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Looking Through a Trauma Lens: A Caregiver's Perspective of Child Welfare Involvement

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Abstract

The majority of maltreatment perpetrated against children is at the hand of their primary caregiver, most often their mother. The reasons why caregivers maltreat their children are still being investigated. However, the caregiver's history of trauma, in particular cumulative trauma that leads to trauma symptomology is emerging as an explanation for maltreatment. Popular theory describes the coercive and oppressive nature of child welfare system policy and practices, as a source of re-traumatization for caregivers with a trauma history (Harris & Fallot, 2001). Currently, the field of child welfare practice is largely guided by the use of trauma-informed practices, which are meant to bring to light the prevalence of trauma in these populations. Yet, little research has focused on examining the experiences of caregivers involved with child welfare through a trauma lens. Additionally, research that investigates caregivers in child welfare almost always focuses on biological mothers. Therefore, we know even less about caregivers who identify outside this norm, such as fathers, kinship providers and adoptive parents. This research seeks to fill this gap in knowledge by asking the question: How do caregivers with a history of trauma experience child welfare involvement? An exploratory design with a phenomenological approach was employed to answer this question. Ten caregivers; seven biological mothers, one adoptive mother, one kinship provider, and one father were interviewed. The caregiver's experiences of trauma in this study were extensive. All caregivers had experienced at least one traumatic event and the majority reported multiple, chronic, and cumulative traumas. For these caregivers the experience of child welfare involvement was filled with potentially traumatic experiences, starting with the initial allegation and the lingering threat of continued involvement even after the case was closed. Caregivers often found these experiences as betraying of their trust, coercive, leaving them powerless, and stigmatizing. It was found that the assumption that child welfare is re-traumatizing was not sufficient to explain the caregiver experience rather, child welfare involvement, in and of itself, is traumatic.

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CHAPTER ONE: INTRODUCTION

1.1 Problem Statement

In 2015, The U.S Department of Health and Human Services (USDHHS, 2017), reported that approximately 4 million referrals for child maltreatment were received and of those, 2.2 million cases were assessed as needing child welfare intervention. The majority of the children (91.6%) with a substantiated maltreatment finding were maltreated by one or both parents, and of those, 70% were maltreated by their mother (USDHHS, 2017). The ways in which state child welfare systems address child maltreatment vary widely, though the three primary goals are the same: safety, permanency, and well-being (Chen & Ling Chan, 2016). The most common intervention offered to parents involved in child welfare is parent education programs (Chen & Ling Chan, 2016). Parent education programs may take the form of a parenting class in a group setting or one on one with the parent(s) in the family's home. While parenting classes are commonly manualized and evidence based, in-home services vary widely in frequency, duration, intensity, and delivery (Chen & Ling Chan, 2016). Despite the wide range of options in the delivery of parenting education the successes are limited. Several meta-analyses have been conducted to explore the efficacy of parent education, including both classroom style instruction and in-home interventions with mixed results, due to lack of program fidelity and stringent research designs (Bugental & Schwartz, 2009;

Duggan et al., 2007; Filene, Kaminski, Valle, & Cachat, 2013; Johnson, et al., 2008).

However, the most striking finding is the lack of reduction in further incidences of child

maltreatment (Bugental & Schwartz, Schwartz, 2009; Duggan et al., 2007; Filene,

Kaminski et al., 2013; Johnson, et al., 2008). Although one study found a reduction in

substantiated abuse reports, as well as self-reported child maltreatment, concerns still

existed (Chen & Ling Chan, 2016). Specifically, it was reported that many parent

education programs lacked a psychoeducational component that helped parents to

understand their reactions to child behavior, within the context of their trauma and/or

environmental stressors, an element indicated in child maltreatment (Chen & Ling Chan,

2016). Chen and Ling Chan concluded that programs, which provide parenting education

need to acknowledge the impact of trauma on parenting and the importance of engaging

caregivers through a trauma-informed paradigm to achieve success.

The lifetime prevalence rates of experiencing a traumatic event with the potential

to lead to diagnosis of Post-Traumatic Stress Disorder (PTSD) in community parenting

samples ranges from 80-91% (Bosquet Enlow, Egeland, Carlson, Blood, & Wright, 2014;

Gillespie et al., 2009; Roberts, Gilman, Breslau, Breslau & Koenen, 2011). In a recent

study of 127 birth mothers who were receiving child welfare services, 91.6% of mothers

had experienced at least one traumatic event and 73.2% had experienced multiple

traumas (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011). Similarly, Becker et al.

