positive effects of parenting programs,

these interventions have the potential to prevent the transgenerational transmission of abuse by identifying patterns of abuse and maltreatment across generations. However, for parenting programs to be effective, women who are trauma survivors must first identify their own history of trauma and abuse, how intergenerational patterns of child maltreatment occurs, as well as the ways in which their own history of trauma affects their parenting practices. A key alternative to support women with trauma histories consists of providing this insight and understanding, as well as providing them with various parenting skills such as emotion regulation, appropriate limit setting, and positive involvement with children (Kaminski, Valle, Filene, & Boyle, 2008). Research substantiates that trauma impairs interpersonal functioning (Briere & Jordan, 2009) and quality of parenting (Bert, Guner, & Lanzi, 2009; Cohen et al., 2008; Gara, Allen, Herzog, & Woolfolk, 2000). However, there is a need for exploration on how the process of trauma impairs parenting behaviors. Additionally, because complex trauma is cumulative and often on-going throughout the lifespan, women exposed to trauma are likely to develop poor interpersonal skills, isolation resulting from the minimization or denial from others with regards to their histories of trauma and abuse, as well as a variety of negative physical and psychological symptoms (Briere & Jordan, 2009). These factors can leave mothers in stressful environments with little support, limited opportunities to emotionally and psychologically heal from their own trauma, and subsequent impaired parenting (Kim, Trickett & Putnam, 2010; Samuels-Dennis, Ford-Gilboe, Wilk, Avison & Ray, 2010). Even if women seek out services, interventions for trauma survivors may be inhibited by clients' particular symptomology, nature and intensity of trauma, limited social support, and stigma.

If interventions lack trauma-informed components they may trigger and exacerbate trauma symptoms leading to early termination, drop out or failure to engage in services

altogether (Stevens, Ammerman, Putnam, & VanGinkel, 2002; Walter, Horsey, Palmieri, & Hobfoll, 2010). Therefore, advocates for women with histories of trauma highlight the great need for interventions to address trauma survivors' management of their trauma symptoms (Briere & Jordan, 2009; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008; Herman, 1992).

There continues to be scarce qualitative research describing how trauma affects parenting behaviors. Therefore, there is a high need for studies aimed at giving voice to women trauma survivors as they embrace in efforts to provide the best parenting they can provide to their children. Data collected in such studies could inform in interventions aimed at empowering women in their parenting efforts, and potentially support greater efficacy and engagement.

Purpose of the Study

The purpose of this study was to create a theoretical model aimed at explaining how women's experiences of cumulative trauma and resulting complex trauma symptoms have affected their parenting behaviors, parent-child relationships, and their immediate parenting contexts. To reach this goal, female trauma survivors were asked to discuss their trauma history and symptoms, their perceptions on how these experiences influence their parenting behaviors and relationships with their children, and their individual coping responses to trauma. Finally, participants were asked about their perceptions of the extent to which the contexts in which they parent are supportive of their parenting efforts.

This study consisted of a series of semi-structured interviews with 12 female trauma survivors. To facilitate data collection, a general set of questions were asked to all participants (e.g., perceptions of their quality of parenting, etc.). Additionally, in an effort to fully explore the specific trauma-related challenges experienced by each participant, individual and tailored

questions were asked based on responses to the Brief Symptom Inventory (BSI: Derogatis, 1984) and the Adult-Adolescent Parenting Inventory-2 (AAPI-2; Bavolek & Keene, 1999).

With regards to the general questions, women were interviewed about their trauma history, symptoms associated with their trauma history, and how they perceived trauma experiences and symptoms influencing their parenting behaviors. In addition, they were asked about their perceptions concerning the level of support experienced in their parenting contexts and ways in which they coped with their trauma. Data was analyzed using methods of feminist-informed grounded theory qualitative research. This involved a three step coding process of open, axial, and selective coding using qualitative research software. To increase trustworthiness, a number of strategies were be implemented in close collaboration with Dr. Parra-Cardona. The current study constitutes a relevant contribution to the field as there are an extremely limited number of qualitative studies focused on how mothers' trauma symptoms influence their parenting behaviors as well as relationships with their children (Armsworth & Stronck, 1999; Jager & Carolan, 2009; Levendosky, Lynch, & Graham-Bermann, 2000). In addition, there continues to be a limited number of therapeutic and trauma-informed parenting interventions focused on promoting healthy parenting by adequately taking into consideration how trauma impairs parenting. Therefore, a key goal of this study is to provide treatment guidelines for these interventions. Primary reasons for poor outcomes in child welfare cases include lack of parental involvement in services and willingness to take responsibility for meeting children's needs (DeRoma, Kessler, McDaniel, & Soto, 2006; Gladstone et al., 2012; O'Hare, 1996). Because it is likely that these issues are rooted in trauma symptomology (Briere & Jordan, 2009), there is a high need for child welfare professionals to better understand the influence of trauma on

mothers' interactions with their children, as well as interactions with caseworkers, judges, lawyers, and other services to which they are mandated.

Research Questions

The major goal of this investigation was to reach a better understanding of how cumulative and complex trauma influences mothers' parenting behaviors. A secondary goal consisted of examining participants' coping strategies, as well as contextual factors that support their parenting efforts. Specifically, the following research questions guided this study:

A. What are the most salient experiences of cumulative trauma reported by participants?

B. What are the most salient trauma symptoms reported by participants?

C. How do trauma symptoms influence the participants' parenting behaviors?

D. How do trauma symptoms influence women's interactions with formal social systems (e.g., child welfare, legal)?

E. How supportive are the contexts in which women engage as related to their parenting efforts?

F. What examples of trauma-coping and resilient parenting behaviors are women most likely to report?

Theoretical Perspectives Justifying the Research Questions

Trauma and PTSD

In field trials for the development of the DSM-IV, 67% of participants with childhood abuse or neglect histories met criteria for a Posttraumatic Stress Disorder (PTSD) diagnosis (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). PTSD criteria include symptoms of re-experiencing the traumatic event, avoidance-numbing, and hyperarousal, with symptoms persisting for more than a month that cause significant impairment (American Psychiatric

Association [APA], 2000). However, interpersonal trauma often results in symptoms related to substantial emotional and interpersonal difficulties, which do not always align with the traditional conceptualization of PTSD (Briere & Jordan, 2004; Briere & Jordan, 2009; Briere & Spinazzola, 2009). As a result, the symptom profile associated with interpersonal trauma has been conceptualized as a complex posttraumatic stress disorder (Briere & Jordan, 2004; Herman, 1992). Individuals with complex trauma symptoms are likely to experience high reactivity to emotionally evocative stimuli, difficulty calming down, anger issues, attachment disturbances, and identity-related issues (Briere & Jordan, 2009; Briere & Lanktree, 2008; Cloitre, Cohen & Koenen, 2006; Goldner, 2007). Complex posttraumatic stress disorder symptoms increase when an individual has experienced multiple traumatic events across the life-span (Briere, Kaltman, & Green, 2008). What is problematic is that these symptoms create challenges in one's intimate relationships, work context, parenting behaviors, and perception of social support (Briere, 1988). Additionally, if a survivor is referred to a parenting program, these symptoms may inhibit her acceptance of and engagement in the intervention.

Cumulative Trauma and Complex Symptomology

Complex trauma symptoms tend to result from the cumulative effects of exposure to multiple traumatic events across the lifespan. In fact, an individuals' trauma complexity has been correlated with the number and nature of traumatic events they have endured (Briere, Kaltman, & Green, 2008). Women are at an increased risk for experiencing cumulative interpersonal trauma in comparison to men, leaving women at higher risk for PTSD and other mental health disorders (Kubiak, 2003; Rishith, Mechanic, & Resick, 2000; Yehuda et al., 1995). Cumulative trauma is also associated with increased vulnerability for revictimization. Therefore, individuals with cumulative trauma are likely to experience on-going traumas that will further exacerbate

trauma symptomology (Turner, Finkelhor, & Ormrod, 2006). Further details of cumulative trauma and complex trauma symptomology will be discussed further in Chapter Two.

Multicultural Feminist Theory

Multicultural feminist theory informs the conceptualization of this study. Rather than solely targeting gender and patriarchy as the basis of oppression, multicultural feminism seeks to critique societal and individual power imbalances based on multiple characteristics including, but not limited to the intersections among race, ethnicity, sexual orientation, socio-economic status, and ability status (McDowell & Fang, 2007). According to this perspective, the researcher should engage in a critical analysis of societal structures that promote and sustain power imbalances and inequality between individuals, families, and minority groups.

A multicultural feminist researcher further seeks to illuminate how individuals of minority status are often pathologized as they are viewed through the lens of white patriarchal society and seeks to challenge this pathologizing perspective. While discussing groups of individuals, the researcher should keep an open, flexible attitude about diverse cultures and cultural influences and needs to remain attentive to stereotypes commonly associated with specific diverse populations. Additionally, multicultural feminist research privileges the participants' voices and perspectives.

From a multicultural feminist perspective, women's behaviors as mothers must be understood within the context in which they exist. For example, when a mother interfaces with the child welfare system she is often labeled as abusive, neglectful, and uncaring towards her child. However, if we look at her trauma history we can find a more accurate understanding of her behavior- an understanding that can inform more empathic, effective interventions. This perspective challenges the blaming position commonly found in society which views mothers as

solely responsible for children's well-being (USDHHS, 1995).

Acknowledging one's social position and biases and how they influence the results of a study is integral to feminist research. Moreover, the primary investigator recognizes that the current study has political implications and has the purpose of stimulating advocacy and change. This study seeks to influence change in social systems with which mothers with trauma interact by providing empirical data to justify a perspective of understanding of maladaptive parenting behaviors associated with trauma, oppression, and social injustice.

Ecological Theory

In this study women's trauma history and trauma responses are understood through an ecological lens, which provides a theoretical structure for understanding contexts in which individuals live (Bronfenbrenner, 1979). Bronfenbrenner (1979) conceptualizes five different systems in which individuals exist including the microsystem, mesosystem, exosystem, and macrosystem (1979). Each of these systems are interdependent and interrelated, meaning that intervention in one system will likely influence the others.

Microsystems are individuals' most immediate settings (1979). A microsystem may be an individual's family, school, or peer context. Guttentag and colleagues (2006) found that close social support predicted positive change in a parenting intervention for disadvantaged mothers. Similarly, women with a sexual abuse history have healthier parenting practices when they have a strong support system (Kim, Trickett & Putnam, 2010). Unfortunately, accessing healthy social support systems is often times a challenge, particularly for women with trauma histories. This is especially the case when the mother's family support system consists of those who perpetrated their abuse (Sharp & Marcus-Mendoza, 2001).

Mesosystems are the interactions between two microsystems (Bronfenbrenner, 1979). For example, a mesosystem may be the interaction between a child's family and school system. Particularly, if teachers or administrators perceive a trauma survivor to be a "deficient parent", collaboration in this mesosystem will likely be poor. Child welfare personnel also often times become intimately related to women's micro-systems as their actions and attributions have the potential of profoundly altering the dynamics of families. Thus, this study will explore the role of mesosystems in participants' lives such as how women navigate relationships with foster parents, school systems, and any other immediate contexts that have a direct influence on their children.

Exosystems are systems that have an indirect influence on individuals (Bronfenbrenner, 1979). For example, if women are in relationships with partners whose families consider trauma survivors as "weak or drawn to deficient relationships," chances are that partners may be negatively influenced by their families' deficit-based perceptions.

The macrosystem is the political and social context in which individuals, microsystems, mesosystems, and exosystems exist (1979). This involves living in a society that privileges white, middle class values and experiences. Currently, the U.S. macrosystem is also characterized by an economic context in which employment and education opportunities are limited. In addition, executive portions of the child welfare systems where policies and decisions are made that directly impact trauma survivors constitutes an example of the powerful influence that macrosystems can exert on the participants' lives. Therefore, this study seeks to understand how women's trauma symptoms may be exacerbated by sociopolitical challenges they have faced throughout their lives. The implications of the Adoption and Safe Families Act (ASFA) are an example of a macrosystemic influence. ASFA allows a judge to terminate a parent's rights if the child has been out of the parent's care 15 out of 22 months. As a result women with a trauma

history who are involved in the child welfare system have a relatively short time-frame to resolve parenting issues that may stem from PTSD symptoms.

Chapter 2: Literature Review

Scope of the Problem

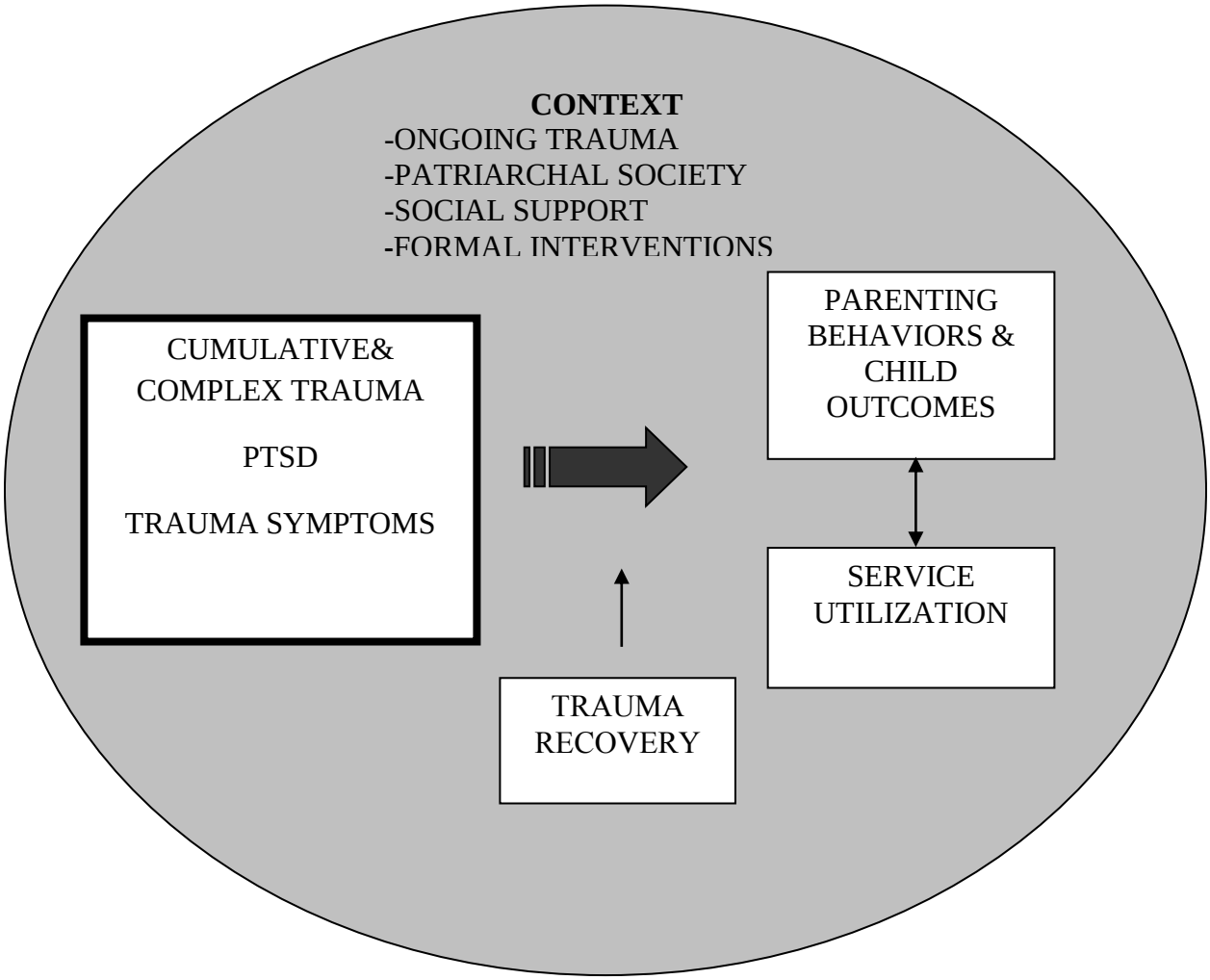
More than 3 million reports of child maltreatment are received by state and local agencies in the U.S. each year (CDC, 2012). Of these reports, approximately 60% of children are maltreated by their mothers and more than 25% are exposed to domestic violence (DHHS, 2010). In addition, at least 740,000 children and youth are treated in hospital emergency departments as a result of violence by caregivers on an annual basis (CDC, 2012). Because child maltreatment costs the U.S. government $104 billion each year (Wang & Holton, 2007), understanding why maltreatment occurs is of great importance.

Maltreatment of children is a phenomenon associated with a multiplicity of factors such as poverty (Lee & Goerge, 1999), lack of resources (Berger, 2004; Paxson & Waldfogel, 1999; Waldfogel, 2000), tendency towards aggression, endorsement of corporal punishment (Black, Heyman, & Slep, 2000), and stress (Rodriguez, 2010). One consistent finding is that parents who maltreat their children are very likely to have experienced maltreatment in their own child and adolescent histories (Dixon, Browne, & Hamilton-Giachritsis, 2005; Hunter & Kilstrom, 1979; Newcomb & Locke, 2001). Bandura's Social Cognitive theory has been used to explain this pathway to maltreatment, which supports the notion that adults maltreat their children based on the observations of their parents' maltreating behaviors (Bandura, 1973, 1977, 1986; Bower-Russa, 2005). However, more recently, alternative perspectives identify parents' trauma symptoms resulting from early abusive experiences and/or abusive relationships as mechanisms by which parents engage and perpetuate abuse on their children (Milner et al., 2010).

To understand how parental trauma symptoms impact parenting, this literature review discusses several related topics. First, trauma and posttraumatic stress disorder (PTSD) are

discussed including subtopics of cumulative trauma, complex symptomology, and women's unique trauma experiences. Next, current literature on how parental trauma and trauma symptoms lead to impaired parenting and poor childhood emotional and behavioral outcomes will be discussed. Finally, the role of contextual factors and recovery will be examined. Special emphasis will be placed on describing how a biased "mother blaming" culture has been promoted in patriarchal societies, an issue that has prevented a more thorough and systemic understanding of child abuse and neglect. Figure 1.1 is a visual conceptual map of the major concepts and elements that provide the theoretical justification of this investigation.

Figure 1.1 Conceptual Framework



Ecological Lens

This literature review takes into account that parenting behaviors should be understood within an ecological context. Belsky (1984) theorized that parenting behaviors are influenced by parent characteristics, child characteristics, and parents' context (e.g., social support, workplace). Of these three factors, Belsky considers that how individuals were parented is the most important factor in determining parenting style and approach. Highlighting the critical importance of context, scholars have repeatedly argued about the importance of thoroughly considering multiple layers of context (e.g., family, neighborhood, society) when examining effective and maladaptive parenting behaviors. The following review looks at how the developmental history of trauma and the context in which trauma survivors live influence parenting and child outcomes.

Defining Trauma and Trauma Responses

Posttraumatic Stress Disorder

Currently, approximately 11 million adults in the US suffer from PTSD and other anxiety disorders resulting from exposure to traumatic events (National Institute of Mental Health [NIMH], 2012). To receive a formal PTSD diagnosis a person must have "experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others" (APA, 2000, p.468). Additionally, they must have responded to the event with fear, hopelessness or horror. Symptoms that must be present for the diagnosis include intrusive recollection of the event (at least one), avoidance or emotional numbing (at least three), and hyperarousal (at least two). Intrusive experiences may involve recurrent images, dreams, or psychological distress and internal or external cues that remind the person of the event.

Each of these three symptom domains may have a variety of emotional and behavioral manifestations. Avoidance or emotional numbing includes efforts to avoid thoughts or feelings related to the event, efforts to avoid any external reminders of the event, dissociation, feelings of detachment from others, or sense of a foreshortened future. Hyperarousal may be characterized by difficulty falling asleep, irritability, difficulty concentrating, hypervigilence, or an exaggerated startle response (APA, 2000). A person must experience symptoms for at least a month and find symptoms distressing or impairing to social or occupational functioning (APA, 2000).

Women's Unique Trauma Experiences

Women are more likely to develop PTSD in comparison to men, with women having a 9.7% lifetime prevalence of PTSD, and men only having a 3.6% prevalence rate (Kessler et al., 2005). Although women are at an increased risk for PTSD, a large proportion of women experience sub-threshold PTSD symptoms (see Merlin & Mohr, 2000). While some researchers argue that women are particularly vulnerable to PTSD due to their gender (i.e. Breslau, Chilcoat, Kessler, & Davis, 1999), others argue that women are particularly at risk for PTSD due to their increased likelihood of experiencing sexual violence across the lifespan and child abuse (Kubiak & Cortina, 2006; Tolin & Foa, 2006). Additionally, women endure daily traumas resulting from living in a patriarchal society in which women are oversexualized and devalued (Burstow, 2003). An increased prevalence for PTSD may also be partially explained by national statistics from the U.S. Department of Health and Human Services on reported incidents of child maltreatment that show that girls are at higher risk for being victims of child abuse and neglect than boys (USDHHS, 2010).

Intimate Partner Violence Intimate partner violence (IPV) affects a large proportion of women in the United States when considering that IPV can be manifested through physical, emotional, sexual, or financial violence (Pence & Paymar, 1993). Unfortunately a significant proportion of mothers engaged in child abuse and neglect are also engaged in abusive intimate relationships. Research has documented the deleterious effects associated with IPV exposure and maternal parenting (Levendosky, 2000). For example, women report that domestic violence impairs their parenting behaviors on issues such as emotional regulation, appropriate limit setting and emotional interaction with their children. Furthermore, children also become IPV victims as they are at high risk of abuse by IPV perpetrators (Renner & Slack, 2006; Saunders, 2003). While the co-occurrence of maternal child abuse and IPV is common, there continue to be important failures in the service-related systems to screen for and detect IPV among women who are referred to social institutions for child abuse and neglect (Kelleher et al., 2006).

Cumulative Trauma

Although the diagnostic criteria for PTSD is considered in relation to a singular recent event, studies show that individuals who have been exposed to multiple traumatic events across their lifespan are at an increased risk for poor mental health outcomes including increased risk for PTSD (Kubiak, 2003; Rishith et al., 2000; Yehuda, 1995). Essentially, the more traumatic experiences individuals have lived, the more trauma symptoms they are likely to have (Follette, Polusyny, Bechtle, & Naugle, 1996; Rishith, Mechanic, & Resick, 2000). For example, Kubiak determined in a sample of drug-convicted women that women's risk for PTSD increased 40% with each traumatic event they experienced (2003).

Early traumatic events make individuals vulnerable for future traumatic occurrences. For example, childhood victimization is associated with revictimization across the lifespan (Spatz

Wisdom, Czaja, & Dutton, 2007). More specifically, Nishith, Mechanic, and Resick (2000) found that child sexual abuse increased vulnerability for physical and sexual abuse in adulthood. Subsequent trauma essentially reinforces problematic beliefs about self and others that early traumas triggered, further exacerbating PTSD symptomatology (Nishith, Mechanic, & Resick, 2000). For instance, Griffen and colleagues (2006) explored IPV survivors' exposure to childhood trauma and how early violence exposure influenced subsequent PTSD symptomology. Findings indicate that women who witnessed their mothers being victims of domestic violence were more likely to experience intrusion symptoms. A history of sexual abuse in childhood was also related to hyperarousal symptoms. According to these research findings, intimate partner violence also mediated a relationship between childhood physical abuse and adult PTSD (Becker, Stuewig, & McCloskey, 2009). Similarly, Samuels-Dennis found that cumulative trauma decreased women's sense of self-agency, which subsequently increased their PTSD symptom severity (Samuels-Dennis et al., 2010).

Complex Trauma

Interpersonal abuse often results in symptoms related to substantial emotional and interpersonal difficulties that do not always align with the traditional conceptualization of PTSD (Briere & Jordan, 2004; Briere & Jordan, 2009; Briere & Spinazzola, 2009; Herman, 1992; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). As a result, the symptomatic profile associated with interpersonal trauma has been conceptualized as a series of disorders of extreme stress not otherwise specified (DESNOS) or also frequently referred as complex posttraumatic stress disorder (Herman, 1992; Briere & Jordan, 2004). Cloitre and colleagues (2009) found that childhood trauma was predictive of symptom complexity in adulthood. Symptom complexity is defined as a number of symptoms above a literature-determined cut-off.

Herman (1992) originally identified seven categories of DESNOS trauma symptoms including dysregulation of affect and impulses, attention or consciousness, self-perception, perception of the perpetrator, relations with others, somatization, and systems of meaning. Subsequently, it was empirically determined that individuals with prolonged interpersonal trauma early in life were at risk for difficulties with affect regulation, memory and attention, self-perception, interpersonal relations, somatization, and systems of meaning (van der Kolk, Roth, Pelcovitz, & Spinazzola, 2005). Briere and Jordan (2009) similarly described six specific symptoms that can result from complex trauma experiences. These include cognitive disturbances, mood disturbances, somatization, identity disturbance, interpersonal difficulties, emotion regulation difficulties, and avoidance responses. Briere and Elliott (2003) found that both physical and sexual abuse in childhood were associated with domains on the trauma symptom inventory including anxious arousal, depression, anger-irritability, intrusive experiences, defensive avoidance, dissociation, impaired self-reference, and tension reduction behavior. Sexual abuse was additionally associated with sexual concerns and dysfunctional sexual behavior (2003). Briere, Kaltman, and Green (2008) found that the number and types of traumatic events women experienced in childhood predicted their future complexity of symptoms. For example, survivors of sexual abuse and maternal emotional abuse are very likely to report various symptoms in all scales of the Inventory of Altered Self-Capacities including interpersonal conflicts, idealization-disillusionment, abandonment concerns, identity impairment, susceptibility to influence, affect dysregulation, and tension reduction activities (Briere & Rickards, 2007). Below, each primary complex trauma symptom is summarized based on Briere and Jordan's description (2009).

Perceptions of Self and Others. Cognitive disturbances refer to the distortions in schemas about self and others. Rather than developing the belief that relationships with others will be trusting and rewarding, a trauma survivor is likely to develop beliefs that relationships will be characterized by rejection, abandonment, and hurt. In addition, the survivor believes that she deserves and is responsible for this type of treatment (2009).

Briere and Jordan (2009) also highlight the issue of identity disturbance for complex trauma survivors in which one's identity and self-awareness becomes distorted. This presents as confusion about boundaries resulting from a lack of ability to monitor personal needs, feelings, thoughts, and behaviors.

Individuals with a child abuse history are likely to report problems in their marital and social relationships (Liang, 2006). Chronic interpersonal difficulties are also associated with complex trauma related to the cognitive disturbances that survivors are likely to hold about relationships and others. As a result, survivors are at increased risk of engaging in abusive relationships as they may not feel worthy to demand respect, attention, and consideration from their intimate partners (Briere, 2009; Cloitre, Miranda, & Stovall-McClough et al., 2005).

Emotional and Physical Problems. Mood disturbances for trauma survivors include increased likelihood to experience symptoms of anxiety and depression (2009). This highlights the frequent co-morbidity rates of posttraumatic stress disorders with mood disorders (Kessler, Sonnega, Bromet, et al. 1995). Related to mood disturbances, emotion regulation can be difficult for complex trauma survivors (Cloitre, Miranda, Stovall-McClough et al., 2005) and often results in utilization of avoidance strategies. Avoidance strategies include substance abuse, dissociation, and tension reduction behaviors (TRBs). Dissociation is characterized by depersonalization and

derealization of experiences. Examples of TRBs include disordered eating, self-mutilation, compulsive sexual behavior, and impulsive aggression (2009).

Avoidance strategies of dissociation and substance abuse seem to be primary areas of concern related to trauma survivors' parenting difficulties (Egeland & Susman-Stillman, 1996; Narang & Contreras, 2000). Dissociation has been strongly associated with revictimization and further exposure to stressful life events (Becker-Lausen et al., 1995). In a sample of parents with child abuse histories, dissociative symptoms were found to be a differentiating factor between parents who abused their children and those who did not (Egeland and Susman-Stillman, 1996). Substance abuse can be of particular concern for women with a trauma history. Substance abuse rates are higher in traumatized populations including women who have a history of physical, sexual (Brems, Johnson, Neal, et al., 2004; Knisely, Barker, & Ingersoll, 2000; Strine et al., 2012), and/or domestic abuse (Salomon, Bassuk, & Huntington, 2002). Severity of substance abuse has also been correlated with severity of victimization (Brady et al., 1994; Clark & Foy, 2000). Although there are multiple contributing factors to women's substance abuse, studies show that childhood abuse is a strong predictor. This connection has been explained as a self-medicating process, in which substances are used to numb trauma symptomatology.

Somatization is another possible consequence of complex trauma that can lead to psychological distress manifesting in physical pain and dysfunction (Briere & Jordan, 2009). Abuse history has been found to be predictive of a variety of health problems and prolonged recovery time (Drossman, Li, Leserman, Toomey, & Hu, 1996; Farley & Patsalides, 2001 Spitzer, Barnow, Wingenfeld et al., 2009).

Parenting and Child Developmental Outcomes

Parenting Styles and Child Outcomes

As this investigation focuses on the extent to which trauma history influences parenting behaviors, an inherent position is taken which differentiates between abusive and adaptive parenting. Specifically, research shows that child socio-emotional outcomes for children are best when parents have adequate skills in key parenting domains such as effective communication, warmth, limit setting, and maturity demands (Baumrind, 1967; 1971). Although these domains are primarily drawn from Baumrind's seminal research, other child development researchers support the crucial role of these parenting behaviors on positive child and youth development (e.g. Adams, 2008; Maccoby & Martin, 1983; Shumow, & Lomax, 2002; Rohner, 2002). Communication involves the extent to which parents clearly convey various expectations to their children, as well as the extent to which they are open to their children's ideas and feedback. Warmth is simply the extent to which parents show affection to their children. Limit setting refers to the restrictions they place on their children's behavior and how much monitoring they do of their behaviors. Finally, maturity demands refers to the extent to which parents expect their children to have age-appropriate responsibilities (Baumrind, 1967; 1971).

Baumrind identifies four parenting styles based on the aforementioned parenting domains. Authoritative parents are those who score high on all four domains. Children of authoritative parents tend to express high levels of positive emotions, have self-control/ self-reliance, high energy, are able to maintain relationships with peers, are cooperative, cope well with stress, and show initiative in new situations (Baumrind, 1967; 1971).

Permissive parents are those who have high communication and warm interactions with their children but set few limits and maturity demands. Child outcomes associated with permissive parenting include domineering, disruptive and demanding interpersonal style,

impulsive, low achievement orientation, high energy and positive emotions (Baumrind, 1967; 1971).

Authoritarian parents are high on setting limits and maturity demands, but are low in providing warmth and communication to their children. Although children of authoritarian parents tend to be better behaved than children of permissive parents, they tend to express fewer positive emotions, are more inhibited, passively hostile, withdrawn, aggressive, and vulnerable to stress (Baumrind, 1967; 1971). Linking research on parenting styles, child outcomes, and trauma is a key premise of the current investigation as there is a high need to investigate how these issues are interrelated in the lives of women with intense trauma histories.

Social Interaction Learning Theory and Parenting Behaviors

Closely related to Baumrind's scholarship on parenting styles, a similar set of parenting behaviors has been connected by researchers to positive child outcomes and maternal well-being. Specifically, 9-year longitudinal data from parenting clinical trials have been associated with positive youth development, reduced maternal depression, and increased maternal per capita income (Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Patterson, DeGarmo, & Forgatch, 2004). Specifically, Forgatch and colleagues implemented the intervention known as *Parenting through Change (PTC)* with a group of low-income and underserved divorced mothers (Forgatch & DeGarmo, 1999), placing close attention to the promotion of both parenting skills and maternal well-being. The intervention was developed according to principles Social Interaction Learning (SIL) Theory, which connects child behavioral outcomes to parenting practices (Reid, Patterson, & Snyder, 2004). According to SIL, stressful environmental factors influence children's behavioral outcomes indirectly and are mediated by parenting practices. PTC aims to reduce disruptive children's behaviors through effective parenting practices (Forgatch, Patterson,

& DeGarmo, 2005). PTC core parenting skills include 1) positive involvement, 2) skill encouragement, 3) setting limits, 4) monitoring, and 5) family problem solving. These concepts fit quite well with concept of authoritative parenting. In a large clinical trial with mothers exposed to intense contextual stressors, researchers confirmed that effective parenting practices led to sustained positive childhood outcomes over time, as well as maternal well-being as demonstrated through improved mental health and economic stability (Forgatch, Patterson, DeGarmo, & Beldavs, 2009).

Trauma and Parenting

Literature on the relationship between parental trauma and parenting is extensive, however there is a wide variety of ways by which this phenomenon has been studied. Generally, women with a trauma history are more likely to have decreased parenting satisfaction, increased neglectful behaviors, and increased likelihood for using physical punishment (Banyard, Williams, & Siegel, 2003; Banyard, 1997). Additionally, specific types of traumas, cumulative trauma, and trauma symptoms have been investigated as influencing poor parenting and negative child outcomes.

Trauma Symptomatology and Parenting

Researchers have confirmed that trauma symptoms mediate the relationship between potential for childhood physical abuse and risk for perpetrating child physical abuse (Milner et al., 2010). For example, in a study with college and US Navy personnel, it was found that for participants in both samples, impaired self-reference, tension reduction behaviors, and defensive avoidance predicted likelihood for perpetrating child physical abuse. For the US Navy sample, but not for the college sample, dissociation, intrusive experiences, and sexual concerns were significant predictors of risk for perpetrating child physical abuse. These findings substantiate

how complex trauma symptoms of disturbances in schemas about self and others have the potential to impair parents' ability to engage in healthy parent-child interactions (Briere & Jordan, 2009).

Mood symptoms can also impair parent-child interactions (Downey & Coyne, 1990) as well as inhibit a mother's ability to actively engage in an intervention. Extensive research has demonstrated the deleterious effects of depression on parenting. Depressed parents have more negative interactions with their children, which tend to be informed by negative attributions such as considering their children particularly rebellious or self-centered (Field, 1995; Guedeney, 2000).

Dissociation, an avoidance strategy that can result from trauma, provides a mechanism by which parents leave themselves and their children vulnerable to further victimization (Hulette, Kaehler, & Freyd, 2011; Narang & Conteras, 2000; Vezina, Mireille, Roberts, & McDuff, 2005). When women with a sexual abuse history display dissociative symptoms, they are less likely to be supportive towards their daughters and more likely to use punitive discipline (Kim et al., 2010; Dixon, Brown & Hamilton-Giachritsis, 2005; Dixon, Hamilton-Giachritsis, & Brown, 2005). When survivors of incest were asked about their parenting experiences they often described their experience as a parent as feeling detached, numb, handicapped, overcontrolling, overprotective, fearful, and anxious (Armsworth & Stronck, 1999).

Substance abuse, for multiple reasons, impairs parenting (Keller, Cummings & Davies, 2005; Pears, Capaldi, & Owen; Smyth, Miller, Mudar & Skiba, 2003). First, it contributes to a variety of negative social factors including low social support, housing problems, and poverty (Daro & McCurdy, 1992; Marcenko & Spence, 1995***;*** Nair, Schuler, Black, Kettinger, & Harrington, 2003). Maternal substance abuse disorder is predictive of neglectful parenting

(Carter & Myers, 2007), punitive discipline strategies (Arellano, 1996; Hans et al., 1999; Kelley, 1998; Miller, Smyth, & Mudar, 1999; Schuler & Nair, 2001; Young, 1997), and out of home placement (Marcenko, Kemp, & Larson, 2000). Substance abuse disorder also moderated a relationship between child abuse history and severity of neglectful parenting (Dunn, Mezzich, Janiszewski, Kirisci, & Tarter, 2008; Dunn, Tarter, Mezzich, Vanukov, Kirisci, & Kirillova, 2002). In a sample of substance abusing mothers, Hien and colleagues (2010) found that anger arousal and reactivity predicted child abuse potential. Women who are substance abusers are more likely to abuse or neglect their children when they are contending with more than five contextual stressors (Nair, Schuler, Black, Kettinger & Harrington, 2003). Children of substance-abusing mothers experience better psychosocial adjustment when their mothers maintain parental warmth and control (Suchman, Rounsaville, DeCoste, & Luthar, 2007).

Specific Trauma History and Parenting Outcomes

Parental history of childhood sexual abuse place survivors' children at increased risk for child abuse and psychological aggression, particularly if women are likely to minimize the potential for engaging in abusive parenting behaviors (Cohen et al., 2008). Additionally, negative family-of-origin experiences and sexual abuse history were related to use of violence during parent-child conflict as well as poor satisfaction with self as a parent (1997). Mothers with a sexual abuse history are at high risk for using punitive discipline (Kim, Trickett, & Putnam, 2010). Furthermore, when sexual abuse survivors had high levels of depressive symptoms they were especially more likely to use physical violence with children.

Mothers with a sexual abuse history also have difficulties caring for the emotional and psychological needs of children. This is related to a number of factors including: less consistency and organization, lower confidence in parenting abilities, less sense of control, and lack of

support from partners (Cole, Woolger, Power & Smith, 1992). In comparison to mothers who did not survive sexual abuse, mothers with a history of sexual abuse are at risk of placing inappropriate maturity demands on their children (1992), being intrusive towards their infants (Moehler, Biringen & Poustka, 2007), being less affectionate and involved with infants (Lyons-Ruth & Block, 1996), having permissive parenting styles (Kim et al., 2010), and relying more on their children for emotional support (Burkett, 1991).

With regards to having experienced sexual abuse, a qualitative study on incest survivors' parenting experiences, poor self-esteem was reported as one of the most inhibiting symptoms to effective parenting (Armsworth & Stronck, 1999). Lack of a concept of appropriate boundaries and discipline also made parenting difficult (1999). Incest survivors also reported trauma symptoms including difficulties with closeness, being touched, and having others depend on them to meet their needs as barriers to effective parenting (1999).

History of childhood physical abuse is predictive of child abuse perpetration, parental punitiveness, psychological aggression, and use of physical discipline (Bert, Guner, & Lanzi, 2009; Cohen et al., 2008). Women with physical and emotional abuse histories also show less responsivity to their infants (Bert, Guner, & Lanzi, 2009). Women with a history of physical abuse are also at increased risk of having poor quality interactions with their children, increased vigilance, and are more likely to have negative perceptions of their infants in comparison to non-abused mothers (Gara, Allen, Herzog, & Woolfolk, 2000).

Cumulative trauma is also predictive of poor parenting outcomes (Cohen, Hien, & Batchelder, 2008). Although maternal trauma history predicts later deficits in parenting, it is critical to consider that this is not a simple cause-effect relationship, but rather consequences of a chain of events. For example, based on her research with low-income African American

survivors, Mapp (2007) found a sequential link by which maternal sexual abuse was associated with maternal depression, which in turn influenced maternal locus of control, leading to increased risk for childhood physical abuse.

Parental Trauma and Child Outcomes

Multiple studies in the early 90's explored child outcomes of women with a trauma history. Parental adjustment after a traumatic event has been connected to their children's overall mental health outcomes (Appleyard & Osofsky, 2003). Particularly when parents report high levels of distress and have experienced PTSD symptoms following such events, their children are at higher risk for internalizing behaviors, externalizing behaviors, lower social competence, PTSD symptoms, and maltreatment (Famularo, Fenton, Kinscherff, Ayoub, & Barnam, 1994). Additionally, parents with a trauma history can experience high levels of fear and hopelessness that may prevent their children from the emotional development task of establishing a sense of trust and security (Appleyard & Osofsky, 2003; Osofsky, 1995; Osofsky, Cohen, & Drell, 1995). Infants of mothers with a history of physical abuse also struggled with recovery after experiencing distress (Lang, Garstein, Rodgers, & Lebeck, 2010).

Context and Trauma Recovery

Women who have experienced trauma and display poor parenting behaviors are not solely responsible for those difficulties. In fact, several of the struggles that survivors experience are related to patriarchal socio-cultural structures that are prone to blame victims of diverse forms of oppression. For example, many trauma survivors are engaged in abusive relationships. However, rather than conceptualizing violence against women as a societal phenomenon in which social systems (e.g., marriage, family) and formal institutions (e.g., child protective agencies) are key contributors to the maintenance of the problem, male perpetrators of violence

continue to be overlooked as well as their contributing role to child abuse and neglect. Specifically, the national study on child abuse and neglect (A Nation's Shame) found that although the majority of perpetrators of child neglect were women, the most intense forms of child abuse including child fatalities were committed by aggressive men (USDHHS, 1995). Furthermore, the study acknowledges that women are most likely to be charged with neglect. This results from the fact that they are the ones who often bear the primary responsibility of caring for their children and interact with institutions in which child abuse or neglect is likely to be detected. Whereas limited paternal involvement protects fathers against being identified as the main perpetrators of child abuse (Risley-Curtiss & Heffernan, 2003; Strega et al., 2008).

Thus, there is a high need for promoting a socio-political awareness of the social structures that continue to oppress women. Otherwise, there is a risk for creating a culture focused on blaming mothers who are trauma survivors, without challenging the patriarchal systems and societies in which they live (Leschied, Chiodo, Whitehead, Hurley, Marshall, 2003; Strega et al., 2008). "Deeply embedded in our cultural psyche is the notion of the idealized mother; typically middle class, married, educated, and with access to resources." (Allen, 2010, p.162). Most women involved in child welfare do not meet these societal standards for 'mothering', and there is question over whether it is appropriate to expect them to do so.

This study will have a strength-focus approach in order to give voice to women and identify their unique experiences of success as they embrace their parenting efforts. To this end, it is critical to investigate which protective factors in the lives of trauma survivors can make a permanent difference in their lives, their parenting practices, and the well-being of their children. For example, Guttentag and colleagues (2006) found that social support predicted positive change in a parenting intervention for disadvantaged mothers. Similarly, women with a sexual

abuse history have healthier parenting practices when they have a strong support system (Kim, Trickett & Putnam, 2010). Samuels-Dennis and colleagues found that social strain mediates a relationship between cumulative trauma and women's PTSD symptom severity (Samuels-Dennis, Ford-Gilboe, Wilk, Avison & Ray, 2010). However, accessing healthy social support systems is often times a challenge for trauma survivors. This is especially the case when the mother's informal and family support systems consist of those who perpetrated the abuse (Sharp & Marcus-Mendoza, 2001).

Self-Efficacy and Recovery

Resilience in the face of trauma is dependent on multiple factors including individual characteristics, family support, and community context (Garmezy, Masten, & Tellegen, 1984). Studies have shown that individual characteristics and sense of self-efficacy have been connected to positive psychosocial outcomes for individuals exposed to traumatic events (Agaibi, 2005; Ammerman, 1990; Benight & Bandura, 2003; Werner & Smith, 1989).

The role of self-efficacy in healing from trauma is clearly valued in the literature on interventions designed for women who have experienced interpersonal trauma (Fallot & Harris, 2002; Kubany & Watson, 2002). This is evident in the permeating emphasis on "empowerment" throughout interventions. Empowerment theoretically mirrors self-efficacy in the sense that it refers to the extent to which individuals feel in control of the events that happen to them in their lives. Literature on these interventions emphasizes the positive effects that empowerment can have on women's lives (Pollack, 2008; Worell & Remer, 1992).

Alternative responses to violence against women that promote empowerment through community advocacy are found to be effective. A model example is the use of paraprofessionals as advocates with women who have been assaulted by a current or former partner (Sullivan,

2003). Specifically, in a randomized trial with advocates assigned to IPV survivors, women who received advocacy support reported less violence over time as well as higher social support and perceived quality of life.

Trauma Recovery

Trauma recovery is a multidimensional process that Harvey (1996) has carefully outlined. According to this author, one key component of trauma recovery refers to establishing control over memories of the traumatic event (1996). An additional component refers to integrating memory and affect, particularly as it refers to emotions associated with traumatic events (1996). For example, the ability to tolerate distressing emotions is a key process in trauma recovery as it requires survivors to identify emotions associated with trauma, but without becoming threatened or overwhelmed by them (1996). Mastery of trauma symptomology is also crucial to recovery. This may occur by using coping strategies or avoidance of negative stimuli. Improvements in self-esteem and self-concept are also crucial to trauma recovery. After a traumatic event challenges one's self-worth, it is important for individuals to no longer blame themselves for the trauma and to accept that they did not deserve the trauma they endured (1996). Especially if an individual has experienced interpersonal trauma, it can be difficult to trust others and maintain healthy relationships. As a result, an important part of trauma recovery consists of restoring safe emotional attachments and healthy social support networks (1996). Finally, trauma recovery involves assigning meaning to the traumatic event. For example, a trauma survivor may interpret an experience of abuse as a painful episode in her life but also one that allows her in the present life to effectively connect and advocate for other trauma survivors (Herman, 1992).

Burstow (2003) addresses trauma recovery through a feminist lens and consequently supports a radical approach in which trauma is not viewed from a deficit-based perspective. She

argues that PTSD guidelines of the DSM-IV-TR do not include the frequent oppressive experiences of women and other minorities that are traumatic and contribute to trauma symptoms; nor does the DSM address the consequences of cumulative trauma. There is also concern with trauma recovery interventions focus on reducing hypervigilence and fear that the world is not safe. Burstow argues for the validity of these responses due to the fact that for some individuals the world is *not* safe. Burstow draws attention to the fact that trauma exists in a context. When a man physically assaults a woman, the trauma is related to a patriarchal, power-imbalanced context (2003). Those who perpetuate traumas tend to hold a position of power. Trauma is further exacerbated when those in power deny or minimize traumas and their effects. This is of particular concern for women who have trauma and child welfare involvement, and their trauma and trauma responses are ignored or misunderstood. Burstow recommends that interventionists should co-investigate the meaning of trauma symptomology with clients, and avoid fostering a victim identity. Interventionists need to promote skills on how to handle difficult situations, rather than attempting to construct a world-view that bad things rarely happen in the world (2003).

Service Utilization and Recovery

A critical concern for mothers with a trauma history is learning to navigate social services. Child welfare involvement results from multiple factors rather than an isolated occurrence of child maltreatment. Thus, the extent to which trauma history influences child welfare involvement is related to how trauma interacts with these factors. Prevention and intervention activities in child welfare systems require addressing key underlying factors associated with child maltreatment such as poverty, lack of resources, substance abuse, IPV history, and unemployment (Connell-Carrick, 2003). Trauma symptoms of poor affect regulation

and interpersonal skills that reduce self-efficacy can sustain these issues (Briere, 1988). When parents enter the child welfare system they are not only required to interact with caseworkers, but they are also referred to a variety of services. However, intense trauma history paired with interpersonal and contextual difficulties would make it difficult for mothers to trust caseworkers and engage in services to which they are mandated. Stevens and colleagues (2002) found this was the case in a sample of women enrolled in a home visiting program. Specifically, non-completion of home visits was associated with history of violent trauma. Therefore, the current investigation will not only explore the trauma backgrounds experienced by participants but most importantly, what are the personal and social resources that have made a positive difference in the participants' lives.

Chapter 3: Methods

Design

Overview of the Qualitative Approach

This study utilized a grounded theory approach to create a theoretical model aimed at explaining how mothers' trauma affects their parenting behaviors. The model seeks to illustrate how participants' context influences their parenting practices. The qualitative approach used in this investigation will also be informed according to feminist-qualitative research principles. Data were collected through semi-structured interviews with mothers who report a cumulative trauma history and current or former involvement with the child welfare system. According to a grounded theory approach, data were analyzed by a sequential process of open, axial, and selective coding. Triangulation, peer debriefing, audit trail, and constant reflexivity are methods that will be used to ensure trustworthiness of the data.

Qualitative Research

Qualitative approaches and methods are those that systematically seek knowledge about phenomena by using means that are not statistical in nature (Strauss & Corbin, 1990). Various qualitative approaches are used to describe and explain subjective experiences of individuals. Data generated in qualitative research often originate from multiple sources but most commonly from direct interviews with participants and field observations (Strauss & Corbin, 1990). Miles and Huberman (1994) summarize additional components that frequently characterize qualitative approaches: (a) Intense and prolonged contact with the phenomena being studied, (b) comprehensive understanding of phenomena, (c) researchers seeking to understand phenomena according to the participants' perspectives rather than their own, (d) data are maintained in the original expressed form despite the fact that are condensed and analyzed by the researcher, (e)

there is an ultimate goal to better understand how people function in their daily contexts, and (f) some components of data are more relevant than others but these should be confirmed by research participants.

Qualitative approaches are used to explore a phenomenon that is unknown, or to arrive at a new perspective for understanding regarding previously explored phenomena (Strauss & Corbin, 1990). Qualitative methods also provide rich descriptions of phenomena that cannot be captured through quantitative methods (Strauss & Corbin, 1990). Unlike quantitative methods, it is not the purpose of qualitative methods to generalize results to a larger population but to reach a deeper level of understanding of the experiences being explored with participants.

Grounded Theory

This study follows a modified, constructivist grounded theory approach (Charmaz, 2006; Glaser & Strauss, 1965, 1967; Strauss & Corbin, 1990). Grounded theory methods seek to formulate and integrate an emergent theory grounded in the data provided by participants. Thus, this approach is an inductive process in which the researcher is not seeking to solely prove an existent theory, but rather to allow for the discovery of an emergent theory (1990). To generate a grounded theory, systematic procedures are used to identify concepts and relationships among these that create a phenomenon of interest (1990). This study is modified grounded theory as it considers the current literature on the topic of study (1990). Additionally, this study is constructivist as the researcher and participants co-construct meanings from participant experiences through interactions in the structured interview (Charmaz, 2006).

The quality of grounded theory studies are assessed according to four categories: (a) fit, (b) understanding, (c) generality, and (d) control (Glaser & Strauss, 1967; Strauss & Corbin, 1990). A grounded theory should comprehensively ‘fit’ the phenomena for which it applies.

Essentially, fit ensures that the emergent theory accurately corresponds to the data provided by participants. Understanding seeks to answer the following question: Does the integrated theory make logical sense to the researchers and participants? Generality refers to the extent to which data is applicable to other situations and experiences of people outside the specific study. Finally, control is associated with the use of systematic and rigorous methodological procedures (Strauss & Corbin, 1990).

Multicultural Feminist Qualitative Research

Multicultural feminist qualitative researchers seek to illuminate and challenge power imbalances or oppressive circumstances in a variety of contexts (Andersen & Collins, 2004; King, 1995; Maguire, 1987). Feminist researchers have historically questioned how knowledge is generated and the extent to which dominant narratives can be oppressive to others (Kleinman, 2007). For example, regarding participants in this study, a dominant narrative consists of depicting mothers involved with the child welfare system as uncooperative and uncaring about their children. Feminist researchers also recognize the privilege and power they have based on their positionality based on characteristics such as gender, ethnicity, SES, and sexual orientation (DeReus, Few, & Blume, 2005; Lather, 1988; McDowell & Fang, 2007). Thus, researchers should use their power and privilege to advocate for others with less power, particularly by privileging their voices and their interpretations of various life experiences. Advocating for participants is an important purpose for feminist researchers and that their research improves the lives of participants (Maguire, 1987). Feminist researchers will work to establish non-exploitive relationships with recruitment sources and participants.

Participants and Recruitment

Sampling

Participants were recruited primarily through a clinician who has a contract with the State of Michigan to provide counseling services to parents involved in the child welfare system. The researcher accessed this strategy of recruitment through a personal and professional relationship with the therapist. Specifically, the clinician provides individual and family-based counseling to women involved in the child welfare system with the purpose of enhancing their parenting skills and the quality of relationship with their children. However, great care was given to prevent coercion, as participants experienced a professional relationship with the clinician. When original recruitment activities did not generate a sufficient number of participants, additional participants were recruited through a flyer distributed to other therapists.

Recruitment Activities. Participants were recruited by utilizing a sampling selection process of mothers with current or former involvement in the child welfare system and therapeutic services. Specifically, the clinician provided her clients who met the study criteria with information about the study and asked them if they were interested in participating in the study. Participants who were interested in the study signed a consent form indicating they would like the clinician to provide their contact information to the study PI. The PI then directly contacted potential participants to invite them to participate in the study. The clinician did not know if clients participated in the study or not. This reduced the potential risk for coercion to the study and concerns that participation would influence participants' therapeutic services. Because there was a risk of coercion based on the professional relationship that participants have experienced with the clinician, it was highlighted to participants that their therapist would not have access to any of the identifying information of the participants. In addition, participants were offered the following options to withdraw from the study: (a) Decline participation after receiving the first invitation, (b) decline participation by phone, email, or letter, and (c) decline

participation after receiving compensation. Participants received a $25 gift card to a local store of their choice (Wal-mart, Meijer, Kroger) as compensation for participation in the study. Participants also received a psychoeducational pamphlet on trauma symptoms and coping strategies created by the researcher.

Inclusion Criteria. In order to participate in the study, each participant: (a) had an open or closed (no older than 10 years) child welfare case, (b) had an open therapy case (c) reported a trauma history of child abuse, neglect, and/or domestic violence as defined by Briere and colleagues (2009), (d) was the biological mother of at least one child, (e) maintained a relationship with at least one biological child that allows for frequent engagement in parenting practices. Specifically, participants must report at least one weekly visitation with their children, (f) was 18 years of age or older, and (g) provided consent to participate.

Exclusion Criteria. Participants were excluded from the study if they: (a) reported intense psychiatric problems that will seriously impede data collection activities (e.g., active hallucinations, intense suicidal crisis, etc.), or (b) refused to provide consent to participate.

Sample Size. Grounded theorists often use the concept of saturation to determine whenever a sampling procedure has led to the generation of sufficient data that can be used to generate a useful an integrative theory of the phenomena under study (Denzin & Lincoln, 2000; Glaser & Strauss, 1967; Morse, 1995). Specifically, Bowen (2008) defines saturation as:

> …bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy. In other words, saturation is reached when the researcher gathers data to the point of diminishing returns, when nothing new is being added. (p. 140)

A large sample size by definition does not necessarily benefit a study with new concepts. Thus, saturation determines sample size according to the heterogeneity of the population, the

characteristics of the inclusion criteria, data collection procedures, and the complexity of phenomena under study (Ritchie, 2003). Saturation is essentially achieved when new data contribute little or nothing to the understanding of previously collected data. Based on previous qualitative studies with similar samples, we estimate that the optimal sample size for the current study should consist of a minimum of 15 women (Mason, 2010). However, due to recruitment difficulties, 12 participants were recruited for the study.

Procedures

Theoretical Sampling

Theoretical sampling involves collecting data and recruiting participants based on concepts that are theoretically relevant to the evolving theory (Strauss & Corbin, 1990). Strauss and Corbin state that, "the aim of theoretical sampling is to sample events, incidents, and so forth, that are indicative of categories, their properties, and dimensions, so that you can develop and conceptually relate them" (1990, p. 177). Theoretical sampling allows the researchers to deepen their focus and to accumulate variation in the data. Denzin and Lincoln (2000) further describe the need for theoretical sampling to ensure that a grounded theory is comprehensive, "theoretical sampling helps us to define the properties of our categories; to identify the contexts in which they are relevant; to specify the conditions under which they arise, are maintained, and vary; and to discover their consequences" (p. 519). In the current investigation, theoretical sampling was implemented to ensure that participants can provide comprehensive responses to the main research questions.

Participant Selection and Scheduling

The recruiting clinician provided the PI with a list of potential research participants who were then be contacted by the PI and asked to participate in the study. They were informed of the

potential benefits and risks of participation. All participants were clearly told about the risk for participation based on coercion due to the professional relationship with their therapist. Thus, confidentiality issues were clearly addressed with participants, as well as the fact that they could withdraw from the study at any point using the previously described methods (e.g., voicemails, emails, etc.).

When an individual agreed to participate in the study, they were asked days and times when they were available for a 2-hour interview during which they would complete an interview and assessments. Participants were asked to meet for an interview at one of two confidential locations suggested by the PI. However, participants generally struggled with finding transportation. As a result, towards the end of the study participants were offered the option of having the researcher come to their home for the interview.

Data Collection

The day of the interview, the PI greeted participants and initiated the process of informed consent by providing participants with a paper copy of the consent form, ensured that participants could read it, and answered any questions they may have about the consent document. The requirement of signed consent was waived by the IRB to further ensure participants privacy. After participants provided verbal informed consent, a copy was given to them to use as future reference (see appendix A). Next, participants completed a demographic questionnaire, BSI, and AAPI-2. They were told that the purpose of completing assessments was to better inform the interview process. The interviewer briefly scanned the results of these inventories to inform probing during the semi-structured interview (e.g., high scores on specific domains).

Self-Report Questionnaires. Two self-report questionnaires were used to inform the interview process. These are described below.

Brief Symptom Inventory (BSI). The BSI is a self-report scale that measures an individual's level of psychopathology (Derogatis & Melisaratos, 1983). It consists of 53 questions related to various psychological symptoms. Participants rate items on a 5 point scale from not at all to extremely, based on the extent to which they experience symptoms (1983). The BSI also includes three global scales that measure general severity of symptoms, frequency of symptoms, and intensity of distress (1983). Dimensions of the BSI have internal consistency Cronbach's coefficient alphas ranging from .75 on the psychoticism scale to .89 on the depression scale. BSI scales have convergent validity with those of the Minnesota Multiphasic Personality Inventory (MMPI) (Boulet & Boss, 1991).

Adult Adolescent Parenting Inventory-2. The AAPI-2 measures an individual's parenting beliefs on several domains (Bavolek & Keene, 1999). This assessment compares an individual's parenting beliefs to those of the general population regarding expectations for children, awareness of children's needs, beliefs on corporal punishment, as well as roles and boundaries in the parent-child relationship. The format of the inventory is a 5-point likert-type scale on which respondents agree or disagree with 40 statements regarding parenting beliefs. Chronbach's Alphas for each scale are $\geq .65$ (1999).

Interviews. After completion of the questionnaires, two audio-recorders (one to be used as a back-up) were started to initiate the conversation according to the semi-structured interview format (see appendix B). A semi-structured interview was advantageous for this study, as opposed to a formal structured interview, because it allowed the interviewer to let participants'

responses guide the interview process and reach a deeper understanding of their experiences (Glaser & Strauss, 1967; Wimpenny & Gass, 2000).

The interview first began with basic rapport building between participant and interviewer. The researcher initiated the interview with validating participants' difficult experiences in the child welfare system. The researcher was also transparent about her own experiences as a therapist working with child-welfare involved families and the challenges she has witnessed. Highlighting the researcher as an advocate was essential to establish trust with participants and allowed participants to be comfortable in describing their difficult experiences. Participants were reminded that they can take a break from answering questions or withdraw from the study at any time. The interview was considered semi-structured because it included selected grand tour questions that were asked to all participants, however the interviewer will use various probing questions based on participants' answers. Probes determined by the PI were used only after all participants' initial responses were explored in depth.

Data Management. Each interview was digitally recorded and transcribed. This allowed the PI to carefully code and analyze participants' narratives. The PI transcribed all of the interviews in order to gain a deep understanding of the data. According to the grounded theory approach (Strauss & Corbin, 1990), data collection and analysis occur concurrently. That is, the interview guide was gradually adapted according to the emerging themes that are particularly relevant to participants in order to ensure that their most relevant life experiences are adequately captured throughout the data collection process. Analytically, this was be accomplished through the constant comparative method and sequential data coding (Strauss & Corbin, 1990).

Data Analysis

Overview

This study followed a modified version of the grounded theory approach (Strauss & Corbin, 1990). Specifically, grounded theory methods used for data analysis included the constant comparative method, sequential coding, audit trial, and triangulation (Strauss & Corbin, 1990). Data analysis was computer-assisted utilizing Nvivo software (QSR International, 2010).

Constant Comparative Method

Data analysis consisted of two core processes: (a) Sequential comparative analysis of data, and (b) integration of a theory by engaging in a process of permanent reflexivity (Strauss & Corbin, 1990). The constant comparison method was a critical component of these processes (Glaser, 1978, 1992; Glaser and Strauss, 1967; Strauss and Corbin, 1994). Bowen (2008) outlines the four stages that characterize the constant comparison method: "(1) comparing incidents applicable to each theme that emerges from the data, (2) integrating themes and their properties, (3) delineate the theory, and (4) writing the theory." (p. 139). Through the constant comparative method, researchers ensure an appropriate fit between the data and emerging concepts and theory (Bowen, 2008; Glaser, 2002; Glaser & Strauss, 1967). The constant comparative method also seeks for unique data that clearly contrast with the emerging theory (Glaser & Strauss, 1967).

Triangulation

Triangulation refers to the utilization of multiple sources of data to ensure adequate interpretation, comprehensiveness, and consistency of the data (Cohen & Crabtree, 2006). To facilitate triangulation of the data, two questionnaires were used to evaluate domains that were explored in the qualitative interview. These instruments were the Brief Symptom Inventory (BSI) and the Adult-Adolescent Parenting Inventory (AAPI-2).

Data Coding

Transcriptions of the data were analyzed according to a sequential process involving open, axial, and selective coding (Strauss & Corbin, 1990). The PI led all coding procedures and consulted with Dr. Parra-Cardona to enhance trustworthiness of the data. Data analytical procedures are described below.

Open coding. Open coding is the first stage of the grounded theory coding process (Glaser; Strauss & Corbin). Open codes can be defined as having the purpose, "to reduce the mass of largely textual data into manageable groupings" (Bowen, 2008, p.144). During open coding, data are assessed for their meaning and relevance to the phenomena being studied. Categories are then formulated along with specific properties of the data. The unit of analysis for open coding in this study was each individual idea as coding individual paragraphs carries the risk of missing critical data (Strauss & Corbin, 1990).

Axial coding. Axial coding is a secondary phase of coding in which open codes are grouped together to create larger categories. After open coding has provided an initial but large categorization of data, the researcher integrates more refined categories of data during the axial coding process (Strauss & Corbin, 1990). It is at this point during the data analysis that the researcher begins forming initial relationships among concepts as well as integrating an emergent theory (Ralph, 2005).

Selective Coding. Selective coding refers to the final stage of the data coding process (Strauss & Corbin, 1990). Specifically, the researcher formulates a theoretical narrative that underlies the main findings of the study according to integrated categories. Thus, selective coding integrates components from open and axial coding and creates additional information that further refines and develops the grounded theory. Selective coding is essentially a higher level of

conceptualization of the data that determines the overarching storyline and relates larger categories to one another around core categories (1990).

Memo Writing

Throughout the data collection and analytical processes, the PI wrote notes regarding personal ideas and reactions to the data, as well as emerging categories and theoretical notions (Strauss & Corbin, 1990). Memo writing is critical to the research process to closely monitor the major factors that influence the process of generating the theory that is expected to be grounded in the data provided by participants (1990). It is recommended to utilize memo writing throughout the research process (1990). For example, in qualitative research it can be easy to get 'lost' in the data. Thus, memo writing can help the researcher move from the raw data to abstract conceptualizations of emergent theory (1990). Reflections in the current study were shared with Dr. Parra-Cardona to enhance trustworthiness of the data.

Trustworthiness of the Data

Trustworthiness of the data refers to the extent to which research findings accurately reflect the essence of a phenomenon under study (Baker et al., 1992). The specific dimensions of trustworthiness will be described below.

Credibility. Credibility refers to how believable research findings are (Lincoln & Guba, 1985). Several strategies can be used to enhance credibility. For example, peer debriefing was one technique used in this study by consulting with Dr. Parra-Cardona on emerging codes, emerging categories, reflections recorded in memo writing, and methodological decisions tracked in the audit trail. An additional strategy to enhance credibility refers to data triangulation. Thus, the PI used data from the BSI and AAPI-2 assessments to inform structured interviews

(Denzin, 1978; Patton, 1999). Specifically, assessments helped the PI identify critical areas of inquiry that may not have been recognized by solely relying on the interview guide.

Transferability. Transferability refers to the "degree of similarity between sending and receiving contexts" (Lincoln & Guba, 1985, p. 316). Specifically, transferability examines the extent to which qualitative data are limited to a particular context. To achieve this goal, memo writing included a detailed description of the context in which the meanings were created as well as the ways in which such contexts influenced the researcher in the process of gathering and analyzing data.

Dependability and Confirmability. These concepts are interrelated concepts and refer to ensuring that findings are reasonable as a result of implementing adequate methodology (Lincoln & Guba, 1985). Specifically, dependability provides critical methodological information that demonstrates the rigor of the study as well as guidelines to allow for the replicability of the investigation. Thus, an audit trail (Rodgers & Cowles, 1993) was created to keep track of key methodological decisions.

Confirmability assesses the extent to which researcher bias has shaped the findings of a study as opposed to the data shaping the findings of the study. Confirmability is achieved if another researcher, following the same procedures outlined in the study, could arrive at similar conclusions. Several methods will be utilized in this study to ensure confirmability. Specifically, memo writing, methodological audit trail, and sharing emerging categories with Dr. Parra-Cardona enhanced the rigor of the study.

Role of the Researcher

Feminist qualitative methodologists acknowledge the critical role of the researchers' perspectives and biases on the research process (Kleinman, 2007; McDowell & Fang, 2007).

Because researchers are the main tool of data collection and analysis, data are biased according to the researchers' preconceived notions and perspectives. Therefore, I acknowledge my influence on this research process as a white, middle-class, heterosexual, single woman, without children or a trauma history.

In addition, I am also a therapist, therefore my approach to understanding clients' experiences may be different from a researcher who has not had clinical experience with this population. I have sat with many women in similar situations to those in the sample and have heard their extended stories and witnessed the deep emotional pain they have experienced. This allows me to have particular compassion and empathy towards their situation. For example, by being a therapist, I have not been in the authority position that characterizes service providers such as by caseworkers, lawyers, or judges.

Computer Software

After each interview was transcribed into a Microsoft Word document, each transcript was uploaded into the Nvivo qualitative software (QSR International, 2010). Nvivo allows the researcher to code and analyze large amounts of data quickly and efficiently. The software also allows for a fast generation of visual maps of the data. In addition, the software can facilitate the fast reorganization of codes during the complex phases of axial and selective coding.

Ethical Considerations

Research activities began after obtaining full approval from the Michigan State University Institutional Review Board. Careful considerations were given to prevent coercion to participate due to the professional relationship between the recruiting clinician and the participants. This study posed minimal to moderate risk to participants as they have were involved in a therapeutic process aimed at processing their trauma history. However, great care

was given to monitor participants' reactions during the interview process to prevent secondary traumatization in telling stories of abuse. It was highlighted to participants that there were no repercussions if they decided to withdraw for the study at any time, including the fact that they could keep their financial compensation.

Dissemination of Findings.

Findings of this study will be disseminated in several ways to ensure that they have a benefit to the population of interest. Findings will also be distributed among academics of the social sciences and professionals providing services to mothers with trauma and parenting difficulties. Finally, research findings will be used to inform a parenting intervention targeting survivors of cumulative and complex trauma.

Participant Characteristics

The average age of participants was 32.3 years, with a range of 22 to 49 years. The majority of participants were Caucasian (n=9), two were Latina, one was African-American. On average participants had 3 children with a range of 1-6. Half of participants were employed, and slightly over half were in a relationship (n=7). Most participants graduated from high school or received their GED (n=8), while two did not complete high school, and two went on to complete some college. Most participants had an income of less than $15,000.

Table 3.1 Participant Characteristics

Participant Characteristic	Mean (range) or n
Mean Age (Range)	32.3 yrs (22-49)
Ethnicity	
Caucasian	9
African-American	1
Latina	2
Mean Number of Children (Range)	3 (1-6)
# of Participants Employed	6

Table 3.1 (cont'd)

# of Participants in a Relationship	7
Education	
Did not complete H.S./GED	2
H.S. Diploma/GED	8
Some College	2
Income	
< 15,000	8
15-30,000	3
>30,000	1

Chapter 4: Results

This investigation focused on the following specific research questions:

A. What are the most salient experiences of cumulative trauma reported by participants?

B. What are the most salient trauma symptoms reported by participants?

C. How do trauma symptoms influence the participants' parenting behaviors?

D. How do trauma symptoms influence women's interactions with formal social systems (e.g., child welfare, legal)?

E. How supportive are the contexts in which women engage as related to their parenting efforts?

F. What examples of trauma-coping and resilient parenting behaviors are women most likely to report?

All questions were guided by an emphasis on identifying women's testimonies of resilience as a way to understand the multiple ways in which they have overcome adversity in their lives.

Overview of the Grounded Theory

The grounded theory developed in this study resulted from integrating the participants' responses to the aforementioned research questions. Emerging data centered on detailed narratives describing the ways in which trauma symptoms influence the participants' parenting behaviors. In addition, women provided remarkable testimonies of resilience in the face of intense adversity.

According to participants, their trauma histories did not center on isolated events, but rather, on the accumulation of traumatic experiences throughout their lives. Types of trauma

women experienced included poverty, the removal of their child from their care, intimate partner violence, sexual trauma, childhood abuse and neglect, parental substance use, death of a family member, and various injuries and health challenges. Women's cumulative trauma was evident to women as they reported attempting to manage multiple distressing trauma symptoms in a variety of contexts. A bidirectional relationship exists between women's trauma and trauma symptoms. Not only does trauma history lead to the development of trauma symptoms, but trauma symptoms can make women vulnerable to on-going trauma. For example, if a woman has a negative view of herself, she may be more likely to stay in an abusive relationship.

A bidirectional relationship also exists between women's trauma history and the contexts they exist in. The most immediate of these contexts refer to interactions with friends, family, partners, caseworkers, and other professionals trauma history influenced women's relationships, and women's relationships were sources of on-going trauma.

A bidirectional relationship exists between women's contexts and their trauma symptoms. For example, women reported multiple health and mental health problems that have negatively impacted their professional lives, parenting experiences, and intimate relationships. Participants also expressed that many of their symptoms and coping responses are not adaptive and place them at higher risk for victimization. Substance abuse was identified by several participants as a coping mechanism and a risk factor for engaging in abusive relationships. . Trauma symptoms, in turn, led to negative parenting behaviors of exposing children to unhealthy relationships, reduced quality and amount of interactions with children, hypervigilence about children's safety, difficulty setting limits, and abusive, neglectful interactions.

Supportive relationships play a critical role in participants' lives. Specifically, particularly important for women were close relationships with friends and relatives who

provided both emotional and instrumental support (e.g., emotional encouragement, financial help, shelter). Case workers and other formal service providers were also identified as supportive by women. Women's supportive relationships had a bidirectional relationship with their ability to cope with difficult experiences and make progress in trauma recovery. However, it should be noted that participants highlighted the fact that their relationships with family members can be particularly challenging, as they can both support and hinder their quality of life.

This theory demonstrates the duality of women's relationships as both supportive and unsupportive. All contexts, with the exception of other professionals, were characterized by both relationships that at times supported women, but also were frequently unsupportive and sources of trauma. These relationships were interconnected with one another. For example, if a caseworker interacts with a friend or family member who has a conflictual relationship with the mother, this interaction can have a detrimental effect on the mother if the caseworker develops an alliance with the friend or family member that is not conducive towards empowering the mother.

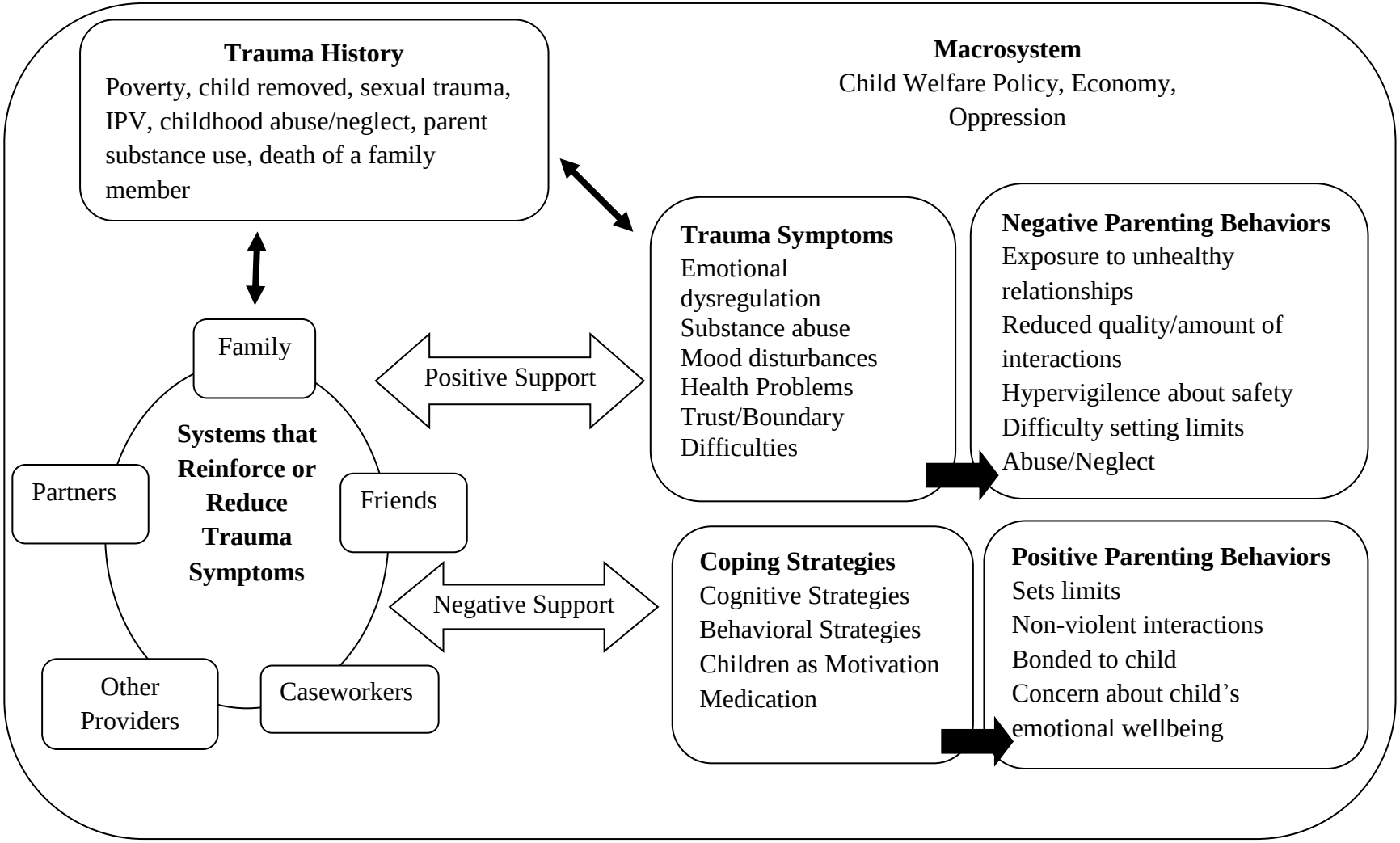
A set of findings that are particularly relevant refer to participants' clear testimonies of resilience, which demonstrate a remarkable capacity to recover from trauma and adversity. In addition to having a personal impact, participants' resilient behaviors also have a bidirectional relationship with women's contexts. Coping and recovery also facilitated positive parenting behaviors of setting boundaries, non-violent parenting strategies, parent-child bond, and concern for child's emotional well-being.

Although the guiding research questions in this study did not focus primarily on analyzing macro-level variables, present findings demonstrate the ways in which variables such as the larger economy, lack of employment opportunities, and inefficiencies in the welfare

system become important barriers in the lives of participants, and at times can also become precursors of trauma symptomatology.

Overall, the grounded theory resulting from this investigation indicates that although cumulative trauma can have pernicious and long-term consequences on the health and mental health of women, such intense adversity can be overcome if participants are surrounded by supportive personal relationships and systems of care, capable of fostering their personal strengths and sense resilience. Figure 4.1 provides a graphic display of the emergent grounded theory, which will be explained in the detail as detailed data are reported for each of the guiding research questions. Pseudonyms are used in quotes to enhance participants' anonymity.

Figure 4.1 Grounded Theory



Findings of Research Question A: What are the most salient experiences of cumulative trauma reported by participants?

All participants reported multiple traumatic experiences in their lives, as well as extremely challenging life events and relationship conflicts. For example, women expressed being negatively impacted by some form of intimate partner violence (IPV) including emotional, mental, and physical abuse. More than half of the participants survived some form of sexual trauma during their childhood, adolescence, or adulthood. Six participants experienced neglect in their childhood including physical and emotional neglect. Four participants lost a significant family member, which they identified as traumatic. One participant lost her parent and three lost their brothers at a young age. Two participants were removed from their parents' custody during childhood. Table 4.1 provides an overview of how many participants experienced each type of trauma.

Table 4.1. Trauma Experiences

Trauma Experience	n
Poverty	12
Removal of Child from Home	10
Intimate Partner Violence	10
Sexual Trauma	7
Childhood Neglect	6
Death of significant family member	5
Parental Substance Abuse	3
Physical Abuse by parents	2
Removed from parents	2

Poverty. According to participants' reports, the totality of women in this sample were impacted by poverty at various phases throughout their lives. When asked about difficult life experiences participant #5 stated, "Well I say central to all of it is poverty", meaning that managing finances with a low income was a contributing factor to the difficult experiences she

had throughout her life. She went on to explain the financial strain associated with limited health care:

> We're very low income. When my son DHS removed my son, I lost my Medicaid., I'm not young, I don't have severe health problems, but I have issues that I need to see a doctor regularly for. If I don't have insurance, that's 40 bucks a pop that I don't have. You know, and then I need prescriptions, you have to pay for those too. Medicaid is a wonderful thing. I'm grateful I have it because I would be lost without it. I hope I never lose it again

Other participants discussed facing challenges such as difficulty finding employment and maintaining stable housing. Due to unemployment, participant #3 and her husband lived with roommates who assisted them with living expenses. However, this left them vulnerable to being taken advantage of:

> Me and my husband we both have had people take advantage of us. With one of, who was supposed to be a friend, we let her stay with us; and then she turned around lost her rights to uh, her son; and then she moved out and she was supposed to give us money for staying with us, help us with food, and she just moved out and completely screwed us with bills and rent and everything.

Participant #11 discussed some of the difficult experiences related to poverty. In order to keep a house she inherited, her brother-in-law lived with her and her family. As a result, her children were exposed to his drug use. She described resentment towards him for "Bringing crack into my house, smoking it. Not giving any regards to the fact that I have two small children in the house." She went on to describe how she ended up losing the home regardless of his financial help:

> Granted, I didn't have to pay rent, but I did have to pay taxes on the house because I inherited the house. I kept that house for 12 years, and we put a roof on it, and then something else would break. I just couldn't, I couldn't afford it anymore.

Removal of Child from Home. All but two of the women had their children removed from the home and placed into foster care. Although those two were still involved in the child welfare system they were able to maintain physical custody of their child. In this study removal of the child from the home is conceptualized as traumatic, since most women noted that this was an extremely difficulty experience for them. The event of child welfare workers physically removing the child was especially traumatic for women.

Intimate Partner Violence. Intimate partner violence (IPV) was frequently experienced by the majority of the participants (n = 10). Specifically, women described experiences of physical, emotional, and mental abuse by their partners. For example, participant #10 described the controlling behaviors of her ex-husband:

> The father of my kids was abusive and controlling, and after getting married, he became very controlling, to the point where he took my truck apart so I couldn't go anywhere when we fought. He also broke my cell phone.

Participant #2 described the threats that she received from a former partner after she decided to end the relationship, "That [ending the relationship] upset him really bad. He called my cousin and threatened her because he was upset that I wouldn't speak to him. He was gonna run in her house, then shoot up all the kids." At the time of this incident, this participant's daughter was living at her cousin's home. Subsequent to his threats, the daughter was moved to an unfamiliar foster home due to safety concerns. This was particularly distressing to the mother because her daughter's placement was a consequence of her former partner's behavior, which was out of her control.

Violent episodes were described by several participants. For example, participant #5 described a violent incident with her partner that occurred earlier in her life before she met her husband and had a child with him:

> The last night I was there we got into some kind of altercation. I'm layin' on the bed and he's on top of me with his hands on my shoulders, and he's basically daring me to hit him. He spit in my face, and that was it.

Participant #2 described a violent situation with a firearm:

> So he came in one day, I was in the room with my daughter and he pulled out his gun, started throwin' me around the room, pointed the gun in my face, cause he thought I was, I don't know another guy or something, I don't know.

In addition to violent situations, women also reported taking action to end abusive relationships, as participant #11 described:

> The last partner I had, we used to get into fist fights. He was an alcoholic. I always went for the bad boys, you know. Two years of being mentally and physically abused was enough, I wasn't gonna take it no more. I was done. I fought back, threw his shit out of the house, and got a restraining order on him.

Sexual Trauma. More than half of the participants reported sexual violence perpetrated against them by their fathers, relatives, and friends. For example, participant #3 described, "The one main difficult thing that I had when I was growing up was when my stepdad molested me when I was about 10." Participant #1 was removed from her parents and adopted, "Cause my dad was molesting me and my brother". Participant #9 also reported a sexual trauma, as she described:

> I ended up getting placed with a home and my foster dad raped me. It was just me and the foster dad a lot, like I said it ended up turning into something awkward and weird. I just didn't wanna be there, and instead of tellin' somebody while I was in the home, I just acted out and didn't go to school. Then they ended up movin' me outta the home.

Participant #4 was sexually assaulted by her father and a family friend on separate occasions. Participants #10 and #12 were raped by a family friend, while participant #11 reported that she was molested by an uncle.

Although a majority of participants reported intense trauma resulting from sexual victimization, two participants reported details of how these experiences were particularly

damaging because others did not believe the victimization they suffered and there were no actions to prosecute the perpetrators. Participant #4 described how this affected her:

> I felt completely unprotected. I felt like I was better than that you know, and I became very depressed at that time. It was very difficult for me because I felt dirty. Afterwards, I just kept quiet and tried to avoid him.

Participant #9 also described her experienced:

> I ended up telling CPS about it and I believe all they did was to take their foster care license and that was about it. That was about it. I don't even know if they quite believed me. Actually, his wife ended up getting the phone number to where I was at and actually called me. She was calling me a liar and I hung up on her and never heard from them again. It was a while later that I did end up sayin' something, and I think that affected the way that DHS reacted to the allegations.

Childhood Neglect. Participants' experiences of neglect were multiple and varied in nature. For example, participant #4 was neglected based on her parents' failure to protect her from a sexual assault and subsequently avoided to take steps to report or prosecute the perpetrator. She described:

> Um, this neighbor who was a buddy of my stepdad's um, he asked me if I wanted to go snow mobiling, well it was something that I hadn't done in a long time. So I went snowmobiling with him, and he tried to assault me and um, my stepfather wouldn't do anything, nothing, nothing was done.

Participants #5 and #6 described feeling emotionally neglected by her parents. Specifically, participant #6 described her upbringing as characterized by 'tough love' as her parents did not provide nurturing support. She eventually was 'kicked out' as a teenager and moved into an Independent Living Program (ILP) for teens:

> My parents were tough love kind of people and I didn't respond well to that. So, I moved out and went to an alternative education program, and lived in a house called Crossroads [Independent Living Program]. They teach you how to live on your own, and stuff like that. Then I moved into my aunt's house and went to alternative education. I graduated from there and um, then I moved back in here when I was about 18 or 19

Other forms of neglect referred to lacking adequate monitoring and supervision, as participant #9 stated:

We were left home alone quite a bit. During my childhood I had no rules and no authority. Both my parents, I don't think they even cared about what we were doing. My mother left when I was seven and my dad raised us for a couple a years, um, till I was about 9 and we got placed in foster care and then I became a ward of the state.

Participant #2 remembered that her father did not set limits with her because he was struggling with addiction:

> My father was using heroin, so he was always sleeping in his room. So, there was never really no boundaries there. I hung out with my friends as late as I wanted, and did what I wanted. It was never really dangerous or anything we just, I never had boundaries, rules like curfew.

Participant #11 discussed how the death of her brother made it difficult for her mother to be emotionally available, "My mother, after my brother passed, was there physically but not mentally. So I basically grew up on my own, grew up in the streets, did what I wanted to do." Because her mother wasn't able to set limits, Participant #12 started using drugs after her brother's death.

Parental Substance Abuse. Several participants' parents abused substances, which exposed participants to inappropriate behaviors and neglect during their childhood. When talking about her parents, participant #2 described:

> My dad and my mom were into drugs really bad. He straightened out till I was about 7, then started doing drugs again. So it was like, he was always in his room high. I really didn't understand he was back into drugs until I was about 12, but he had been since I was about 7. He had started back up and I was too young to understand that until I was about 12. That's when I would find bloody needles in drawers. Then I figured it out.

Participant #10 described her mother's alcohol use by affirming that, "She was a drunk, and so my brother took care of me most of my life." Participant #9 described neglectful behavior while her parents were using substances:

> My parents were always drunk and drinking. As long as we were outside playin' with our friends, they really didn't care what we did. I was out terrorizing the neighborhood. I burnt down a garage, we were out smoking. We were doing everything bad.

Physical Abuse. Two participants experienced physical abuse as children, which had pernicious effects including conflictual relationships with their fathers into adulthood. Participant #9 described the consequences of her father's physically abusive behavior, "He didn't hit us a lot, but he left bruises where it was noticeable to school, so school ended up reporting it."

Participant #11 also reported her father was physically abusive to her, her mother, and siblings. To illustrate her pain and lack of respect towards him, she referred to him as "The Sperm Donor" to her mother, rather than as her father.

Removed from Parents. Three participants reported growing up while involved with child welfare services. For example, participant #1 was adopted at a young age due to sexual abuse by her father. Participant #10 was removed from her parents based on their drug use, as she expressed:

> I was too young to even remember, but my dad would tell me that the courts were involved and my mom and dad were into drugs really bad. So the court said that either you straighten that out or they were gonna take me. So my dad did, but my mom wouldn't so he took me from her.

Participant #9 was removed from her father due to physical abuse and neglect. After his rights were terminated, the participant was relocated to several foster and group homes until she eventually aged out of the foster care system.

> Um, I well, first I um, my mother left when I was uh, 7, my dad raised us for a couple a years, um, till I was about 9 and we got placed in foster care and then became a ward of

> the state. That's pretty much the gist of it. Well that and then, I really, I went through several foster homes, but most of the time in foster care I did in group homes.

This participant further explained that while in group homes and foster care, it was difficult to trust adults and have meaningful emotional connections because she did not trust any of her foster parents. She believed that if she had caregivers who were genuine, she might have been better able to take their guidance. Based on her own experiences in the child welfare system as a child, she felt especially guilty for having her children removed from her care.

Child Welfare Involvement. Many of the women viewed removal of children and involvement with the child welfare system as a traumatic experience. Participant #8 affirmed that, "The worst thing I've been through in my life is having my kids taken, and the situation I'm going through right now with DHS." Two parents reported that their children were harmed while they were in foster care. Participant #8 described an event when a Euro-American foster parent cut her African-American daughter's hair because they did not know how to care for it:

> Listen, they cut her hair bald, ok. So, I'm, uh, I talked to my caseworker about it, well they're not supposed to cut it, she said, well they're not supposed to do that, so I'm like, what made them do that? I mean they couldn't do her hair, I said well, I will do it! You know. I will do it. So they took upon themselves to when they're in foster care, they took it upon themselves and cut my daughter's hair.

This event was extremely distressing to the participant. She described many instances in which she felt powerless as a parent due to child welfare involvement. This was one of the most difficult events she experienced. Furthermore, this mother reported intense frustration by not being able to do anything about what happened, particularly because there were no repercussions for the foster parents.

Participant #2 described her intense emotional reaction when DHS came to remove her daughter:

> When they came and took her, yeah I was angry. I was so angry when they put her in the car, I followed them. They had to like pull her from me cause I wasn't gonna just hand her over. Did they expect to be ok with that? Like, oh yeah here take her, bye. I just, I didn't understand. It didn't make sense.

Participant #12 reported that the length of time she was involved with the child welfare system was particularly challenging. Due to her struggles with managing her child who has a mental illness, she has been involved with the Department of Health and Human Services (DHS) for intermittent periods of time throughout 10 years. At the time of the interview, the court system mandated a no-contact order between her and her partner due to intimate partner violence. She reports that this forced separation has been especially difficult for her and her family.

Death of Significant Family Member. Several participants experienced the death of a close loved one and viewed the experience as traumatic. One woman's child was murdered after her rights were terminated. Three participants lost a brother at a young age. For example, participant #4 lost her brother due to an over dose, "I've read part of the police report. I was told that in the autopsy police report it says that he died from an overdose."

Participant #11 also experienced the loss of her brother due to an overdose. She reported that this loss led to her intense use of drugs throughout high school. Participant #10's brother committed suicide. This was especially traumatic for her since her brother was a parenting figure in her life. Participant #2 lost her father, her primary caregiver, when she was 16. She reported that she responded to this with acting out behaviors including drug use and sexual activity:

> His liver failed. It was Hepatitis C. He was the only one there so when he was gone I was angry. I acted out really bad and got pregnant when my dad passed away, because it was like my dad's gone can't nobody tell me what to do now. Not like he really did so much before, but while he was around it was always in the back of my head, is what would my

> dad think about, you know, this, or you know before I did anything. So once he was gone it was like, it doesn't matter what anybody thinks anymore. So I acted out. I would drink and smoke weed

Participant #10 described how her brother's suicide impacted her:

> Yeah, my brother committed suicide. That happened about 5 years ago, and just watching him in the hospital bed kinda took a toll on me. Now I have nephews that I don't get to see because of all the stress that went on with my brother.

Physical Injuries. Participants also reported physical injuries and accidents that negatively affected their interpersonal relationships. For example, participant #11 described how a car accident challenged her core sense of safety. This accident also left her physically disabled and unable to work:

> Once the car accident happened, I was not able to get up, go to work…I had to be helped up off the couch, not being allowed to sleep in my bed because I can't get out of my bed, yeah, it, it just changed my whole life.

Although the participant was affected by this accident physically, she also reported psychological symptoms of anxiety due to a decreased sense of safety. She also reported this accident compromised her ability to trust others because the driver in the other vehicle fled the scene after the accident.

Participant # 2 also suffered injuries from a car accident during her pregnancy:

> There was a stop sign hidden behind one of the bushes and we didn't see it until it was too late. We got hit by a big truck. It hit my door and I wasn't wearing my seat belt, so my door bent in half and I flew from the car. This happened two weeks before I was supposed to have my daughter. I was knocked unconscious, I broke my ankle, and there was big chunk of glass that stabbed me in my side. They airlifted me to the hospital, and I was in the hospital for about a week and a half. I had a c-section, so I never really went through the labor. I went to sleep pregnant and woke up not pregnant, and my daughter was just there.

Other injuries reported by participants were an electrocution accident (participant #4), and complications from kidney surgery due to medical negligence (participant #12).

Findings of Research Question B: What are the most salient trauma symptoms reported by participants?

Participants reported trauma symptoms in six primary categories. All participants expressed difficulty trusting others, which often led to rigid or diffuse boundaries as they establish interpersonal relationships. Most participants reported mood disturbances, predominantly symptoms of depression and anxiety. Six participants reported emotional dysregulation, particularly when it referred to controlling feelings of anger and frustration. Similarly, half of the participants also reported substance abuse histories and having negative views of themselves. Five participants reported a high frequency of health issues including chronic pain, infections, heart problems, and migraines.

Table 4.2. Trauma Symptoms

Trauma Symptom	n
Difficulty trusting others and setting boundaries	12
Mood Disturbances	9
Substance Abuse	7
Emotional Dysregulation	8
Negative View of Self	6
High frequency of health issues	5

Difficulty Trusting Others. The most salient symptomatology reported by participants referred to difficulty trusting others and setting appropriate boundaries in their interpersonal relationship. Participants either had diffuse boundaries, rigid boundaries, or wavered between the two extremes. Participant #1 described her approach to trusting others, "You can only trust somebody to a certain point. The only one you can trust is yourself. You know, yourself is the one who is gonna get you where you gotta go." Although participant #1 described difficulty

trusting others, at the height of her addiction she had extremely diffuse boundaries as she had many people in and out of her home who eventually took advantage of her.

Several participants expressed challenges with being vulnerable to others, as participant #6 described her rigid boundaries, "I'm a wall for sure." Participant #3 also described her tendency to isolate herself, "If I'm in a mood where I don't wanna be around anybody I'll stay in my bedroom while everybody is in the living room." She connected her difficulty trusting other to past experiences, "Because my ex-boyfriend lied to me during our relationship, it takes me a very long time before I trust anybody."

Although participant #3 said that she struggles trusting others, she also described instances where her boundaries were diffuse, as she affirmed:

> We had people staying with us then and they'd just take off and screw us. So given the chance, I think people would take advantage of us. I'm a really kind-hearted person, and can't really say no to some people.

She further explained that she and her husband would let various people stay with them because she felt sorry for them. On several occasions, the people they helped left without contributing to rent or other expenses. This was especially a difficult challenge for her and her husband because they were unemployed and experienced intense financial difficulties.

Participant #9 also reflected on the challenges associated with wavering between rigid and diffuse boundaries:

> I keep people at a distance, and then, if I do let someone get close then it's really, really close where we're together all the time. Even with girlfriends. I'll pick one friend and then we spend all of our time together, we're inseparable. For the most part I keep people at a distance.

Participant #12 explained how her past experiences led to a desire to have extremely close relationships:

> You know, just like having my dad absent, now I struggle with wanting my partner there all the time. I can get clingy maybe out of fear in the back of my mind that they're gonna take off or leave.

With regards to deciding whether or not to trust someone, participant #11 stated:

> I used to be the opposite of what I am now. I have a good heart, and if you need help, I'll do the best that I can to help you. But I don't trust people like I used to. I don't like being around [others]. My gut instinct, it's not there anymore. I trusted one friend, found out some crap that I shouldn't have found out, now I don't talk to that person any more. So just wash my hands, and be done with you. Push 'em away. I ain't got nothin' for you. I'd rather stay in my own crib.

Participants' answers to the Brief Symptom Inventory (BSI), also highlighted a strong trend among participants to not trust others. Although it is critical to analyze these scores with caution to prevent a deficit-based interpretation, one third of the participants had high scores on the sub-scale measuring difficulty to trust others. One third of participants also had high scores on behaviors indicating interpersonal alienation and social withdrawal.

Mood Disturbances. Although the majority of participants struggled with symptoms of depression and anxiety, only four participants had clinically significant scores on the depression scale in the BSI and three on the anxiety scale.

Examples of reported mood disturbances for participants included obsessive-compulsive tendencies, depressed mood, low energy, sadness, and frequent worries. These symptoms were distressing for mothers, particularly if they had a cumulative effect, as one participant affirmed:

> Well when I was drinking I didn't really care about anything. Definitely when I quit drinking and then my husband went to jail, I lost my kids, lost a source of income, heck yeah, I thought I was goin' crazy, like I, oh my gosh, like, my anxiety is out of control, and then they put me on Zoloft for my depression, I went through 4 rehabs, and oh my, it was, it was bad.

When asked if she continues to experience anxiety or depression, participant #11 offered her testimony, "I can check out at any time. I'm not hearing anybody, I'm like in my own little world." Participant #6 further elaborated on the detrimental effects of depression:

> Sometimes I guess it does get in the way of my interactions with Natalie. Like she'll wanna do something and I'm just not motivated. You know, I can't motivate myself sometimes. I'm so tired.

Participant #2 described intrusive thoughts and lack of focus when experiencing anxiety:

> I definitely have racing thoughts. I'll think about a hundred things in like 60 seconds, and then all of the sudden I'll draw a blank and forget everything where I don't even remember where I was. For example, I was going to a doctor's appointment and a lady asked me a question, it was as simple as something like what's your birthday, and I just stared at her like 'what?'

Emotional Dysregulation. Participants described the negative effects associated with a limited ability to regulate their emotions, as well as how extended this symptomatology was as it affected their interactions with family members, partners, children, and caseworkers. For example, when discussing an interaction with a Department of Health and Human Services (DHS) caseworker, a participant expressed, "I went off on them a couple of times verbally, on the phone, then I wouldn't let them say anything and then hung up on them…I did not want to let them get the last word."

Challenges with emotional dysregulation also negatively impacted their parenting skills, in a way that was particularly distressing, as participant #10 affirmed:

> I lost it, and I admit it, I lost it, when they came to me and they asked me what was going on, I told them, I lost it… I'm sitting there telling him [her child] not to pee himself for 2 months, and then he does it as I'm telling him not to and then I expect him to go and get on the bus…I lost it, and he did, he was expecting to walk out the door and walk on the bus, I'm like…"You just peed yourself, what are you thinking?!"…You need a shower a change of clothes and now I have to take you to school!"

Struggles with emotional dysregulation also were expressed through violent behavior as participant #2 reported:

> I would break things. I remember I punched a hole in my wall, I would break my phones, I would be so angry and like I didn't know, where to direct it, how to deal with it, I would just break stuff.

The most distressing consequence of emotional dysregulation referred to the negative effects that these symptoms had on their interpersonal relationships, as participant #11 stated:

> (Referring to her family…) They are all glad that I am on my anti-depressants, because I'm calmer, I'm quiter. Cause I have a big mouth, and I know how to use that mouth. You push me far enough, and I'm gonna strike out at you. If I bite you like a cobra, you better lay down and die cause I'm not gonna stop.

Participant # 3 further elaborated on this issue, providing a clear description of how emotional dysregulation permeated conflict resolution in interpersonal relationships:

> A friend's boyfriend beat on the front door like he was the cops and it woke up the baby. It like made me really angry because we had already asked him not knock like that, and he did it anyways. I literally cussed him out, up one side and down the other. Told him if he ever came to the front door beating on it the way he did, next time I'll probably come out the front door with a baseball bat. After I went off on him, I went downstairs, lit a cigarette and calmed down.

Substance Abuse. Substance abuse was a common and painful challenge for participants. Women also agreed that substance abuse was a way to cope with trauma and other trauma symptoms. Participants reported using a variety of substances including alcohol, marijuana, and methamphetamines. Associated with their early experiences of trauma, substance abuse typically started early in life. Participants who used substances, also reported substance abuse by other relatives in their families of origin. Participant #9 recounted her alcohol abuse:

> Yeah, once I got introduced to the partying and it was like so hard for like, at first it just started off on the weekends you know…But then, it turned into an everyday thing, I'd wake up and start drinking, I mean it spiraled out of control really fast.

Participant #10 described how she used alcohol and marijuana to cope with relationship stress:

> For a minute my drug use was really bad. Then it became just an every once and a while thing, like a joint a day two joints a day and I was good. But at one point when me and the kids' father had split up he had called CPS on, well he had his friend call CPS on me, and she told them that I punch my son in the face, I shake him by his feet, I do this, I do that., That made me real depressed for him to say them things about me. So, I became a bad pothead when I was, still livin' with him at the trailer. I became an alcoholic because of all the stress he would put me under.

For some participants, using drugs became a coping mechanism to deal with loss in their lives, as participant #11 described how drugs helped her to cope with the death of her brother, "I was dealing with it the wrong way, with the death of my brother. Cause that led me into the drugs." Participant #2 described how she coped with the death of her father:

> I acted out really bad and got pregnant when my dad passed away, because it was like my dad's gone can't nobody tell me what to do now you know, not like he really did so much before but while he was around it was always in the back of my head is what would my dad think about you know this, or you know before I did anything. So once he was gone it was like, it doesn't matter what anybody thinks anymore. So I acted out. I would, I would drink and smoke weed.

Negative View of Self. Based on their past experiences, participants reported having a negative view of themselves as they struggled with considering that they were not worthy as human beings, women, and parents. For example, participant #1 developed a negative view of herself based on her past behaviors as she stated, "The feeling of self-worth is always in question. I mean, just because of what I've done in the past."

Participant #5 described a long-standing poor view of herself, "I really had no value, for a really long time I didn't have any value." Similarly, participant #12 said, "I'm down on myself all the time." Participant #6 connected her negative view of herself to recent experiences with child protective services:

> It's hard to view myself positively when you're going through everything in this situation. It's overwhelming at times. Being here now (living with her parents) because without having the child support that I need, and the job that I need and I mean that's demeaning, it's hard to live with your parents and be 30 years old and have a child, it sucks.

Participant #3 initiated contact with DHS to get support. She reported having a negative view of self based on her decision-making, "Sometimes I see myself as a bad mom because I went to them, went to protective services to get help, and they turned around and screwed me." Although half of the participants were able to identify having a negative view of self, most did not see this getting in the way of relationships with children, caseworkers, other professionals, family, or friends. Participant #4 described how her father's abuse affected her view of herself:

> I think it made my self-esteem just very, very shallow. It was very difficult for me to be able to thrive. I was just very shy. I was not outgoing. It really influenced how I saw myself. I felt very small.

Health Problems. Participants described struggles with several health issues. Examples of these challenges were frequent migraines, infections, chronic pain, heart disease, and diabetes. As one participant affirmed:

> I had a heart attack, which I didn't believe that one, but evidently I did. I was having chest pains yesterday, my head hurt yesterday, and Sherry's (participant 11's daughter) like, you wanna go in? I didn't go into the hospital. I should have, but I didn't. I went and I laid down in the bed. I didn't wanna go in. Sitting for 5 hours in the emergency room is not cool. Cause then I get mad and then the anxiety starts.

Participant #11 also describes how health problems affect her, "Not being able to go to work, having to be helped up off the couch, not being allowed to sleep in my bed because I can't get out of my bed. Everyday I'm in pain." Participant #4 described her health struggles:

> I had a complete foot reconstruction. I also had an electrocution accident and so that took away a lot of my mobility. My whole left side was affected, I had 40% of the use of my left hand for, for a while. So um, my mobility is not always the best, um, sometimes it's really hard for me to get up and down.

Participant #6 also struggled with chronic pain, "I have pain all the time. They diagnosed me with fibromyalgia probably about four years ago, but now they're saying its Allers-Downlo syndrome, where my joints pop out. Who knows what it really is."

Cumulative Trauma and Co-occurring Symptomology. Women who experienced more traumatic events reported a higher frequency and intensity of symptoms. These participants also reported low levels of support, more negative views of themselves, and higher incidence of substance abuse. Participants who reported lower levels of trauma, had stronger support systems, higher views of themselves and lower levels of substance abuse.

The co-occurrence of symptomatology was reported by participants as particularly distressing. For example, substance abuse was used as a coping behavior to manage chronic pain or mood disorders. Depression was usually associated with negative self-view. Health complications could also trigger chronic anxiety or depression. Participant #5 described the intersection of emotional dysregulation, anxiety, and substance use:

> Towards the end of my drug use I was nothing but a screaming bitch all the time. I had all kinds of anxiety, knowing that we were eventually gonna get caught. Eventually all the shit that happened (child welfare involvement) was gonna happen if we didn't stop doing what we were doing.

Substance use and lack of boundaries also co-occurred, as the following participant affirmed:

> I'd just let anybody and everybody come in the house. You know, say yes to anything. I was more centered on making other people happy, than making the kids happy. When I was getting high I'd just let anybody and everybody around.

Brief Symptom Inventory (BSI)

Although the BSI can be interpreted from a deficit-based perspective, the measure includes relevant items indicating level of distress and provides a point of comparison to

qualitative data. Interestingly, the frequency of symptoms reported in the BSI was not as high as the qualitative reports of symptomatology provided by participants. Specifically, six participants had clinically significant scores on the obsessive-compulsive domain. Four participants had clinically significant scores on depression, paranoid ideation, and psychoticism domains. Three participants had clinically significalnt scores on anxiety, hostility, and phobic anxiety domains. Two participants had clinically significant scores on Somatization and Interpersonal-Sensitivity domains.

Table 4.3 BSI

Symptom	Participants with a T-Score > 63
Somatization (SOM)	2
Obsessive-Compulsive (O-C)	6
Interpersonal-Sensitivity (I-S)	2
Depression (DEP)	4
Anxiety (ANX)	3
Hostility (HOS)	3
Phobic Anxiety (PHO**B**)	3
Paranoid Ideation (PAR)	4
Psychoticism (PSY)	4

Findings of Research Question C: How do trauma symptoms influence the participants' parenting behaviors?

Individuals in this study developed trauma symptoms that subsequently influenced their parenting behaviors as mothers struggled trusting their children, experienced their parenting skills negatively affected by mood disturbances, and engaged in neglectful or abusive parenting due to factors such as substance abuse or health problems. A brief overview of these challenges are presented in table 4.4.

Table 4.4 Trauma Symptoms & Parenting Behaviors

Trauma Symptom	Parenting Behavior
Difficulty trusting others/ setting boundaries	Worry about children's safety Exposed children to unhealthy relationships (Neglect) Decreased quality and amount of interaction with children (Neglect)
Mood disturbances	Decreased quality and amount of interaction with children (Neglect) Worries about children's safety Difficulty setting limits
Emotional dysregulation	Decreased quality of interactions with children (Neglect & Abuse)
Substance abuse	Decreased quality and amount of interactions with children (Neglect) Exposed children to unhealthy relationships (Neglect)
High frequency of health issues	Decreased quality and amount of interactions with children (Neglect)

Trust, Boundaries, and Parenting.

Hypervigilance about Safety. When asked how difficulty to trust others affected their parenting behaviors, participants described engaging in overprotective behaviors due to increased anxiety about their children's behaviors. For example, participant #3 stated that her sexual abuse history affected her parenting as she became hypervigilant and over-reacting. She provided an example of this type of reaction:

> My daughter was half an hour late one day and I called the school and I had a panic attack. I told them "My daughter's not here, it's been a half an hour." She tells me, 'Calm down, the bus broke down'…I'm like, 'No, I'm not gonna calm down, she should have been here a half hour ago…where is this bus at?'…and I'm on the phone yelling at the

> person… 'Well, here come the bus.'… I hung up on her, ran outside and grabbed Jennifer… I'm like, no more. I'm done with the bus, I will take her myself.

Children Exposed to Unhealthy Relationships. Mothers reported engaging in neglectful behaviors due to difficulty with setting boundaries and failing to protect children from being exposed to unhealthy relationships and behaviors. For example, participant #1 described her failure to protect her children:

> I'd just let anybody and everybody come in the house. You know, say yes to anything. I was more centered on making other people happy, than making the kids happy. When I was getting high I'd just let anybody and everybody around.

***Decreased Interaction with Children*.** Two participants also found that their tendency to isolate themselves decreased the amount and quality of interactions with their children and significantly increased the risk of parental neglect. For example, participant #1 noted that she tends to isolate herself because it is difficult for her to trust other people. This leads to an experience of loneliness and increased risk of parental neglect, as she affirmed:

> I think sometimes the part about being lonely and everything is because I keep to myself…And I, but I don't want that for my kids…I'm trying but I might not interact the way I'm supposed to with them… I might just let them play and do nothing with them.

Mood Disturbances and Parenting.

Decreased Energy and Desire to Interact with Children. Mothers with depression symptoms found that depression impaired their parenting behaviors by decreasing their energy levels, which in turn made it more difficult to interact with their children. For example, participant #6 described the exhaustion she experienced resulting from depression, which in turn hindered her ability to interact with her child:

> Sometimes I guess it [exhaustion and depression] does get in the way of me and Natalie. Like she would want to do something and I'm just not motivated. You know, I just can't motivate myself sometimes, I'm just like, I'm so tired.

Participant #9 explained how depression was linked to parenting:

> I became a parent way too early. I think depression and anxiety from that are why I just clung on to drinking. I was just tired of taking care of the kids. I was tired of not really having a life.

Difficulty Setting Limits. Due to various health symptoms or mood disorders, mothers reported a marked decrease in energy, which also impaired their ability to adequately monitor their children and establish consistent and clear limits with them. As participant #10 acknowledged, "I gotta say I let the kids get away with a lot more." Participant #6 further described how her parenting was impaired due to chronic anxiety:

> He is a very smart kid and he, he's a manipulator….and he is just a kid…but yeah, he is one of those kids who will keep pushing and pushing and pushing…. and back in those days, after about 3 pushes, I was like 'Fine, fuck, whatever!'… you know, and that's no way to parent a child and that's one of the things I had to realize".

Participant #11 described how her mood related to increased physical altercations with her teenage daughter:

> They saw me with my anti-depressants and then they saw me for five months without them, and everybody was glad when I got back on 'em. I was real irritable. Me and Sherry used to get into a lot more fights than what we have been. And that, that shouldn't be like that. She shouldn't try to take a swing at me, and I shouldn't try to knock her out.

Emotional Dysregulation and Substance Abuse Leading to Abuse and Neglect.

Mothers' lack of coping skills was commonly associated with emotional dysregulation during difficult parent-child interactions, which in turn significantly increased the risk for parental neglect or abuse. For example, many mothers acknowledged blaming their children for 'triggering' their anger. Mothers who struggled with regulating their emotions also accepted their tendency to perceive their children as having a 'difficult temperament.'

Participant #10 provided a vivid account of a painful reality for many mothers in this study:

> As I was lecturing my kid and telling him not to wet himself…but he wet himself, right, standing right in the living room. And I lost it. I whooped his butt with a belt and left marks, so when he went to his dad, he told his dad about it…. And apparently putting him on the toilet and making him look, this is where you pee, for a half hour, they call that child abuse.

Participant #11 further elaborated on this struggle by describing how losing control of her emotions would lead to harsh parenting practices:

> I try not to let it [emotional dysregulation] get in the way, but there, there are times where it, it is in the way… I'll just start fighting with my children or arguing with them… and making them feel bad because I feel bad."

Participant #6 described her difficulty controlling her emotions when facing her child's defiance, a problem commonly shared by participants:

> She's very defiant, so it is difficult, and she knows how to push my buttons. So, it is very hard to get her, and to set limits with her, and to know how to deal with it and, so yes, it is very difficult.

Substance Abuse Precipitating Neglect. Participants reporting substance abuse, were also able to identify how their addiction led to situations of neglect and abuse, as one mother described:

> There were a lot of times when I'd get drunk and come home from the bar at like 2 or 3 o'clock. The kids would have school and I would just be screaming, waking them up because I did not want to be sitting downstairs drunk by myself.

The same participant further described how abusive situations alternated with neglect, a painful reality shared by participants struggling with addictions:

> When I was drinking, I wanted to run around with everyone else who was drinking. Wherever they went, I went and I pushed the kids to the side; because nobody wanted to sit home and take care of kids with me. You know, so, it was always let's run around, so the kids did get pushed aside.

Participant #5 described a challenge commonly shared by mothers impacted by drug addiction and alcoholism, which refers to the anxiety associated with being identified by law enforcement and CPS:

> Towards the end I was nothing but a screaming bitch all the time…I had all kinds of anxiety, knowing that I was going eventually gonna get caught…Eventually all this, all the shit that happened was going to happen if I didn't stop doing what I was doing

Examples of neglect by parents also included black out episodes due to substance abuse, as one mother described:

> I would get so messed up on pills… I remember the incident because somebody told me about it ...One Easter we were supposed to go over to a friend's house and and we did…but I had absolutely no memory of being there at all. None. And it's like, 'did I remember to put my teeth in?'… I don't remember any of it. Once you lose time like that, it really starts to scare you because it's like, 'how many times have I done this before?'

Negative View of Self and Parenting Role. Although participants reported struggling with a negative view of self, the majority of participants did not view this issue as interfering with their ability to parent. Only two mothers were insightful in describing how a negative view of themselves led them to perceive parenting responsibilities as distressing. To these participants, viewing oneself negatively led to viewing their parenting as overwhelming. Thus, a negative view of self-informed a negative view of their identity as mothers, as participant #9 said:

> So I still have a lot of dependency issues. Like, you know, sometimes feel like, I still like you know my husband still kinda tells me what to do, you gotta do this, I'm not very, feel like almost can't make decisions on my own, or like if do it's the wrong decision.

Health Issues and Parenting

Decreased Amount and Quality of Interactions with Children. Participants' health issues predominantly interfered with their parenting practices by decreasing their ability to

interact with their children. Mothers reported a wide range of health problems including migraines, chronic pain, stress-related illnesses, and hospitalizations. Participants reported how health issues interfered in their daily interaction with children as participant #6 reported when describing her struggles with chronic pain, "It's exhausting and it's very painful, it's hard to do the physical things. My daughter likes to jump on me, and climb on me. That part's hard." Participant #12 expressed sadness by realizing how her hospitalizations have impaired her parenting practices, "With all my hospital visits, there are some days where I'm in the hospital 16, 17 straight days in a row." Mood disorders resulting from health problems also represented a significant challenge to mothers as these negatively impacted their parenting, as participant #11 affirmed,

> I'm bitchy, and I yell a lot. I tell my kids that they don't care about how I feel. I like going to the zoo. I can't go to the zoo, cause I can't walk to the zoo. So, if I were to go do anything, I have to have a wheel chair. That's embarrassing to me because I am only 47 yrs old and I should be able to do the things that I had done before. You know? Get up, work 8 hours, come home, clean my house, feed my family, go to bed and do it all over again. Well I can't do that now.

Adult-Adolescent Parenting Inventory-2 (AAPI-2)

The AAPI- w2as administered to obtain specific quantitative indicators of parental abuse and neglect. In summary, the majority of participants scored at medium levels of risk in each domain of the measure. Specifically, regarding appropriate expectations, one participant scored at high risk for inappropriate expectations of children, and 11 at medium risk. Regarding risk for low empathy, four participants scored at high risk, seven at medium risk and one at low risk. For corporal punishment, three participants scored at high risk, six at medium risk, and three at low risk. On the scale of appropriate family roles, three participants scored at high risk for inappropriate roles, seven at medium risk, and two at low risk. In the scale of children's power

and independence, two participants were at high risk for not valuing their children, nine at medium risk, and one at low risk.

Table 4.5. AAPI-2

Domain	High Risk	Medium Risk	Low Risk
Appropriate Expectations	1	11	0
Empathy	4	7	1
Corporal Punishment	3	6	3
Appropriate Family Roles	3	7	2
Values Children's Power-Independence	2	9	1

Findings of Research Question D: How do trauma symptoms influence women's interactions with formal social systems?

Individuals in this study reflected about specific trauma symptoms that influenced their interactions with formal social systems. According to participants, trauma symptoms that predominantly impacted these interactions were difficulty trusting others, setting boundaries, mood disturbances, and emotional dysregulation. Mothers also reported how these symptoms exacerbated whenever case workers displayed behaviors such as rigidity, emotional barriers, distortion of their cases, or perceived lack of interest to return children to their care.

Difficulty Trusting and Setting Boundaries. The majority of participants reported struggles with regards to trusting their caseworkers, particularly if women perceived that caseworkers did not assume a supportive and empowering stance. For example, participant #1 affirmed:

> I felt that the minute I met her she didn't want me to get my kids back. She told me flat out she didn't want me to have my kids back. The relationship with my caseworker has gotten a little better. At the same time I wouldn't put it past her to say some B.S. to make it so I couldn't get my kids back.

Another example refers to participant #7 struggling to trust that her caseworker was committed to ensuring the safety of her children, *"*My caseworker says my kids are in a safe place and she knows because she goes over there…But I tell her, you don't know what goes on at night time though, you don't know that." Participant #8 had similar concerns:

> They take him and put him in some foster care, I don't where he's at, I don't know if he's safe, I don't know if they're hurting him. Just like they don't know if he's safe. It's sad because you hear about foster parents hurting children. I don't know if he's getting fed before he goes to bed, I don't know if he's getting bathed, I don't know if they're making him brush his teeth, I don't know any of this, and it really irritates me.

Mistrust towards caseworkers also related to painful experiences with the social welfare system, as participant #3 affirmed when reflecting on the effects of being in foster care:

> When it comes to caseworkers or anybody that has to do with the State, I don't trust them because of what happened with my son. They were supposed to be putting him in a home where he would be well taken care of, and he wasn't.

Mood Disturbances. Depression and anxiety negatively affected participants' relationships with caseworkers. For example, participant #1 described avoiding her caseworker when feeling depressed:

> When I am depressed, I feel more snappy. When caseworkers would come over, I just didn't answer the door (laughing)… I responded to them with avoidance. I'd turn my phone off cause I knew they would be calling.

Anxiety was especially triggered in response to thinking about children's safety in foster care, particularly because of the impossibility to confirm the children's well-being and quality of life, as participant #8 stated:

> Just because you think they're safe, they're not. And I don't know, and know where he's at, and I don't know if he's getting fed before he goes to bed, I don't know if he's getting bathed, I don't know if they're making him brush his teeth, I don't know any of this, and it really irritates me.

Emotional Dysregulation. Participants reported how emotional dysregulation negatively affected their interactions with caseworkers, as participant #8 said, "Yeah, I went off on them a couple times verbally, on the phone, then I wouldn't let them say anything and then hang up on them."

Mothers also reflected on how emotional dysregulation was particularly problematic when experiencing confrontations with caseworkers due to escalation in the interaction, particularly if women perceived caseworkers as being disrespectful, as participant #12 described:

> "It was very hard for me to hold my tongue with her, and there was even a couple of times when I didn't, and it came out, you know, with her, and it was not controllable… I actually had someone say to me, ok you need to leave the room... Somebody had to remind me, like ok go out and smoke a cigarette, go, leave the room… Because I mean, it was getting pretty heated.

Findings of Research Question E: How supportive are the contexts in which women engage as related to their parenting efforts?

Although the majority of participants identified important sources of support in their lives, women also reported unsupportive relationships with regards to family, friends, and service professionals. Table 4.6 illustrates the complexities of social support reported by participants. Detailed narratives are presented below.

Table 4.6 Supportive and Unsupportive Systems

Support System	Supportive	Unsupportive
Parents/Family	8	6
Current/ Former Partners	6	10
Friends	5	5
Caseworkers	8	12
Other Services	7	0

Unsupportive Relationships

Parents/ Family. Although parents and other family members were the largest source of support for participants, they were also identified as important sources of stress. For example, participant # 9 described how her father lost his parental rights when she was a child due to abuse and neglect. Even though he was identified as a source of support once she became an adult, this participant identified him as having a major negative impact on her, particularly as it referred to her own parenting difficulties:

> My dad lives right down the street, but he was just a drinking buddy. We would get drunk together. When I was pregnant with my daughter my dad would drink with me. According to him, everyone else who thought I shouldn't be drinking was wrong. He would always say, 'Its ok, your mom drank with you. You turned out fine.'

Mothers also reported how family members were unsupportive if they overstepped their boundaries, as participant #10 affirmed, "My mom supports me to a point, but she also wants to be a parent, and she wants to control the way I parent my kids." Participant #2 also described unwanted input from her step-mom about her parenting:

> We had got into this argument because she said that I needed to quit treating my daughter like a princess. So I told her, you parent your way, and I'll parent mine. Just because you ignore your child, doesn't mean I have to do the same to mine. I'll do this my way and you parent your way.

One of the most painful expressions of lack of support from families refers to legacies of parental abuse and neglect experienced by participants, particularly as it referred to strained relationships and lack of involvement in participants' lives. Participant #5 explained:

> It's been 15 years since I've seen my parents. They live in Oregon, so there's no way I could get there. They could come here any time, but they don't. They've never met they're grandson, which really, really pisses me off.

Participant #4 described her lack of contact with her father:

> My kids have only met him one time and that was not what I wanted to do. It was at a funeral. So just a casual meeting. I explained to my kids later who he was. It made me

very sad. My daughters asked a lot of questions about him. I answered them the best that I could.

Current/Former Partners

Fathers' Absence or Lack of Involvement in Parenting. For many of the participants, the fathers of their children were uninvolved in their lives. One participant affirmed:

> He is no good. He was like one-time thing. We were all drunk at a friend's house. As far as I know to this day, he still sells weed, smokes weed, drinks, stays in the streets, you know? I will never let him be around my daughter, ever."

Participant #6 elaborated on her story:

> He doesn't even call on the days that he's supposed to, so I have her call him a lot, and make her make him cards. He went out of state and told her that he was going to visit his dad that was sick in the hospital, he'd be back in a couple days, and never came back. She still thinks he's coming back, and I don't think he's ever gonna come back. So all I can tell her is that your daddy's sick and he's with her grandparents out of state. It's hard for her.

Participant #1 reflected on her experience, "My daughter's dad. He's abusive and an alcoholic. He showed up at my house a couple times. I had a PPO order out on him and that didn't matter so I think they put him back in jail."

Partner Interactions Leading to or Exacerbating Involvement with the Child Welfare System. Eight participants provided detailed accounts of how their partners or children's fathers led them to or prolonged involvement with the child welfare system. In some instances, such as in intimate partner violence, fathers were fully responsible for instances of child abuse and neglect. In other situations, fathers led women to engage in destructive behaviors such as substance abuse:

> I had done meth in the past, and I liked it too much so I stopped doing it. When I got with my husband, I realized that he had a serious habit. At first I didn't want anything to do with it. Methamphetamine can really mess up your head, and it makes you incredibly sexual. If the other person's not that way, it's really annoying. So, it got to a point where

> it's like ok, if you're gonna be a junkie, then I'm gonna be a junkie. I thought that would open his eyes and stop it, but didn't work that way

Participant #6 described how her ex-husband's behavior caused CPS involvement:

> We shared 50/50 custody and it went fine for a while. Then I noticed my daughter she stayed, at 28 to 29 pounds for like a year and a half and it was concerning to me. I started noticing that she would gain you know 2-3 pounds on my weeks and then when she would come back from her father's house she would lose those 2-3 pounds. I was noting it for you know a few months and then I was like, alright I'm, I'm gonna take her to the doctor. They did say that it um, they were going to call dhs because her prealbum level was down, the nutrition level in her blood. So basically he said, if, if you don't call, I'm going to. So they were called, and that was the first time that they were brought in.

Friends. Participants reported that unsupportive friends frequently increased their risk for substance abuse, as participant #5 affirmed:

> The people that you're involved with in an addiction, well, everybody takes advantage of everybody else…Everybody loves you if you have money or dope, and when you don't, they're not there for you.

Participant #10 confirmed this experience:

> Yeah, and that's what we come to realize when, now that we're dealing with all this [substance abuse recovery] and we completely quit, I'm like 'dude nobody calls us no more, nobody wants to hang out'… I'm like, 'where's everybody at? Oh they're just getting high'… And now that we don't get high, it's like well, now I see who our true friends were.

Caseworkers. According to participants, unsupportive behaviors by caseworkers refer to (a) unprofessional behaviors, (b) lack of understanding and support, and (c) caseworkers' background.

Unprofessionalism. Participants reported several instances of lack of professional behaviors and ethical violations, as one mother described a caseworker telling her ex-partner word-for-word what she had told the caseworker when reporting him for neglect:

> I wouldn't know anything that he said to her… but he could repeat to me word for word what, what I said to her… So, it would just really make me mad… and then he said, he said she just told me that you're doing this to be vindictive.

Participant #7 expressed frustration about not being informed of her children's placements:

> My kids were not all together, but the caseworker never told me that the judge ruled for my kids not to be together all in one house. So they split my kids up, there's two there, and two there. So, I'm like ok, but they never told me that they got split up.

Participants also reported lack of professional behavior associated with service delivery practices, as participant #8 stated:

> The caseworker didn't do what she was supposed to. We went to court and the judge yelled at her because she did not do it. She wasn't doing what she was supposed to do. So, we were supposed to start different counseling, things like that…But she would wait until about a week out, you know, until the court date, and then she'll start throwing everything at you. This stuff should've been done with enough time before the court date.

Lack of follow-through by caseworkers was frequently reported by mothers, as participant 4 said:

> After Malorie was removed from my home, I was told by the juvenile court officers, that there would be some services that would open up…Finally, after months and months, I was able to see Malorie again.

Another woman reported issues related to lack of ethical behavior:

> For one, she doesn't do the home checks like she's supposed to. She also has lied to my children. I don't appreciate that. You don't promise somebody something and then not come through. And she did that a lot.

Lack of Understanding and Support. It was a common belief among all participants that caseworkers were unsupportive at times and did not understand the participants' experiences. Participant #1 explained, "They need to understand where the parent is coming from, and at the same time, they need to listen to what they're going through before they make any decisions about that person." When asked about how caseworkers could be more supportive, participant #8

replied, “Compassion. Learn it. Use it.”

Participant #6 stated that she sought out DHS, for support however, *“*Every, any time I called her for any advice or any help, they would only give short answers, were not nice and were not helpful.” When asked if caseworkers were a source of support, participant #10 replied, *“*I gotta say, no. Because every time I brought an issue to them, they kinda blew it off.”

Mothers also perceived caseworkers being unsupportive whenever they focused on the problems without acknowledging their strengths, as participant #3 explained, *“*For a long time, it was like no matter what I did, it was wrong, wrong, wrong, wrong…And I’m like you know, you get really frustrated with that. It’s like they never see what you do right. Participant #12 summarized this feeling, commonly shared among participants, “They’re quick to jump on the gun, and judge someone without even meeting them.”

Caseworkers’ Backgrounds. Mothers were reactive to the fact that many caseworkers are young and have no children, as participant #1 stated:

> My foster care worker doesn’t have any kids right now. Yet, she’s telling me how I need to raise my kids. I hate that. Until you have a kid, don’t tell me what to do with my kids. And then I got switched to another one, she’s nice and everything, but gosh what is she, 24, 25. They don’t have a grasp on raising children is hard. They do not come with a handbook.

In addition, many mothers considered that caseworkers did not share the experience of knowing how painful it is to have a child removed from one’s care, as participant #8 said, “I try to explain to them, ‘you have no idea, put yourself in my position right now, then you would have a clue, but you don’t’”. Participant #3 suggested:

> Caseworkers need to be more understanding, because parents like me don’t always get to experience the pleasure of keeping all their children. The caseworkers do. If they haven’t had kids, then they need to be considerate of how the parent might feel when children are taken. Especially if the parent has raised their children for a couple years. Especially with a mother. She’s carried the baby for 9 months, and then raised the baby. It pretty much

> ripped my heart out when my children were taken. So they need to be more considerate that.

Supportive Systems. Although women in this study faced many challenges in their relationships and contexts, they were also many instances in which these environments were helpful. According to participants, supportive systems played a critical role in their lives by helping them to reduce trauma symptoms, improve their interpersonal relationships, and enhance their interaction with institutions and others. Specifically, women identified family members, partners, caseworkers, friends, and service professionals as important sources of support in their lives. This finding is relevant as participants also identified interactions with these individuals as problematic in their lives.

Parents/Family

Emotional Support. Parents provided support to participants in a variety of ways. Participant #3 received emotional support from her mother and other family members by, "…always telling me that I did really good raising Jacob for the three years that I had him." Participant #4 also received emotional support from her mother when she needed someone to talk to about her ex-husband, "… she has helped me sometimes when I get frustrated with him, I call her and can tell her, "he's driving me nuts!" Participant #2 acknowledged:

> My mom is definitely there whenever I need her. I have a lot a lot of cousins and aunts and we all live in like kind of the same area. My brother lives two apartments down from me. If I ever need anything big or little, even as simple as a question, I can always call somebody. I've never felt like, 'What am I gonna do? Oh my gosh, I don't know, I'm alone in this thing.' I have a lot of support.

Participant #8 was proud of her level of family support:

> We're never far from family. You know the saying, it takes a village, that's actually true. We have a great support system. Before my son started school, he always went to my dad's. We always did stuff with my son as a family. Our family is very odd. Even though

> they're divorced, my mom still talks to my dad. Everybody in the family is still connected even though they may not be together. It's awesome, but at the same time it's odd, because you look at other people, and that's not how it is. It's cool because, we can all as one big group go places together, we've done things before, all of us, divorced, married, new married, new boyfriends.

Instrumental Support. Over half of the participants reported the critical emotional and financial support they received from their parents, as participant #6 affirmed:

> My parents have stood behind me the entire time with my ex. They have helped me get full custody. They have, I mean, they've let me move in with them with my child. They take her to daycare during the week. They help tremendously.

An additional example of support referred to taking care of children whenever women experienced life challenges, as participant #12 said, "My mom had to step in and did the parenting while I was in the hospital." Participant #7 reported a similar experience of support:

> My mom and dad are a support to me. If I need anything my mom and dad is there for me. I would depend on them more than anybody. If I need anything I can call them and say, 'mom well I need this, dad I need this'; and they'll say, 'ok I'm gonna bring it to you or come get it.'

Partners. Over half of the participants reported how partners provided varying levels of support. One mother affirmed the strong support that she has received from her spouse, "In the beginning, when I lost my son, it was really depressing and then, my husband helped me work through it. It is still hard sometimes to talk about it, but my husband makes it easier." Participant #5 also highlighted the level of support she receives from her spouse:

> He was the first person ever in my entire life who accepted me without question. He absolutely adores me, there's absolute no doubt about that. There's nothing I can't talk to him about. He will take anything from me. It would be so easy to take advantage of somebody like that, but that's not who I am.

Participant #8 reported an uncommon experience for participants, in which she had a positive relationship with her ex-partner:

> We aren't together, but we still talk when it comes to our son. He'll call me and tell me what happened in school, or you know stuff like that. I was with him half my life. We never were married, but we, practically would be. It's a crazy scenario, but I love it

Mothers also reported instances of moderate to minimal help from parents, as well as expressions of support characterized by controlling behaviors. For example, participant #1 stated, "The dude I'm with now, he is supportive, but not. He's working on himself too." Participant #9 described her husband as supportive but also o controlling, "…my husband supports me too, but he's more of like a backseat driver, he wants to tell me what to do all the time."

Caseworkers. Participants viewed their caseworkers positively whenever they were helpful, seemed to care, were collaborative, and used direct communication. Half of the participants identified caseworkers as sources of support. For example, participant #1 appreciated that caseworkers were a resource for various services, "Now, I can go to any kind of case worker (laughing) and can get all the support I need*."* Participant #6 found her second caseworker to be very helpful, as she stated:

> The last caseworker was great. She listened. She literally spent probably 45 minutes with me, and listened to everything, and then asked me for all of my medical records. She asked me for everything…I told her, 'You can have whatever records you want, take them. Do what you want. I just need you to help me.

Another mother described how she was open and receptive to her caseworker because she was also collaborative and empathic:

> Jennifer was pretty understanding. Even when there were times that I did get upset, she still tried to work with me, or tried to compromise... You know, it wasn't always 'just what I say goes,' you know? It was definitely a compromise…She would say, 'Well if you don't feel like… can you at least do this?'

Following the same order of ideas, participant #3 described how supportive her caseworker was:

> We were getting to like her and trust her because she was very open and honest with us and everything about. She would even pick us up and take us to our appointments, or we would meet her at DHS and she'd take us to where we needed to… like Henry's doctor's appointments.

Mothers also highlighted how critical a direct communication style from caseworkers was for the strength of the helping relationship, as participant #10 said, "He is 100% honest and straight forward. He tells us how it is. He tells us what we gotta do to get it done." Participant #7 described her varied experiences with caseworkers:

> With my first caseworker, I was feelin' real down because he would make negative statements about me. Everything I asked him he would say one thing, and then by the time I go to court it'd be somethin' different. But my caseworker who I got now, I mean it's cool or whatever, we goin' through it step by step basically, you know, we're goin' through it step by step, and it's pretty cool.

Other Service Providers. In addition to DHS staff, women also identified additional service providers as sources of support. For example, participant #12 found staff associated with her wrap-around program as being helpful to her as a parent. Members of this team included a parent support partner and foster parents. With regard to the assistance she received from this team, she affirmed:

> She has been through it, done it, you know…So, we meet once a week and she can help me come up with strategies. We talk, you know, and sometimes it's nice to just talk. So I think that that's been really, really helpful.

Participant #9 had a lay-person recovery coach whom she found to be helpful:

> I'd call my recovery coach and she would come to get me and go have coffee or something. And, you know talking about cravings and how they only last for like 20 minutes…You just have to make it through, you know, then you're like oh thank god…I didn't know, they can get rough.

Participant #1 described how another type of professional offered support:

> I have a medical case manager, she's really good. She helps with housing and you know basically 'cause I'm on some other medications. She's my biggest supporter, I mean she knows everything.

Participants also identified therapists as important sources of support, as one mother affirmed:

> You know, the therapist gave me some good resources and some good things…You know, some good ways of trying to redirect and trying to do things differently….Like when I was trying A, she would tell me, 'Why don't you try B?... She was very resourceful.

Friends. A few participants identified friends as sources of support, as participant #6 said, "I have a really close-knit group of friends." Similarly, participant #8 stated, "Like I have a bunch of people. I have my close friends. My roommate is one of my closest friends. You know, she's always there." Of the participants who identified friends as resourceful, frequently stated how they would help them battle challenges in their lives such as addiction, as one mother stated:

> I gotta say she really didn't drink that often because she knew that I was struggling. I was drinking all the time, and she wanted to protect the kids. It got to the point that she'd have my daughter sleeping in her room at night just so my daughter didn't wake me up. I'd wake up and Joanne wouldn't be in her crib. I'd realize, she's in Lisa's room, good she's in Lisa's room. I'm goin' back to bed.

Findings of Research Question F: What examples of trauma-coping and resilient parenting behaviors are women most likely to report?

All participants reported examples of coping and resilient behaviors that effectively helped them to manage their trauma symptoms, regulate their emotions, enhance their interactions with children, and change their thoughts and cognitive schemas as they overcome adversity. Table 4.7 presents an overview of how many participants utilized each type of coping strategy.

Table 4.7 Coping Strategies and Substance Abuse Recovery

Coping Strategy	n
Behavioral Strategies	7
Psychotropic medication	6
Children as motivation	11
Cognitive strategies	8
Substance abuse recovery	7

Behavioral Strategies. Participants reported behavioral changes that helped them cope with difficult experiences. These included increased physical activity, relaxation strategies, and setting specific goals when facing challenges. For example, participant #1 affirmed, "I make myself get up in the morning and make myself get out. At least go for a walk once a day. Participant #2 said, "I'll even go in the bathroom and just take a bubble bath, and just sit there and think, and just straighten my thoughts." Participant #4 also used relaxation as a way of coping, "I know my limits too. If I'm feeling a certain way or if I'm feeling overwhelmed, sometimes taking 5 minutes and putting on my headset, typing in youtube and just listening to some music."

Participant #9 identified setting goals as her best coping strategy:

> I set goals for myself, like I said this summer, 'I wanna learn how to drive, I think that will make it….I think that will get me out of the house and make me feel a little more independent. I think that that will definitely make me feel better about my self-esteem. So, I think that I set goals for myself.

Participant #12 pays attention to physiological indications of anxiety during her interactions with her children. If needed, she removes herself from the situation.

Psychotropic Medication. Participants struggling with mood disturbances and emotional dysregulation reported using psychotropic medication to medically treat these issues. For these participants, their medical treatment was an important support to keep their mood regulated and

to enhance their ability to cope with daily stress, as participant #1 affirmed, "I'll be really, really depressed or I'll just be to a point where I can't even stop moving. So I take a little happy pill or whatever and I'll be good to go." Participant #9 described:

> I still take Zoloft. That helps a lot cause when I don't take it, like my emotions start going all crazy. I can tell if I haven't taken my medication. Even my husband can tell. When he notices, he'll ask, 'did you take your medication today'. I get real irritated when I don't take it.

Children as Motivation in Life. Participants identified their children as a particularly strong motivator in their lives, particularly when facing intense adversity, as participant #2 stated:

> I do it all for my daughter and the baby I'm about to have. I just think about them constantly. All my decisions affect my kids in some way, so I always put them first. I think about them before I do anything. It's really them that makes me wanna do the right thing. Like before I didn't really care, it's like I don't have nothing, or no responsibilities, nobody. So it was just like, I'll do what I want, and now I have my kids. So it's lot different. Now, I always base my decisions on them.

Similarly, participant #4 affirmed, "I'm very blessed in my life, and I feel that my children are a really big gift to me, and that's what keeps me going." Participant #7 provided a detailed description of how she finds motivation in her children when feeling depressed:

> Every time I see my kids, I feel so happy….Oh my god, I can't wait to see them when I go to my visit. That's how I am like so ready to go to my visit… I can't wait until 4 o'clock so I can visit my kids."

Cognitive Strategies. Participants took action to change their thoughts when facing various stressful situations, in an effort to better cope with contextual stressors. For example, taking one day at a time was a strategy used by women as participant # 6 affirmed, "I go day by day. If I look a year down the road, it stresses me out."

Participants also talked about not letting little things get to them and focusing on the positives, as one mother said, "I don't sweat the small stuff in my head." Staying positive, and acceptance of self and reality were also important strategies, as participant #4 affirmed:

> I'm an honest person. I'm not a perfect person. Nobody is perfect, and I'm the first person to admit when I make a mistake. I'll sometimes throw up my hands and say "oh, I just totally messed up, I said that wrong or something.

Substance Abuse and Trauma Recovery

Trauma recovery is operationalized as any evidence that women displayed of improvement in trauma symptoms investigated in this study.

Substance Abuse Recovery. The fact that all participants with a substance abuse history were currently abstinent is evidence of trauma and substance abuse recovery, as one mother said:

> I never looked at myself like an alcoholic, even when I was drinking every day, I'd say 'Oh I can stop any time I want, you know I can quit, you know I just don't want to." Then, when I tried to quit, it was like the hardest thing I ever had to do, and that's why I just can't even imagine me drinking again because of just coming out of it and trying to quit was just so hard, and depressing…It was such a hard, hard, hard thing. Like I'm just so glad that's over with because it was one of the hardest things I ever had to do.

Participant #5 described her recovery process:

> When you go to rehab, they tell you that, you have an addiction, it's not your fault. Your ability not to stop is not your fault. Well you feel like after a while, it's kind of a cop out. Especially when you get past it. You know, then you're like well, why couldn't I do that before? And it's like, because you couldn't. You didn't, you were not in the right mind space.

When asked how she keeps drug free, participant #1 replied:

> I needed a reason. I don't wanna say I needed a reason to quit using drugs. I needed for me to figure out that I didn't need the drugs. I realized my kids need a clean and sober mom. They need somebody that's gonna be there for them, not just with them. Jail time and treatment centers also helped.

Improved Boundary Setting and Trust of Others. Participants reported improved ability to set healthy boundaries and trust others as participant #8 stated:

> I always give people a chance. Even though I have a hard time, you know I give them a chance. You just hope and pray, don't screw me over. I want to teach my son to give everybody the benefit of the doubt, you know not to jump to conclusions,

Participant #3 reported working on setting boundaries with others:

> Me and my husband have both been doin' really good for the last 11 months of staying away from others' drama after we moved out of where we were staying at and got our own place. If we have friends come over, we tell them if you have drama, leave it at the front door as you come in otherwise you go home.

Participant #1 shared her story:

> I've tried to set better boundaries. You know I quit the drug use, so that helped out a lot. I kinda made my house mine again. Now, you have to ask me to come in. If I let you in that's fine, if not I can shut the door on your face. Now I am able to tell people, 'certain things are mine, don't touch 'um.'

***Improved Emotion Regulation*.** Participants reporting success with regulating their emotions and described how this acquired ability improved their quality of life, as participant #3 stated, "Me and Henry have our arguments, but now we walk away from each other for a little bit and then we come back and we talk about it and solve our problems"**.** Participant #4 reflected on the positive impact of emotion regulation and child rearing, "Even if I'm having a really bad day, you know, we have to put our emotions aside and try to do what's best for our kids, and that's what I'm trying to do." Participant #4 described a strategy she uses to prevent emotional dysregulation:

> I take time to sit down and think about like think about, like really think about things um while I let me daughter off and watch movies or play with her toys or whatever. I'll even go in the bathroom and just take a bubble bath, and just sit there and think, and just straighten my thoughts.

Participant #2 explained:

> Whenever I get those racing thoughts, I tell my daughter I need to sit here by myself for minute. I'll go put a movie on in her room for her and let her sit down and watch a movie and play with her toys. Then I'll kinda collect myself in the living room, so I won't let her in the middle of that. So I just put her in her room and tell her, mommy needs to sit out here by herself for a minute and think.

Positive View of Self. Participants made statements that demonstrated self-confidence and positive views of themselves despite difficult experiences. For example, participant #4 stated:

> I saw how my father treated me, and I certainly did not want to ever have my children treated in that way and you know I've always been very protective of my kids, I think that a lot of maybe those experiences with my father caused me to make some very bad relationship decisions; and maybe sometimes I'm too soft with disciplining my kids. However, I feel that I did the best that I can with what situations have brought.

Participant #8 discussed how holding on to a positive view of herself has led her to be resolved about self-care behavior, "No, I don't throw myself into pity parties. I know that I'm a good person, I know that I'm a good parent, I know, you know what I mean, so I just know I'm ok with myself."

***Confronting Problems*.** Over time, mothers learned that confronting problems led to better outcomes rather than avoiding them. For example, participant #2 expressed:

> I've learned to deal with my problems because you know, they are not going to go away unless you deal with them. You have to do something about it, or else they are just going to always going to be there.

Participant #4 gave an example of how she confronts problems by addressing conflicts with difficult family members:

> I'd tell myself, "you know what? I really have to do this…" So, I'll put it on the schedule…Like for example if there's a family member that I don't particularly like very much, I will like randomly pick a date on a calendar and write "OK, it's 3 o'clock and you're going to call this person or send this person an email."

Positive Parenting Behaviors. Parents reported remarkable improvements on their parenting behaviors and practices as a result of involvement in therapy and supportive services. These improvements in their lives were deeply relevant as one of their major motivations in life is to be good parents to their children. Thus, it was important for mothers to learn from their mistakes and become the best parents they could be. They reported achieving this by strengthening the mother-child bond, embracing effective limit setting practices, and nurturing the emotional bond with their children.

Parent-Child Bond. Mothers reported that healing from trauma allowed for improved bonding with children and that bonding with children facilitated additional healing, as participant #2 described:

> I really did not want to be pregnant and I was so against it…I was like "I don't care, I'll just leave her at the hospital when I have her"…I was just so rebellious. But then, it was like when I saw her, everything changed. It was like "Wow, I made her, she is mine…and you know, it was great.

Participant #3 reflected on her experience:

> I actually love bein' around my son. If I had him with me and I was in one of my moods of not wantin' to be around anybody, he and my husband would be the only two I'd wanna be around. Maybe even my son would be the only one I'd wanna be around and not my husband.

Participant #8 described her bond with her son:

> I've gotten into the river with him and caught crayfish with him. I was raised a tom-boy, I'm an only daughter, you know, so I'm not scared to get dirty, and that's probably why he loves hanging out with me so much.

Limit/Boundary Setting. A critical indication of growth refers to participants' ability to use effective and non-punitive limit setting strategies, as participant #3 described, "If my baby is going for something he's not supposed to have, we'll pick up and turn him away and will get him

star playing with the toys." Participant #5 described the importance of monitoring and rigorous limit setting with her older child:

> It's very much a set of boundaries that don't change, you know, in other words he doesn't go and spend the night anywhere if I don't know the parents. He has to be in at a certain time…He is not allowed to go as far as he'd like to go…Those things are non-negotiable.

Participants also reflected on how they improve their skills to allow their children to make choices within reasonable limits, as participant #2 affirmed:

> I try to like I let her make some decisions, like, what pajamas do you wanna wear to bed tonight, or what do you wanna wear to school. Within reason, you know. I let her make some decisions about things, like what vegetables she wants or what type of dinner. You know, just little things. It's not like I'm trying to control everything, just the major things."

Participant #12 discussed how it is important for her to protect her children when she is struggling with difficult events and emotions, "When I'm with the kids I try to keep it happy". Participant #3 described tactics for redirecting her infant:

> If he's going for something he's not supposed to have we'll pick him up and turn him away to start playin' with toys. For example, we'll turn his attention away from it by showing him blocks because he loves blocks. If we pick him up and turn him away, or if we pick him up and just walk around with him bouncin' him around, he'll laugh. If we're bouncin' him, then it'll take his mind off of it and then we'll be able to put him back down. Then he'll run off and play with more toys.

Emotional Support. Several participants wanted to learn from their parent's mistakes and challenging upbringings. For example, mothers considered essential to offer their children the emotional support that they did not receive. Participant #1 stated:

> I don't remember my adoptive family being there for me very much. I could never talk to them. I know my kids will talk to me. You know, and I want them to be able to trust me too. I'm not going to be gone for them. I'm always going to be there for them. My son has a lot of angry tantrums. He's very violent right now. He's only two though, he doesn't know how to express himself, and I understand that. He has emotions he doesn't know how to deal with.

Similarly, participant #2 said:

> I never knew my mom, so I will never be away from Ann. I want her to always feel like I'm there, so she can always come to me for whatever she needs. And I teach her how to express her feelings, like something's wrong, to talk to me about it, don't just act out like I did.

Participant #6 expressed a similar desire:

> From my parent's tough love, I learned what I don't want for my daughter. She's my life. I talk to her about pretty much everything. She comes to me for anything. I want her to be able to come to me, cause I couldn't do that.

Participant Profiles

The following chart shows the profiles of each participant based on their trauma history, assessment scores, and coping strategies to demonstrate the variance in women's presentation and experience. This helps to visualize how these different variables hang together for participants.

Table 4.8 Participants 1-6

	Participant #1	Participant #2	Participant #3	Participant #4	Participant #5	Participant #6
Trauma Events	Poverty Child Rem IPV Sex Trauma Rem frm Pt	Poverty Child Rem IPV Neglect Fam Death Parent Sub	Poverty Child Rem Sex Trauma Fam Death	Poverty Child Rem IPV Sex Trauma Fam Death	Poverty Child Rem IPV Neglect	Poverty Neglect
BSI Sig Dom.	 O-C I-S DEP ANX HOS PHOB PAR PSY	0 sig scores	0 sig scores			SOM O-C DEP PAR PSY

Table 4.8 (cont'd)

AAPI-2						
Expect	Med Risk	Med Risk	Med Risk	Med Risk	Med Risk	Med Risk
Empathy	Med Risk	Med Risk	Med Risk	Med Risk	Med Risk	Med Risk
Corp Pun	Med Risk	Low Risk	Low Risk	Med Risk	Med Risk	Med Risk
Roles	Med Risk	Med Risk	Med Risk	Med Risk	Med Risk	Low Risk
Pwr-Ind	Med Risk	Med Risk	Med Risk	Low Risk	Med Risk	Med Risk
Coping Strategy	Behavioral Child Mot. Medication	Behavioral Child Mot. Cognitive	 Child Mot. Cognitive Medication	Behavioral Child Mot. Cognitive	Behavioral Child Mot. Medication	Behavioral Child Mot. Cognitive Medication

Notes. Rem frm Pt= Removed from parent; Fam Death= Death of significant family member; Corp Pun= Corporal Punishment; Pwr-Ind=Power-Independence; Child Mot=Child motivates

Table 4.9 Participants 7-12

	Participant #7	Participant #8	Participant #9	Participant #10	Participant #11	Participant #12
Trauma Events	Poverty Child Rem IPV	Poverty Child Rem IPV	Poverty Child Rem IPV Sex Trauma Neglect Parent Sub Phys Abuse Rem frm Pt	Poverty Child Rem. IPV Sex Trauma Neglect Fam Death Parent Sub	Poverty IPV Sex Trauma Neglect Fam Death Phys Abuse	Poverty Child Rem. IPV Sex Trauma
BSI Sig Dom.	O-C PHOB	0 sig scores	O-C	O-C DEP HOS PSY	SOM O-C I-S DEP ANX HOS PHOB PAR PSY	0 sig scores
AAPI-2						
Expect	High Risk	Med Risk	Med Risk	Med Risk	Med Risk	Med Risk
Empathy	High Risk	Low Risk	High Risk	Med Risk	High Risk	High Risk
Corp Pun	High Risk	Low Risk	High Risk	High Risk	Med Risk	Med Risk
Roles	High Risk	Low Risk	High Risk	Med Risk	High Risk	Med Risk
Pwr-Ind	High Risk	Med Risk	Med Risk	Med Risk	High Risk	Med Risk

Table 4.9 (cont'd)

Coping Strategies	Cognitive	Child Mot. Cognitive	Behavioral Child Mot. Cognitive Medication	Child Mot. Cognitive Medication	Medication	Behavioral Child Mot. Cognitive Medication

Notes. Rem frm Pt= Removed from parent; Fam Death= Death of significant family member; Corp Pun= Corporal Punishment; Pwr-Ind=Power-Independence; Child Mot= Child motivates

Chapter 5: Discussion

The results of this investigation document the cumulative trauma and symptoms experienced by mothers with a history of involvement in the child welfare system. Women's narratives confirm the deleterious effects that trauma symptoms and cumulative trauma have on their parenting experiences. However, qualitative and quantitative data also illustrate the participants' remarkable sense of resilience. Whereas many of the findings of this study are consistent with current literature on trauma survivors, the results also offer new and relevant insights. Current findings have been used to integrate a framework explaining how their trauma symptoms influence their parenting, which encompasses the role of formal and informal support systems. The sections below will review the study findings according to relevant literature in the field. Finally, strengths and limitations of the study will be highlighted as well as suggestions for practice and future research.

Cumulative Trauma Experiences

It has long been known that women with children in the child welfare system experience multiple stressors and are likely to report a range of trauma symptoms and cumulative trauma (Burns-Jager & Carolan, 2010; Chemtob et al., 2011). This has been recently documented in a study with 127 child welfare involved mothers, which found that 92% of participants experienced one or more traumatic events and half experienced trauma symptoms (2012). Findings from the current investigation confirm this trend as participants reported a wide range of trauma symptomatology, as well as cumulative trauma. Specifically, women reported intense narratives of adversity such as poverty, domestic violence, sexual trauma, childhood neglect, loss of significant family members, and various forms of childhood abuse.

Poverty

Although poverty is not traditionally conceptualized as trauma, the stress of managing intense long-term poverty can be viewed as a cumulative traumatic experience, leading to the development of complex trauma symptoms (Briere & Jordan, 2009). Access to resources can act as a buffer against the negative effects of trauma, whereas the absence of resources can intensify those effects (2009). Furthermore, it has been confirmed that poverty and lack of resources can become direct precursors of abusive and neglectful treatment of children (Berger, 2004; Lee & George, 1999; Paxson & Waldfogel, 1999; Waldfogel, 2000). All women in this study reported being exposed to chronic poverty in addition to adverse trauma history. According to the participants' narratives, the prolonged exposure to poverty was particularly detrimental to their physical and mental health.

Intimate Partner Violence (IPV)

In addition to poverty, IPV was the most common traumatic event reported by women. This finding is relevant because it confirms research indicating that among child welfare-involved trauma survivors, IPV is a common occurrence (Chemtob et al., 2011; Kelleher, Gardner, Coben, Barth, Edleson, & Hazen, 2006). Moreover, data indicate that child maltreatment and IPV are highly likely to co-occur, which has important implications for provision of services as there is a risk for professionals to be informed according to a "tunnel vision" that only monitors child abuse and neglect, which can lead to overlook and thoroughly address IPV. Whereas child welfare professionals generally know that IPV is an issue for mothers, screening continues to be inconsistent (Bourassa, Lavergne, Damant, Lessard, & Turcotte, 2006). Remaining attentive to co-occurrence is essential not only to ensure the safety of women and children but also to address common mental health problems resulting from

exposure to IPV such as depression, negative view of self, and parenting deficits (CDC, 2012; Levendosky & Graham-Bermann, 2001).

Sexual Trauma

In concurrence with the epidemiological literature on sexual violence, findings from this study confirmed the widespread occurrence of sexual trauma, which particularly affects women in positions of socio-economic disadvantage. In this study, 58% of participants experienced at least one event of sexual trauma across the lifespan. In the general population, approximately 18% of women experience sexual trauma (CDC, 2012). Therefore it is not surprising to see a higher rate in a child-welfare involved sample as these participants have been exposed to numerous contextual challenges that constitute critical risk factors for sexual assault (2012). Attention to the increased prevalence of sexual trauma in this population is of high relevance as sexual trauma has been linked to emotional and psychological distress (Briere & Elliott, 2003; Kim, Trickett, & Putnam, 2010; Griffen et al., 2006; Nishith, Mechanic, & Resick, 2000), which women in this study confirmed. Furthermore, sexual abuse history is associated with a variety of problematic parenting responses consistent with what mothers reported in this investigation. If the critical influence of past experiences of sexual trauma is overlooked, the identification of problems in mothers served by the welfare system can be narrow and thus, ineffectively address the problematic symptoms resulting from their abuse history.

Childhood Abuse and Neglect

Neglect was a common childhood experience for women in this study, confirming previous CDC reports indicating that neglect continues to be a widespread problem in the U.S. (CDC, 2013). Participants in this investigation primarily experienced emotional neglect and lack of appropriate supervision as children. No participants reported neglect related to lack of

adequate provision of shelter, food, or medical care. Given that CDC reports also indicate child abuse is major social issue, it was unexpected to find that only two participants reported physical abuse as children. These participants went on to withstand multiple subsequent traumas and trauma symptoms that drastically reduced their ability to parent. However, only one of the two perpetuated physical abuse towards their children.

Findings support previous studies on the intergenerational transmission of abuse and neglect (Dixon, Browne, & Hamilton-Giachritsis, 2005; Hunter & Kilstrom, 1979; Newcomb & Locke, 2001), and confirm a need for interventions that acknowledge the cyclical nature of family violence. Because deficits in parenting abilities can be traced back to early childhood exposures to abuse and neglect, it is essential for this history be addressed in treatment.

Exposure to Parental Substance Abuse. One of the mechanisms that contributed to childhood neglect for women in this study was their parents' substance abuse (Briere & Jordan, 2009). Although women did not report their parents displaying additional mental health problems, their narratives described home environments characterized by weak boundaries, unstable parents, and increased risk of abuse by others due to lack of adequate monitoring and supervision. These findings are relevant because research indicates that early exposure to parental substance abuse and unstructured family environments are significant risk factors for mental health problems, substance abuse, and deficient parenting (Carter & Myers, 2007; Daro & McCurdy, 1992; Marcenko & Spence, 1995***;*** Nair, Schuler, Black, Kettinger, & Harrington, 2003).

Death of Significant Family Member

One third of participants experienced the trauma of losing a family member to suicide or drug-related issues. The prevalence of these losses was an unexpected finding in this

investigation. Furthermore, the narratives illustrate that women were not the only family members struggling with painful life experiences. Rather, family members who died from substance abuse or suicide were also suffering mental health problems. According to research participants, the loss of family members further exacerbated unstable family environments, especially if the loved one was a primary support system.

According to ambiguous loss theory (Boss, 2007), these findings are relevant because not only women were experiencing present contextual challenges, but also the loss of loved ones that continue to be present at an emotional level in their lives. According to Boss, if important losses in our lives remain unaddressed, they will translate into considerable mental health problems such as depression or anxiety, which were also reported by women in this study that suffered the death of loved ones.

Trauma Symptoms and Parenting Resulting from Cumulative Trauma

As expected, women with higher frequency and severity of trauma reported increased complexity of trauma symptoms (Briere, Kaltman, & Green, 2008; Kubiak, 2003; Follette et al., 1996; Rishith et al., 2000). The development of trauma symptoms and their impact on parenting is due to the fact that women experience multiple traumas, rather than a single difficult event. Overall, findings confirm previous research indicating the detrimental, cumulative effects of trauma which include decreased ability to adequately function in several areas of daily life. Early traumatic events are not disconnected from later traumas. Previous research that indicates due to trauma symptoms, early trauma events can leave women more vulnerable to trauma later in life (Spatz Wisdom, Czaja, & Dutton, 2007).

The most salient symptoms reported by mothers were difficulty trusting others, mood disturbances, emotional dysregulation, identity disturbance, avoidance strategies, and health

problems. This is in line with the symptoms that are addressed in interventions for complex trauma survivors and disorders of extreme distress (DESNOS; Herman, 1992; Briere & Jordan, 2004). Specifically, complex trauma interventions address the issues women reported in this study, including emotion regulation (Cloitre, 2011; Fallot & Harris, 2002), interpersonal skills (Cloitre, 2011; Dorrepaal et al., 2011; Fallot & Harris, 2002; Zlotnick), cognitive distortions about self and others (Waldorf & Zlotnick, 2001; Zlotnick et al., 1997) avoidance strategies and mood disturbances (Fallot & Harris, 2002).

Women's narratives supported the extensively documented intergenerational transmission of child abuse and neglect (Dixon, Browne, & Hamilton-Giachritsis, 2005; Hunter & Kilstrom, 1979; Newcomb & Locke, 2001; Reid, Patterson, & Snyder, 2004). In fact, a major concern reported by mothers referred to the possibility of replicating the abusive and neglectful parenting behaviors that have been modeled to them. This confirms seminal parenting research stating that both parental developmental history (i.e. abuse and neglect), and one's interpretation of their parents behaviors as 'good' or 'bad' parenting, influences parenting choices (Belsky, 1984). Similar to other child welfare involved trauma survivors, the participants' abuse histories served as motivation to parent differently (Burns-Jager & Carolan, 2010). For example, many emphasized how they wanted to be different from their parents and provide an experience of emotional connection and security to their children through their parenting. Although women desired to be better parents and had parenting beliefs focused on nurturing their children, they also found themselves perpetuating abusive and neglectful parenting practices due to unaddressed symptoms of depression, difficulty with trust and boundaries, emotional dysregulation, and substance abuse.

Trauma symptoms are an understudied factor in the intergenerational transmission of violence, but have been shown to mediate the relationship between trauma and perpetration of child abuse and neglect (Milner et al., 2010). Confirming existing research, these findings not only indicate how trauma symptoms have a significant impact in the lives of participants, including their ability to parent, but document this process in more detail (Armsworth & Stronck, 1999; Briere & Jordan, 2009; Downey & Coyne, 1990; Keller, Cummings & Davies, 2005). Therefore, the women's narratives illustrate how critical is to embrace a trauma lens and strength-based perspectives to fully understand maladaptive behaviors of mothers involved in the child welfare system (Chemtob et al., 2011; Famularo, 1994). For example, the ways in which trauma negatively impacted the parenting practices of mothers in this study is consistent with what has been found in research identifying trauma as a critical precursor of decreased interaction and engagement with children, negative interactions with children, parental emotional dysregulation, hypervigilance about children's safety, and exposure of children to other abusive adults (Banyard et al., 2003; Becket et al., 2010; Samuels-Dennis et al., 2010). Although child characteristics also influenced mothers' parenting behaviors, trauma symptomatology resulting from cumulative trauma and intensified by unsupportive contexts was a key determinant in deficiencies associated with parenting skills. More specifically, parents struggled with ineffective limit setting, monitoring, positive involvement, and parent-child communication.

Difficulties with Trust and Boundaries

A core experience across participants was difficulty trusting others due to repeated interactions with others characterized by hurt and rejection (Briere & Jordan, 2009), which has been previously documented in trauma survivors who are navigating the child welfare system (Chemtob et al., 2011; Burns-Jager & Carolan, 2010). This trauma response inhibited

participants' relationships with children, partners, and caseworkers. While this issue proved to be problematic, it is understandable why participants would adopt such a worldview based on their trauma histories. From a feminist perspective, we can argue that the world has not been a safe place for participants, consequently lack of trust of others is an adaptive response that has the intention of promoting physical and emotional safety (Burstow, 2003). Participants re-counted betrayal by friends, family members, and professionals, therefore, it would be reasonable to expect they would have rigid boundaries within their relationships. Furthermore, participants confirmed that survivors are likely to hold beliefs about relationships characterizing them as sources of rejection, abandonment, and hurt (Briere & Jordan, 2009). However, women in this study did not articulate that they deserved or were responsible for the abuse and trauma that they have experienced in their lives, calling into question internalization processes proposed by other researchers (Cloitre, Miranda, & Stovall-McClough et al., 2005). Following these same order of ideas, participants' responses to the BSI paranoid ideation scale captured women's challenges trusting others (Derogatis, 1982). Items on this domain include feeling others are to blame for most of your troubles, feeling that most people cannot be trusted, feeling that you are watched or talked about by others, others not giving you proper credit for your achievements, and feeling that people will take advantage of you if you let them (Derogatis, 1982). Positive responses to some of these items can be expected from trauma survivors, particularly if they are involved in the child welfare system. For example, if a participant responds positively to feeling that she is being watched or talked about by others, rather than an indication of paranoia, such a positive response reflects the state of hypervigilance women developed when experiencing constant monitoring and supervision from case managers and other service providers (Burstow, 2003; Wells, 2006).

One third of participants had a clinically significant score on the psychoticism scale, which captures internal processes related to interpersonal difficulties. Items on this domain include thinking that someone can control your thoughts, feeling lonely even when you are with people, thinking that you should be punished for your sins, never feeling close to another person, and considering that something is wrong with your mind. Again, positive responses to several of these items indicate long term effects of exposure to trauma. For example, although no participants had a positive response to the idea that someone can control your thoughts, some participants responded positively to other items in this domain, revealing their challenges associated with getting close to others as well as having a negative view of themselves.

In contrast, participants also described times in which they had diffuse boundaries, and were seemingly too trustful of others. This phenomenon is explained by identity disturbances in which women struggle with monitoring personal needs, feelings, thoughts, and behaviors (Briere & Jordan, 2009). Women viewed the support they received from others as inconsistent. However they had difficulty identifying how weak boundaries and unconditional trust of others left them vulnerable to on-going trauma and revictimization. Despite this, they recognized that poor boundaries with others was not healthy for their children.

The aforementioned findings are particularly relevant because there is a risk to interpret specific symptomatology from a deficit-based perspective. However, the responses of research participants describe the adaptations women have made to survive in an environment in which they have been used by others and often times, judged by service providers without considering the role of trauma and adversity in their lives (Blakey & Hatcher, 2013; Sykes, 2011).

Influence on Parenting. According to the data, participants' experiences with trust and boundary setting generally oscillated between two extremes, from rigid to diffuse boundaries.

Similarly, their parenting practices were also characterized by these extremes. For example, a major finding for some women referred to how difficulty trusting others led to hypervigilance of their children. This issue confirms existing literature documenting how trauma symptoms underlie a framework for interactions from others that is based on the perspective that the world is a hostile place (Burstow, 2003; Briere & Jordan, 2009). Because women were concerned about their children having the same traumatic experiences as their own, they had a heightened sensitivity to their children's environment and often times displayed extreme anxiety when considering their children's safety. These findings are consistent with research conducted by Armsworth and Stronck (1999) with incest survivors. According to these findings, survivors permanently experience an intense fear of their children being abused, and can engage in extreme protective behavior. Contrary to expectations, the capacity for women to be emotionally close to their children was not affected by a difficulty trusting others. Other trauma survivors have explained that difficulty trusting others can make it difficult to have emotionally close relationships with their children and feel detached in their parenting (Armsworth & Stronck, 1999).

Other participants found that at times they struggled to set boundaries with others. This carried the potential for their children to be exposed to abusive people and interactions, as well as harm and abuse. Difficulty setting boundaries also played out in mothers' direct interactions with children which manifested through difficulty in limit setting practices.

Mood Disturbances and Influences on Parenting

Like other trauma survivors, participants in this study commonly experienced depression, fatigue, and frequent worries (Briere & Jordan, 2009; Downey & Coyne, 1990; Kessler et al. 1995). These findings confirm existing literature of trauma survivors and multi-stressed parents

involved in the child welfare system (Blakey & Hatcher, 2013; Marcenko, Lyons, & Courtney, 2011). Present findings also confirm previous studies demonstrating how depression impairs parenting practices by increasing negative interactions and distorted perceptions of children (Field, 1995; Guedeney, 2000). Furthermore, parents with a trauma history are more likely to report lower parenting satisfaction when they specifically struggle with depression (Banyard, 2003). For women in this study, depression significantly reduced the quality and amount of interactions they had with their children, including their ability to discipline. These findings corroborate the high need for multi-stressed mothers involved in the welfare system to receive mental health services beyond accountability-oriented interventions (Westad & McConnell, 2012). According to previous research (Kim, Trickett, & Putnam, 2010) when sexual abuse survivors experience high levels of depressive symptoms they are more likely to use physical violence with their children. However, this was not an overarching issue for the women in this study.

Avoidance Strategies

It has been documented in research that avoidant coping strategies often lead to worse outcomes for sexual abuse survivors, particularly if such strategies consist of risky behaviors leading women to further victimization or decrease their abilities to function in various roles (O'Dougherty, 2005). These premises were identified in the narratives provided by participants in this investigation. Substance abuse was the primary avoidance strategy as reported by several research participants. These women provided detailed descriptions of the ways in which substance abuse has been as a coping strategy for trauma experiences and related emotions. These findings have important implications for interventions with mothers engaged in the child

welfare system because studies consistently indicate that women who abuse substances are also at high risk for engaging in severe child abuse and neglect (Cash & Wilke, 2003).

Substance Abuse, Parenting, and Abusive Relationships. Substance abuse led to neglectful behaviors by parents including decreased quality and interactions with children, exposing children to potentially abusive relationships, and engaging in extreme limit setting practices (e.g., yelling, harsh physical punishments, complete lack of monitoring). These findings are in line with research indicating strong correlations between substance abuse disorders and neglectful and punitive parenting (Arellano, 1996; Carter & Myers, 2007; CASA, 1999; Cash & Wilke, 2003; Hans et al., 1999; Kelley, 1998; Miller, Smyth, & Mudar, 1999; Schuler & Nair, 2001; Young, 1997). Furthermore, substance abuse sustained abusive and exploitative relationships with friends, family, and partners which in turn created a damaging environment for children. This confirms that the detrimental influence of substance abuse in women's family functioning and community networks are associated with more neglectful parenting practices (Cash & Wilke, 2003). Of particularly concern is the fact that when substance abusing mothers are dealing with multiple contextual stressors, they are even more likely to abuse or neglect their children (Nair, Schuler, Black, Kettinger & Harrington, 2003). Child welfare-involved parents are certainly dealing with multiple stressful situations, which puts them at risk for on-going problematic parenting.

Emotional Dysregulation

Most women struggled with regulating their emotions. This symptom exhibits the physiological impact of cumulative trauma. According to women's narratives, those who experienced intense trauma, were likely to report that specific distressing situations triggered responses as if they were experiencing the original traumatic event. These findings confirm

existing research on the long-term effects of trauma as well as manifestations of post-traumatic stress disorders (Briere & Jordan, 2009; Cloitre et al., 2005; Herman, 1992; van der Kolk et al., 2005). A resounding theme across interventions for complex trauma interventions is that women must receive emotion regulation skills training before exposure to trauma memories can take place (Cohen , 2008 Tull, 2007). This originates from Herman's (1992) three stage model in which she recommends that individuals must first engage in skill building, then process trauma, and finally re-engage into life in a way that is less affected by trauma experiences. It is also emphasized that emotion regulation skills have to be taught early in treatment because emotional dysregulation impairs women's daily functioning and is a barrier to treatment engagement (Waldorf & Zlotnick, 2001; Zlotnick et al., 1997).

Influence on Parenting. Emotional dysregulation was a catalyst for negative interactions with children, which ranged in severity from arguing with children to becoming physically abusive towards them. Although research on parenting identifies emotional regulation as a critical area of intervention that can support positive parenting in other domains including limit setting and communication (Forgatch et al., 2005; Parra-Cardona et al., 2012), research on child welfare-involved trauma survivors has not sufficiently explored the ways in which emotional dysregulation affects parenting (Siegel, 2013).

View of Self

Negative view of self occurs when trauma survivors associate the traumatic event with who they are or when they blame themselves for the trauma they have experienced (Briere & Jordan, 2009). Women confirmed that their trauma experiences influenced a negative view of self, however they denied they were to blame for the traumatic event. Although participants had

insights about the connection between trauma and view of self, they struggled to identify how it impacted their interpersonal relationships.

Influence on Parenting. Research indicates that parents tend to have a poor self-concept if they perceive themselves to have ineffective parenting skills (Forgatch et al., 2005). A negative perception of self is particularly prevalent among trauma survivors (Banyard, 1997; Armsworth & Stronck, 1999). Current findings indicate that this was a struggle for participants in this study. However, much like Sykes (2011) found, women in the current study maintained positive views of themselves in regards to their parenting, denying that viewing themselves negatively had any impact on parenting. This documents women's resilience and how the identity of 'mother' can be a source of strength for trauma survivors. Sykes discusses this process in the context of the child welfare system. He found the positive view of self as a parent as an attempt by mothers to reject the 'bad mother' label that they are at risk of receiving from the child welfare system. One issue he found is that holding onto an unwavering positive view of self as a parent can lead to rejection of child welfare goals and non-compliance for recommendations for change, which can damage progress towards having children returned to their care (2011).

Health Issues and Parenting

Fewer women in this study reported health problems compared to those who reported mental health issues. For women reporting health issues, somatization was a salient finding, which confirms research demonstrating that somatization can become a central life challenge particularly because of the slow recovery time resulting from health problems (Drossman, Li, Leserman, Toomey, & Hu, 1996; Farley & Patsalides, 2001 Spitzer, Barnow, Wingenfeld et al., 2009). Interpersonal trauma has been associated with physiological effects including decreased

immune system leading chronic health problems. Participants reporting somatization issues in this study found that health complications significantly impacted several areas of their lives including low quality of their parenting practices due to pain and fatigue.

Abuse and Neglect

A critical finding in this investigation refers to narratives of women describing abusive and neglectful behaviors towards their children. Often times, this issue is minimized in the literature on survivors as deficit-based and victim-blaming perspectives continue to be widespread in the literature and practice (Leschied, Chiodo, Whitehead, Hurley, Marshall, 2003; Strega et al., 2008). According to research findings, participants' abusive and neglectful behaviors are thoroughly related to their experiences of cumulative trauma. Data also indicate the participants' desire to offer a nurturing and safe upbringing to their children, a finding that challenges assumptions that depict women involved in the welfare systems as "bad or uncaring" mothers. At the same time, data indicate the great need to avoid minimizing the severity of abusive and neglectful behaviors perpetrated by women in this study.

Despite widespread experiences of trauma and abuse suffered by participants, only two participants admitted using physical violence with their children. This finding is surprising given that studies show high incidence of physical abuse among mothers who have been impacted by negative family of origin experiences, various forms of childhood abuse, and depression (Banyard, 1997; Kim, Trickett, & Putnam, 2010). Thus, although a majority of participants experienced cumulative trauma and adversity in their lives, the type of abuse mostly perpetrated by mothers in this investigation was more related to intense neglect and exposing their children to unsafe situations (e.g., doing drugs at home with strangers). Having stated this, the two participants who perpetrated physical abuse had a history of cumulative trauma including sexual

abuse. This confirms literature indicating the high risk for sexual abuse survivors to engage in punitive parenting practices if they have not been able to process their experience of abuse (Dixon, Brown & Hamilton-Giachritsis, 2005; Dixon, Hamilton-Giachritsis, & Brown, 2005; Kim et al., 2010).

Parenting Beliefs

Findings indicate that participants hold parenting beliefs resembling those of the general population on all domains of the AAPI-2 (Bavolek & Keene, 1999). The fact that most participants fall within this range of parenting beliefs constitute evidence of their strong sense of resilience and contributes to the existing literature on mothers engaged in the child welfare system (Baumrind 1967; 1971). Although one third of participants scored high risk on the empathy domain (e.g., fear spoiling children, lack nurturing skills), most participants reported high levels of empathy towards their children and had an appropriate understanding of their children's emotional needs.

Current data indicate that although results of the AAPI-2 document women's resilience in demonstrating developmentally appropriate beliefs about parenting, there are limitations to what this means for women's parenting behaviors. That is, for women in this study embracing positive parenting beliefs did not necessarily translate into implementation of nurturing parenting behaviors, a finding that has been thoroughly documented in the general parenting literature (Forgatch et al., 2005).

Influence of Trauma on Women's Interactions with Formal Social Systems

Despite the fact that it is well-established that parents served by the child welfare system are likely to experience strained relationships with service providers, particularly if cases lead to removal of children and loss of parenting rights (Alpert & Britner, 2009; Smith 2008), there is a

scarcity of research focused on documenting the impact of trauma as mothers interact with the child welfare system (Blakely & Hatcher, 2013; Chemtob et al., 2011). Women in this study viewed three complex trauma symptoms as predominantly interfering with caseworker interactions. These symptoms referred to difficulty trusting others/setting boundaries, mood disturbances, and emotional dysregulation.

Attention to these findings is relevant because when mothers display trauma symptoms, they may negatively impact the quality of professional relationships with their caseworkers and the extent to which they are able to benefit from these relationships (Dawson & Berry, 2002). There is a need for more consideration of the additional stressors associated with being monitored by caseworkers that may trigger emotional dysregulation (Alpert & Britner, 2009; Smith, 2008). If mothers are experiencing high emotional dysregulation and appear to case managers as highly anxious, defensive, or uncooperative, a misinterpretation of these symptoms could lead to the denial of supportive services or an eventual termination of parental rights, particularly if trauma-related behaviors are recurrent. For example, some mothers in this study described times when they yelled at caseworkers, which resulted in immediate negative consequences such as reduction of the caseworkers' willingness to compromise or work collaboratively with the client. These findings confirm the call from professionals in the field to thoroughly inform services with welfare clients according to trauma-informed frameworks because service beneficiaries must be given all the opportunities to address unresolved trauma and contextual challenges before custody decisions are reached (Blakey & Hatcher, 2013; Marcenko, Lyons, & Courtney, 2007).

Alternative findings indicate that some trauma symptoms did not present problems for interactions with caseworkers. According to the data, these symptoms were related to issues

primarily affecting mothers but that did not bring intensity or conflict to the relationship with caseworkers. For example, mothers reported that caseworkers were understanding of certain issues such as substance abuse and health problems. In fact, all participants who reported substance abuse problems were recovering successfully at the time of the interviews and they attributed their involvement with the welfare system as a critical factor for their process of recovery. Furthermore, participants did not consider that their negative view of self affected their interactions with caseworkers because they saw themselves as being able to prevent their internal struggles from impairing interactions with others. These findings highlight women's resilience and efforts to prevent trauma symptoms from affecting their relationships with caseworkers and others (Banyard & Williams, 2007; Wright et al., 2005).

However, it is when mothers displayed aggressive or rejecting behaviors towards caseworkers that the professional relationship was more likely to be damaged. Current findings confirm the vast literature in the mental health field indicating that the nature of the professional-client interaction is a core pillar of the helping process (Duncan, Miller, Wampold & Hubble, 2009). Furthermore, current findings indicate the high need for training service providers in the management of aggressive or defensive behaviors directed towards them but that stem from clients' histories of trauma and adversity.

Supportive and Unsupportive Contexts

As an ecologically-informed study, women's context was considered in relation to the process by which trauma influences parenting. Supportive contexts reduced the possibility for women's trauma symptoms to negatively impact their parenting practices. This is consistent with research indicating that even when parents have a challenging developmental history, cumulative trauma, or individual mental health problems, a supportive context can be essential to improve

parent-child interactions (Banyard, 2007; Belsky, 1984 O'Dougherty, 2005). For example, Stevens and colleagues (2002) found that supportive systems were strong mediators in helping trauma survivors manage stress, anger, parenting beliefs, and parent-child interactions. Likewise, an unsupportive system or lack of support system exacerbated trauma symptoms, which concur with data from this investigation.

It is important to clarify that for the women in this study, supportive and unsupportive systems were not dichotomous groups. That is, women reported that their most immediate social networks were at times supportive as well as unsupportive, a finding that has important implications for provision of services as providers should always keep in mind the possibility for women's support networks to represent contrasting realities. Finally, data indicate that positive support led to positive parenting practices, whereas negative support or lack of support intensified trauma symptoms and negative parenting behaviors (Kim, Trickett & Putnam, 2010).

Family Members. As previously stated, women reported that family members were sources of support as well as stress. According to participants' narratives, when families were supportive they provided a buffer for mothers to cope with difficult experiences and trauma symptoms. Supportive family members also assisted in providing women with emotional and instrumental resources that improved their parenting practices and involvement with the child welfare system.

Alternatively, family members were also a source of stress and trauma for women, leaving women feeling vulnerable to hurt and disappointment, particularly if family members engaged in abusive behaviors that further exacerbated women's trauma symptoms. Present results confirm existing research indicating the potential dual nature of immediate social networks for women who are trauma survivors and who are exposed to multiple contextual

challenges and adversity (Sharp & Marcus-Mendoza, 2001). Thus, these findings indicate how critical is to consider the potential duality of immediate social support networks in the lives of women that share common backgrounds and life challenges with the participants in this study.

Current and Former Partners. According to O'Dougherty (2005), supportive partners can offer a particularly buffering effect that helps trauma survivors cope with trauma symptoms (e.g., depression), as well as enhance their parenting behaviors. A few participants confirmed these findings as they described the positive effects of being in relationships with supportive partners. However, the majority of participants reported relationships with current or former partners characterized by inconsistent support and even abuse. For example, although half of participants viewed their current or former partners as supportive, they also had survived some form of IPV with these same partners. Furthermore, the narratives of women confirmed findings by Johnson and Sullivan (2008) describing how battering partners are likely to engage in manipulative behaviors with caseworkers, which in turn made navigating the child welfare system more challenging for mothers particularly if batterers are effective in conveying an image of mothers as "uncontrollable or crazy."

Resembling previous studies with a focus on IPV, women believed child welfare workers did not have sufficient skills to screen for IPV nor the necessary knowledge to handle these cases (Douglas & Walsh, 2010). Similarly, studies have found discrepancies between child welfare professionals and mothers on the topic of managing domestic violence (Schim et al., 2010). For example, mothers may want to end the abuse but maintain their partnership and caseworkers may only pursue termination of IPV and the abuser-victim relationship.

Finally, four participants reported that their children's fathers were uninvolved. These findings confirm existing research identifying women as the primary caretakers of children,

experiencing high levels of stress and minimal support from fathers, which leaves them at a high risk for perpetrating abuse and neglect (Risley-Curtis & Heffernan, 2003; Strega et al., 2008).

Friends. Slightly less than half of participants found their friends to be supportive, whereas the rest of the sample characterized their relationships as highly conflictual or maintained solely around substance use behaviors. Various studies (Coker et al., 2002; Coker et al., 2003; Samuels-Dennis et al., 2010) have established that social support networks can prevent survivors from engaging in abusive relationships and serve as protective factors against trauma symptomatology. Conversely, research (Samuels-Dennis et al., 2010) also shows an association between women's trauma experiences and deteriorated friendships. In this study, although participants were able to identify the type and level of support provided by friends, there were no reflections about how their personal behaviors impacted relationships with friends.

Caseworkers. Caseworkers were also perceived as supportive in various situations, but also as uncommitted to success of parents. Regardless, a consistent tendency among participants was to describe caseworkers as instrumentally supportive. These findings are relevant and confirm existing literature indicating the critical role of caseworkers in the lives of child welfare recipients (Alpert & Britner, 2009; Hill et al., 2012; Ryan et al., 2006; Smith, 2008). The current study confirms that parents in child welfare would like more emotional support from caseworkers (Alpert, 2008). Furthermore, present findings confirm the need to investigate ways in which the unrealistic and strenuous demands placed on caseworkers by the system and their lack of training (e.g., cumulative trauma), may set professionals up for failure in the face of relationships with clients suffering intense trauma symptomatology (Font, 2012; Kyonne, 2008).

Mothers' commitment to the goals set by child welfare caseworkers is conducive to promoting child safety and well-being (Waldfogel, 1998). Therefore, finding ways to increase

mothers' engagement is essential. Current results highlight the need for caseworks and child welfare professionals to remain attentive to the ways in which the investigation of service recipients' parenting practices may further trigger trauma-related responses from survivors (Hill et al., 2012). Attention to this issue may alter women's perceptions of caseworkers and improve their willingness to collaborate with caseworkers.

Other service providers. Generally, non-caseworker professionals were viewed positively by participants. Some of the supportive professionals participants found particularly helpful included therapists, parent-support partners, and medical case managers. These findings confirm that non-caseworker helping professionals who do not have the responsibility of evaluating parenting performance do not have the additional burden experienced by caseworkers whose responsibility is to make recommendations about returning children to biological parents (Font, 2012; Kyonne, 2008). These referrals were primarily supportive to clients, with less of an emphasis on evaluation of parenting, which allows for greater capacity to trust and establish working relationships. Having these types of referrals is beneficial to improving parenting, but also facilitates healing from trauma through trusting relationships. Although not surprising, these findings indicate the high need for interdisciplinary work and collaboration in the child welfare system under the umbrella of cumulative trauma and healing, particularly because there is a risk of labeling some professionals as the "good" helpers while holding caseworkers on a negative lens (Sykes, 2011). Furthermore, these findings highlight the need for research aimed at experiencing the personal and professional experiences of caseworkers committed to help others but operating in a resource-exhausted system and engaging in frequent emotionally straining interactions with parents and children (Font, 2012; Kyonne, 2008).

Trauma-coping and Resilient Parenting Behaviors

According to a feminist perspective, it is essential to highlight the strengths of women in this study. Despite intense stories of adversity, all women in this study embraced a remarkable sense of resilience, as has previously been documented regarding child welfare involved-trauma survivors (Chemtob et al., 2011; Burns-Jager & Carolan, 2010). Utilization of coping skills is essential to healing from trauma. As a result, skills-training is often emphasized in treatment for complex trauma survivors. Interventions for trauma survivors teach the coping skills women in this study displayed including confronting problems, positive self-talk, and relaxation (Waldorf & Zlotnick, 2001; Zlotnick et al., 1997).

Coping and Resilient Behaviors Reported by Women

Garmezy (1990) has described three types of resilience according to level of individual functioning. This typology is helpful to understand the nature of resilience reported by women in this study. The first type of resilience identified by Garmezy refers to the highest level of adaptive functioning individuals can reach despite the adversity they have experienced. The second type of resilience refers to individuals being able to maintain normal functioning levels despite adverse life experiences. The final type of resilience refers to individuals who initially display adverse effects resulting from difficult life experiences, but who are able to gradually adapt and display normative functioning. Women in this investigation tend to fall in the third category of resilient individuals. In essence, all participants experienced profound trauma and subsequently displayed maladaptive coping strategies in response to adversity. However, over time and with the support of meaningful personal and professional relationships, they have adapted and displayed remarkable resilient behaviors. Findings in this study parallel assertions by other studies indicating that effective trauma coping is associated with relationship

satisfaction, less isolation, improved health, and use of healthier parenting skills (Wright, Crawford, & Sebastian, 2007).

For example, women in the current study used cognitive and behavioral strategies to cope with trauma and the effects of trauma. Armsworth and Stronck (1999) observed similar resilient behaviors in their study on child welfare involved mothers. Specifically, their participants engaged in cognitive strategies methods such as stopping self-defeating thought processes and integrating behavioral coping behaviors to reduce the negative effects of trauma symptoms. Similarly to current findings, the relationship women had with their children was a significant source of resilience and many of the women also cited their children and past experiences as motivation for making changes in their lives (1999; Burns-Jager & Carolan, 2010).

A point of divergence with Armsworth and Stronck's research, referred to women in the current study being more likely to use medication to deal with trauma symptoms. Specifically, women felt that the medical treatment of their mental health was a crucial component of their recovery. Although it is not common in the resilience literature to identify the use of medication as a coping mechanism (Chemtob et al., 2011; Sholtes, 2001), current findings indicate the high need to remain attentive to preconceived notions of resilience and always nurture the promotion of resilient behaviors according to what women identify as meaningful resources for recovery. Women's descriptions of the benefits of medication to regulate symptoms should not go without notice.

Additional Signs of Recovery

A primary step of trauma recovery requires the capacity to master trauma memories and associated physiological reactions and emotions. Women in this study displayed progress towards achieving these skills, which improved interactions with children and caseworkers

(Harvey, 1996). Another sign of trauma recovery was women's capacity to develop a positive view of self. Specifically, when survivors reported being able to feel satisfied with themselves in interaction with others, they were more able to make further strides in their process of recovery, which confirms existing literature on the important effects associated with developing a strong sense of self (Banyard, 2007). However, it is important to highlight that for some women in this study having a positive view of self, did not seem to prevent them from having on-going relationships that were abusive or exploitative. One possible explanation for this phenomenon refers to Harvey's (1996) considerations on trauma and relationships, which states that exposure to trauma significantly damages the ability to trust others, hindering the capacity to engage in healthy, non-exploitative, and secure relationships.

Although some authors consider that an essential step in trauma recovery consists of assigning meaning to traumatic events (Herman, 1992; Walker, 2007), and that if trauma is not processed the individual's mental health will continue to deteriorate, research participants did not uniformly reported engaging in this meaning-making experience. What participants did commonly state is how they wanted to learn from their parents' mistakes. Thus, one meaning derived from their trauma was learning what type of parent they wanted to be to their children.

Scholars have proposed that experiencing cumulative trauma does not constitute a sole predictor for an individual's perception of sense of control in life, however, the more traumatic events an individual experiences, the more challenging it will be to reach a sense of control in life (Agaibi, 2005; Ammerman, 1990; Benight & Bandura, 2003; Werner & Smith, 1989). Furthermore, high levels of self-efficacy support women in continuing to participate and expand their "resource network" despite the presence of trauma symptoms (Walter, 2010). Both premises were confirmed in this study according to the data.

Positive Parenting

Women reported several authoritative and engaged parenting behaviors. Moreover, the results of the AAPI-2 demonstrate that mothers' parenting beliefs concur with those of the majority of parents in the general population (Bavolek & Keene, 1999). For example, mothers reported feeling bonded to their children, learning how to set appropriate and non-punitive limits, and increasing emotional and nurturing-based patterns of communication with their children. The participants' ability to embrace these parenting experiences constitutes evidence of their process of change and recovery from trauma and adversity (Banyard et al., 2003; Banyard & Williams, 2007; Baumrind, 1967; Baumrind, 1971; O'Dougherty, 2005; Reid, Patterson, & Snyder, 2004).

Furthermore, despite qualitative reports of incest survivors describing feeling numb or detached from their parenting roles (Armsworth & Stronck, 1999), mothers in this study conveyed a very different experience. Specifically, research participants felt highly connected to their children and over time, viewed themselves positively in their parenting role. This finding also confirms research indicating that holding a positive self-perception as parent, further enhances a process of recovery from adversity (Banyard, 2007).

Strengths and Limitations of the Investigation

Important limitations associated with this study must be identified. First, results are limited to self-report data, which inherently carries the risk of bias as the parenting literature has confirmed when comparing and contrasting self-report and parent-child observations of parenting interactions. Thus, participants may have experienced personal biases when reporting how trauma affects various areas of their lives

Because this study was qualitative in nature, findings cannot be generalized to the larger population. This investigation was also limited based on sampling characteristics as participants

in this study were predominantly of Euro-American descent, excluding the possibility to fully capture the experiences of racial and ethnic minority women.

Furthermore, important macro-level variables were not sufficiently explored due to research design limitations. Thus, the impact of variables such as economic and employment climate, child welfare policies, institutional patriarchy, sexism, and racism were not sufficiently explored.

Finally, the sample size is small for a grounded theory study. Although several strategies were implemented to increase the sample size, the multiple challenges experienced by this population became considerable barriers to the recruitment process as women initially screened reported multiple contextual stressors that competed with their participation in this study (e.g., transportation and child care challenges, personal and medical emergencies).

Because participants were of a convenience sample, there are inherent biases. Several other women were recruited to participate in the study. It is hypothesized that the women in the sample's ability to participate make speak to their resilience. Women who wanted to participate were potentially unable to due to on-going stressors. Therefore, this grounded theory may not capture the intensity of trauma or life challenges of other women in the child welfare system who may not have had the instrumental or emotional resources to participate.

Notwithstanding these limitations, this study offers a relevant contribution to an understudied area of research and applied scholarship. First, there is a scarcity of research documenting how cumulative trauma and trauma symptomatology constitute barriers to the parenting experiences of women involved with the child welfare system. Thus, this study captures with detailed personal accounts how trauma symptoms impact the participants' parent-child interactions, as well as other meaningful life experiences.

This investigation also gives voice to women regarding their trauma and child welfare experiences. This population holds a minority status and position in the system, and they run the risk of being looked down upon as being 'bad' parents. Therefore, this study acknowledges and privileges their perceptions of events as opposed to others in the child welfare system who hold more power and who may only depict them according to deficit-based perspectives.

Finally, the collection of quantitative and qualitative data provides an opportunity to triangulate information, as well as obtaining an in-depth description of the complexity of women's parenting experiences, cumulative trauma, and trauma symptoms. This data collection strategy also allows for the identification of data focused on resilience that may not be captured by relying exclusively on one method of data collection.

Future Research Directions

Future studies would benefit from interviewing caseworkers and other professionals about their interactions and perceptions of clients with a trauma history. It would be particularly beneficial to learn how caseworkers interpret and view their own responses to survivors' narratives of adversity. For example, caseworkers and therapists could be interviewed about how they have seen trauma influence their clients. It would be equally beneficial to investigate with these professionals how equipped do they consider their agencies are to deal with such issues, as well as to the extent to which their level of training is sufficient to deal with the confounding problems that affect women (e.g., cumulative trauma and neglectful parenting).

There is also a need for in-depth quantitative investigations on the connection between trauma symptoms and parenting behaviors. Quantitative research in this area is imperative. For instance, an important contribution would consist of studies aimed at quantitatively assessing the level of impact of cumulative trauma on women's parenting practices and skills. Currently,

quantitative research has established that trauma history predicts poor parenting, however, much more detailed research is needed to further clarify mechanisms of moderation and mediation associated with these processes.

Because trauma symptoms are not mutually exclusive, future research needs to investigate patterns of association among specific trauma symptoms in order to maximize diagnosis and treatment focused on co-occurring disorders (i.e., mental health and substance abuse disorders). Future studies also need to explore the potential benefit of adapting parenting interventions by fully considering the nature and impact of cumulative trauma and trauma symptomatology. For example, research with mothers in the general population with a history of adversity have reported benefiting from parenting interventions that emphasize self-regulation and non-punitive parenting strategies (Forgatch et al., 2005). Future studies should also investigate the differential impact associated with differential level of adaptation aimed at addressing cumulative trauma. Finally, because this study was characterized by multiple implementation challenges, research is needed to document the most optimal recruitment and retention strategies aimed at engaging women in applied research with this underserved populations.

This will be extremely important to explore as racial minorities face the added trauma of social inequality and racism. Professionals need to understand minority women's experiences as they are overrepresented in the child welfare system (CDC, 2012; Blakey & Hatcher, 2013).

Implications for Interventions

Current findings have important implications for caseworkers, mental health professionals including family therapists, and administrators committed to working with mothers

with a trauma history who are involved with the child welfare system. Specific recommendations are discussed below.

Recommendations for Caseworkers. Viewing women's problematic interactional and parenting behaviors from a trauma perspective will be particularly helpful to caseworkers, particularly because it provides a direction for intervention that has the potential to be more effective and engaging for women in the child welfare system. Thus, it is essential that providers acknowledge the role of trauma in the lives of women involved in the child welfare system. As Burstow (2003) states, overlooking this factor minimizes their trauma, thus further perpetrating women's difficulty trusting others and preventing healing from taking place. Acknowledging trauma in and of itself can be validating and trust-building for clients. The results of this study can inform provision of services to mothers with a trauma history who are child welfare involved. It is essential that services are provided in a trauma-sensitive manner (Chemtob et al., 2011; Burns-Jager & Carolan, 2010). For this population it is irrelevant to suggest that painful or traumatic events will not happen. Rather, counselors and caseworkers need to assist clients in developing skills to cope and problem solve whenever painful events occur.

Establish Trust. Caseworkers and professionals need to expect that mothers will struggle to trust professionals. As a result, caseworkers need to react to mistrust with empathy and understanding. One way of establishing trust will be to communicate with trauma survivors in a clear, direct manner. Failure to do so, will likely heighten mistrust towards caseworkers. Caseworkers will also benefit from approaching cases collaboratively with clients. Women who have been abused often times feel powerless. Thus, whenever a caseworker takes a punitive authoritarian approach resembling perpetrator actions, survivors are exposed to secondary victimization through triggering trauma symptoms and perpetuating feelings of powerlessness.

There is concern that trust between caseworkers and mothers is strained because caseworkers are focused on parent accountability for abuse or neglect, while parents deny accountability to maintain a positive view of self as a parent (Sykes, 2011). As a result, it has been suggested to first secure a trusting relationship and parent engagement, prior to promoting accountability (2011). Rather than abandon parent accountability, caseworkers may benefit from seeking parents to understand behaviors as abusive or neglectful as a result of trauma experiences.

Set and Model Appropriate Boundaries. Mothers involved in the child welfare system have had many negative interactions with people that fuel lack of trust. One way to establish trust and build a relationship with this population will be to use a strength-based approach rather than deficit-based. Women in the current study often felt like their caseworkers focused heavily on what they did wrong and rarely acknowledged successes. Plenty of research supports that strength-based approaches and positive reinforcement are more effective ways of changing behaviors than use of criticism and punishment.

Understand Emotional Dysregulation. Responding calmly to the behaviors women commonly display with caseworkers would be challenging for most people. When someone is screaming or cursing, it is definitely hard to be understanding. No doubt, caseworkers often face this issue with the clients they serve. As a result, caseworkers must be able to approach these tresponses from a trauma-sensitive lens. In these situations, it is appropriate for caseworkers to communicate boundaries and expectations for interactions. Clients must also be supported to identify and eventually control behaviors resulting from emotional dysregulation. Compassionate responses will benefit the relationship by further establishing trust between caseworkers and clients.

Response to Supportive and Unsupportive Contexts. The child welfare system carries the risk of being perceived as insensitive to the role of IPV in mothers' lives and of blaming the woman for children's exposure to IPV. For example, women survivors of IPV have had their children removed due to their 'failure to protect'. This dismisses the extent of the power that a batterer establishes over his partner through manipulation and tactics of power and control.

Caseworkers need to be aware of up-to-date recommendations on managing cases where IPV has occurred as well as to be guided by women's desires with regards to their relationships. For example, traditional IPV services have an agenda of complete separation from the abuser, which alienates women who wish to end the abuse but preserve the relationship. Thus, caseworkers must always remain attentive to the participants' desires and life goals.

Recommendations for Child Welfare Administrators. Participants' experiences with caseworkers in the current study highlight the need for structural improvements within the child welfare system, particularly because the burden of implementing trauma-sensitive practices in the child welfare system cannot be fully placed on caseworkers. Thus, administrators play an important role in creating a system that can promote and sustain these types of interventions. Primarily training on trauma-sensitive practice must be valued and implemented at the administrative level. Moreover, in order for caseworkers to maintain a trauma-informed practicewith survivors, caseworkers will need a more supportive, less stressful work environment. Burn-out is a very common problem in the child welfare field correlated with high case-loads, low pay, low autonomy, and emotionally taxing work responsibilities (Font, 2012; Kyonne, 2008). Therefore, funds need to be allocated to better compensation of caseworkers and hiring of more staff to mitigate these issues that likely impair the quality of service that is

provided. Providing trauma-sensitive services would require extra time and care with clients, which may be challenging for caseworkers who are in over-exhausted agencies.

Recommendations for Family Therapists and Other Mental Health Professionals. Few interventions for complex trauma have been tested in the mental health field and debate exists regarding the most efficacious approaches (Cloitre, 2002; Waldorf & Zlotnick, 2001; Zlotnick, Shea, Rosen et al. 1997). Conclusions from the research suggest that complex trauma interventions for childhood maltreatment should focus first on skills training to assist in symptom reduction before focusing on trauma- exposure components (i.e. Cloitre, 2002). According to the data, the recommendations for treatment proposed by Briere and Carol (2004) are timely and should consist of safety planning, establishing an empathic therapeutic alliance, trauma processing, addressing negative view of self, working on mood disturbances, treating, and promoting advocacy and use of psychotropic medications for mood disorders.

Establish trust. Clinicians must take time to establish trust and ensure that they are using clear and direct communication with mothers. Whereas this is crucial in joining with any client, therapists must take extra care and time to establish trust with child welfare-involved trauma survivors. This is in-line with Briere's recommendations. He emphasizes that trust is an essential technique with trauma survivors and that without it, therapy will be unsuccessful. He further insists that gaining the trust of survivors takes time. Therapist should not expect to quickly join with survivors, and be patient in earning their trust. It is critical that therapists do not underestimate the importance of this step in therapy.

Another way to establish trust is to focus on clients' strengths. As indicated by the results of this study, there is a potential disconnect between parenting beliefs and actual behaviors. Although this may be the case, it provides a starting point for parenting interventions with the

goal being more integration of parenting beliefs and behaviors. Therapists can validate parents that mothers' beliefs about parenting are accurate, however it is trauma symptomology that interferes with their ability to adhere to belief systems.

Psychoeducation. Before parenting-specific interventions are used, interventionists will need to educate participants about typical trauma symptoms associated with complex trauma including interpersonal disturbances, emotional dysregulation, identity and cognitive distortions, avoidance responses, somatization, and mood disturbances (Briere, 2009). It may be helpful for professionals to describe how traumatic events and specific triggers can lead to trauma symptoms. Understanding their reactions can be empowering for survivors and a first step to mastering their symptoms. This is a way to acknowledge that women are having interpersonal problems, but also removes blame and instills personal agency. Psychoeducation further helps to balance acknowledging abuse and neglect, while being empathic to the causes of these issues.

Inclusion of Support Systems. Therapists must be cognizant that that women will learn healthier interactional and parenting styles in therapy, but will return to social contexts that are likely to uphold abusive or exploitative relationships. Therefore, clinicians should always find ways to expand informal support systems.

Furthermore, IPV survivors are often held responsible for abuse against their children overlooking the role of perpetrators. In many cases, child welfare agencies such as Child Protective Services (CPS) refer to this as failure to protect their children, without considering key IPV dynamics. As a result, interventionists need to be familiar about dynamics commonly associated with IPV and the risk for secondary victimization of survivors.

Emotional Regulation Skills Training. For women in this study poor ability to regulate emotions hurt relationships with others including interactions with their children. As a result,

parenting interventions need to provide skills training on emotion regulation. Examples of skills that could be taught include deep breathing, taking a time-out from distressing situations, identifying emotions, and awareness of physiological responses associated with emotions.

Treatment of Mood Disturbance and Substance Abuse. Mood disturbances and substance abuse are additional major concerns for trauma survivors. Therefore, women need strategies for self-care, cognitive behavioral strategies for negative thoughts and underlying depression. Given the frequency of substance abuse as a coping strategy for trauma and symptoms, it is crucial that parents are assessed for substance abuse and referred to adequate services as needed. The use of medication to treat mood disturbances was a major finding in this study, highlighting to mental health professionals the critical need for interdisciplinary work.

Self of the Researcher

It's important for me to acknowledge that I hold a dual role as a researcher and as a therapist who provides services to child-welfare involved mothers. My experiences as a therapist informed the analysis of the data. Particularly, my experiences have allowed me to witness the pain child-welfare involved mothers endure and how the child welfare system contributes to women's trauma and reinforces trauma symptoms. As a feminist researcher and therapist, my position is not neutral, but rather as an advocate for improved interventions for trauma survivors. This investigation, as a result, had the purpose of privileging mother's narratives of resilience and trauma and connecting these narratives to the context in which women exist. I was amazed by women's ability to be resilient despite the horrific experiences they've been through. Additionally, their commitment to their children and getting better for their children was very powerful to witness; especially given that this narrative is often silenced.

One concern I had in conducting interviews was that women would be rightfully guarded in speaking with me. However, women were incredibly open and candid during interviews. I was humbled when many of the women were appreciative of the study, for having the opportunity to tell their story, and to have their experiences validated. Women were interested in providing any information that might help make another parent's experience with the child welfare system better.

I also want to acknowledge my position of power in organizing and synthesizing the results of interviews, as well as my social position which is one of a White, middle-class graduate student. The position I hold influences the way I view participants and interpret the data. However, I attempted to use this position of privilege to advocate for trauma survivors and the adaptation of interventions to better suit survivors' needs.

Conclusion

This study offers a contribution to our understanding of the life and parenting experiences of mothers involved in the child welfare system. Despite limitations associated with a small sample size, this investigation offers meaningful first-person accounts of the participants' experiences with trauma and adversity, as well as powerful testimonies of personal resilience. Moreover, this study offers relevant information for adapting interventions for survivors served by the welfare system. Findings clearly confirm the need to inform services and interventions for this population according to a thorough understanding of the adversity they have experienced, as well as the multiple resources and sense of resilience that inform their lives.

APPENDICES

APPENDIX A

Study Consent Form

How Child Welfare Involved Mothers' Trauma History Influences Parenting: A Grounded Theory Study

Consent Form

Purpose of the Study:

The study entitled, "How Child Welfare Involved Mothers' Trauma History Influences Parenting: A Grounded Theory Study" is being conducted to explore how difficult life experiences influence how parents interact with their children. The goal of this study is to inform caseworkers, therapists, and other professionals on how clients' difficult life experiences explain some of the struggles they have with their parenting and in navigating the various services to which they are referred. We hope that this study will promote greater empathy and understanding for clients and that it will help make services and interventions more effective.

What your participation would include:

There are two components to this study that you would complete if you choose to be a part of the study. One component is an interview that would take approximately 1 hour. During the interview you will be asked questions about any difficult life experiences you have had throughout your life and how you think these difficult experiences have influenced your parenting. You will also be asked about your experiences dealing with caseworkers and service providers who are associated with the Department of Human Services (DHS). It is necessary that interviews are audio-recorded to ensure that we accurately document your responses. By consenting to participate in the study you are consenting to have your responses in the interview audio-recorded.

The second component of participation in this study consists of paper and pencil assessments. One assessment asks questions about your parenting beliefs, and another assessment asks questions about different symptoms you have experienced in the past. You will also answer some general questions about yourself (marital status, age, etc.). For your time and effort given for participating in the study you would be compensated in a $25 gift card to a local department store of your choice (Meijer, Kroger, Wal-Mart).

Privacy and Confidentiality:

Your confidentiality will be protected to the maximum extent allowable by law. Confidentiality would only be broken if you report abuse of children, elderly adults, or if you report you are going to harm yourself or someone else. If we suspect a child is or may be abused or neglected, we must contact Children's Protective Health Services immediately. The assessments you complete will be assigned a participant ID number and will not have identifying information so you will not be linked with any results. Unidentified data will be shared will be shared with members of my doctoral committee. The Michigan State University Human Subjects Protection Program may also have access to your data in the event of an audit. The recording of your interview will be labeled with an ID number and will not be linked in any way to your contact information. Your contact information and unidentifiable results of assessments and the interview will be stored in a locked file in a locked office and on the researcher's password protected computer. We will keep all data associated with this research project for three years after the project is closed, during which time it will be stored in a locked file in the principal investigator's office.

The findings of this study will be reported to many people and organizations. People who may hear the findings of this study include students and faculty and Michigan State University, the Ingham County Department of Human Services, the Institutional Review Boards monitoring the project, and the larger academic community. When the results of this study are presented and published, pseudonyms will be used and any identifying private information will be modified or omitted to protect the identity of participants.

Although Kathleen Burns-Jager referred you to this study, the researcher will not inform her about whether or not you participated in the study. However, if you choose to hold your interview at Perspectives Therapy Services, there is a chance that she will see you since her office is located in this building. If this were to happen, her knowledge of your participation will not affect your therapeutic services.

Your Rights to Participate, Say No, or Withdraw:

Participation in this research study is completely voluntary. You may say no to participation or you may change your mind and decide to stop participating at any time with no negative consequences. You may also choose not to answer any question you do not want to answer. Withdrawing from the study or not answering questions would not prevent you from receiving compensation for participation in the study.

Potential Risks and Benefits:

There is a risk that you might experience some discomfort while participating in this study. For example you might feel uncomfortable reporting demographic information or discussing difficult experiences you have had throughout your life. Please remember that your confidentiality will be protected and your identity will not be connected to your answers. If you do experience discomfort you may choose to not answer a question, take a break from answering questions, or you may stop participating in the study at any time with no penalty.

You may experience benefits from participating in this study. You may experience some relief in discussing past life experiences and to explain how you perceive those difficult life experiences have interfered with your parenting. You can also provide feedback on how services can better meet your needs. You may experience a sense of satisfaction in knowing that you are a part of a project that is seeking to better inform DHS professionals on the difficult life experiences of clients and how those life experiences have effected them so that DHS professionals can better meet their needs.

Contact Information for Questions or Concerns:

If you have questions or concerns about this study including scientific issues, how to participate, or to report any harm, please contact the researchers directly:

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In addition if you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this research study, you may contact, anonymously if you wish, Michigan State University Human Research Protection
Program at 517-335-2180, FAX: 517-432-4503, or email irb@msu.edu, or postal mail at: 408 West Circle Dr., MSU, East Lansing, MI 48824.

Informed Consent

You indicate your voluntary agreement to participate in this research and have your answers included in the data set by completing and returning the attached questionnaires.

If we suspect a child is or may be abused or neglected, we must contact Children's Protective Health Services immediately. *You will be given a copy of this form to keep.*

APPENDIX B

Demographic Questionnaire

Demographic Questionnaire:

1. How old are you? _____

2. What is your ethnicity? _____

3. How many children do you have? _____

4. What are your children's ages? _____

5. Do your children live with you? _____

6. If your children don't live with you, how often do you see your children? _____

7. Are you employed? _____

8. What is your relationship status? _____

9. What is the highest grade in school you completed?_____

10. What is your approximate annual income?_____

APPENDIX C

Structured Interview Guide

Structured Interview Guide

INTRODUCTION: Thank you for agreeing to participate in this study. First let me tell you a little bit about why I'm doing this study and what I am looking for in our interview today. I am a family therapist and for the past few years I have primarily been working with parents and families who have been involved with the Department of Human Services (DHS) and foster care. One of the things that I have noticed in working with parents is that they often have had a lot of really difficult life experiences before ever dealing with DHS. One of the problems that I have run into is that these difficult experiences are not always taken into account by caseworkers, judges, and even therapists in understanding why parents may be having difficulties with their children. So what I am trying to do is put together some ideas on how parents' difficult life experiences influence their parenting to help all of those professionals really understand parents' struggles with their children. I am hoping that this information can help them also be more effective in getting parents the services and help they need. So I'll be asking you about some of the difficult experiences you've had and how you think they may or may not have influenced your parenting. I will also tell you a little bit about ways we know how difficult experiences can influence parenting and ask you if they fit with your experience or not. Finally, I'll be asking you about whether or not service-providers have been understanding of your experiences, and if you have any suggestions for service-providers related to this topic.

GRAND TOUR QUESTION #1: TRAUMA HISTORY

First, please tell me about the most difficult experiences you had while growing up?

Probes:

- How do you think each experience affected you?
- How do you think each experience affected how you interact with others?
- How do you think each experience affected how you see yourself?
- How do you think each experience affected how you interact with your children or how you make parenting decisions?

GRAND TOUR QUESTION #2: TRAUMA SYMPTOMS

You completed one assessment that refers to many symptoms commonly experienced by people who have been exposed to intense challenges in life.

Which of these symptoms do you consider constitute the greatest challenge(s) to your parenting efforts?

Probes:

How challenging are the following with regards to your parenting efforts?:

Identity disturbances
How challenging does confusion about your feelings, thoughts, and goals that make it difficult to set boundaries with others make it for you to…

- parent your child?
- maintain healthy social relationships?
- interact with child welfare professionals?

Mood Disturbances
How challenging do depression and anxiety make it for you to…

- parent your child?
- maintain healthy social relationships?
- interact with child welfare professionals?

Avoidance responses
How challenging do difficulties dealing with or confronting problems; wanting to use strategies to avoid dealing with problems; using substances, dissociating, hurting self make it for you to…

- parent your child?
- maintain healthy social relationships?
- interact with child welfare professionals?

Interpersonal difficulties
How challenging do difficulties with trusting others, getting close to others, fear of rejection or abandonment make it for you to…

- parent your child?
- maintain healthy social relationships?
- interact with child welfare professionals?

Cognitive disturbances
How challenging do negative views and beliefs about yourself and other people make it for you to…

- parent your child
- maintain healthy social relationships?
- interact with child welfare professionals?

Somatization
How challenging do any sicknesses or illnesses make it for you to…

- parent your child
- maintain healthy social relationships?
- interact with child welfare professionals?

Emotion regulation difficulties

How challenging do difficulties calming down when you feel sad or angry make it for you to…

- parent your child
- maintain healthy social relationships?
- interact with child welfare professionals?

GRAND TOUR QUESTION #3: CONTEXTUAL SUPPORT

Who are the primary people who support you in your life/ parenting? Who do you feel safe with? How and to what extent did the following people support you as a parent?

- Partner?
- Child's Father?
- Family?
- Friends?
- Place of employment (if applicable)?
- Child's school (if applicable)?
- Others in the community (e.g. religious organizations, community organizations)?
- Case management/social workers associated with your case?
- Therapists or counselors that have provided therapeutic services to you?
- Other professionals relevant to your case (e.g., judges)?

GRAND TOUR QUESTION #4: TRAUMA RECOVERY

Is there anything/ anyone currently threatening your safety? What have you done that has helped you deal with:

- Depression and/or anxiety
- Difficulty trusting others, feeling close to others, and fears of rejection or abandonment?
- Confusion about your feelings, thoughts, needs that make it difficult to set boundaries with others
- Difficulty calming down when feeling angry or sad?
- Difficulty dealing with or confronting problems; wanting to use strategies to avoid dealing with problems; using substances, dissociating, hurting self
- Difficulty with sickness or illness
- Negative views and beliefs about yourself and other people

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