(2005) found among a large, nationally representative sample of women with co-

occurring mental health and substance use disorders that 91.3% reported being physically

abused, 90% reported sexual victimization, and 74% reported multiple traumas.

Importantly, 86.7% of these women were mothers and 69.9 % of these mothers reported

contact with child welfare agencies within the previous 6 months, which resulted in

removal of their child (Becker et al., 2005).

The National Comorbidity Replication Study conducted from February of 2001 to

April of 2003 estimated that the lifetime prevalence of Post-Traumatic Stress Disorder

(PTSD) among American adults was 6.8% (Kessler et al., 2005). Other studies

have found estimates of PTSD to be between 10-20% with higher rates in samples of

low-income and non-white women (Gillespie et al., 2009; Parto, Evans, & Zonderman,

2011; Roberts et al., 2011). For mothers involved with child welfare the lifetime

prevalence rates of PTSD vary widely from 7.7% in a multi-national study to 54.3% in a

study focused on mothers in child welfare in the US (Chemtob, et al., 2011; Loveland

Cook et al., 2004; Smith, Poschman, Cavaleri, Howell, & Yonkers, 2006). Despite

the high prevalence of PTSD in parenting samples, Chemtob and colleagues (2011) found

that only 5.6% of the mothers with probable PTSD were receiving services to address

their mental health concerns. Studies of child maltreatment tend to focus on biological

mothers, as mothers provide most of the direct caregiving to children in the US, however

this demographic appears to be undergoing some change.

In 2015, 91% of maltreatment cases were attributed to the child's parent, with

approximately 70% of being attributed to the child's mother. It was reported that 40.9%

of those mothers acted alone (USDHHS, 2017). The remaining cases (28%) that

implicated the child's mother also identified a father or other caregiver as a co-

perpetrator. Twenty-one percent of total cases were attributed to fathers; however, it was not stipulated if these fathers were founded as acting alone or with a co-perpetrator. These findings are not surprising as women head most single parent households and by and large, are still primarily tasked with direct caregiving. However, single father households are one of the fastest growing family structures and men are increasingly taking on caretaking roles (Pew Research Center, 2013). Individuals who become involved with child welfare because of maltreatment are those responsible for the care of the child, and not always the biological mother. Caregivers may look different that the dominant stereotypes and represent a broad array of individuals including fathers, adoptive parents, and kinship providers. In addition these "alternative" versions of caregivers can share the impact of a trauma history, impacting their child rearing decisions. There is a wealth of research that demonstrates the link between trauma and child maltreatment, leading to child welfare involvement.

1.2 Significance of the problem

 1.2.1 Trauma. The current knowledge base related to trauma and its impact on the brain, behavior, and relationships may inform how caregivers experience child welfare involvement and intervention. The American Psychiatric Association (APA) (2013) defines trauma as: "…exposure to actual or threatened death, serious injury or sexual violation" (para. 1). However, research literature at times takes a broader approach to understanding the individual experience of trauma as subjective, therefore extending beyond immediate threat to life or limb (Perry, 2001). Perry's (1999) research on the effects of trauma on the brain has shown that when faced with a trauma that elicits a fear

response, regardless of the event impetus, the brain activates several different systems to interpret the event (for a full review see Perry, 1999). Additionally, Perry (1999) demonstrated that this "cascade of activity" is subject to the individual's biological risk and environmental experiences. It is the subjective interpretation informed by our past that shapes the individual response to a traumatic experience. Often those responses are necessary to survival in the moment, but maladaptive in everyday life. Therefore, trauma is understood as a *spectrum of events* that are unexpected and uncontrollable, which may or may not include a direct threat to life or limb; matched with a *spectrum of responses* that may not always reach the level of a PTSD diagnosis (Kira, 2001; Perry, 2001).

The *spectrum of responses* is represented by the APA diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). This study utilizes Post-Traumatic Stress Disorder symptomology as it is the most widely used framework for understanding the manifestation of traumatic symptomology. The use of PTSD symptomology to understand traumatic response in this study was chosen due to its prevalent use in understanding trauma in most literature. In previous versions of the DSM, symptomology was limited to: intrusion, avoidance, and hypervigilance. However, in the most recent publication of the DSM-V, hypervigilance is separated into two different manifestations:

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negative alterations in mood and cognitions and alterations in arousal and activity. Each

symptomology is identified by an expression of symptoms and behaviors that have been

correlated to caregiving behaviors, including abuse and neglect (Ammerman, Putnam,

Chard, Stevens, & Van Ginkel, 2012; Ammerman, Shenk, Teeters, Noll, Putnam, &

Van Ginkel, 2013; Banyard, Williams, & Siegel, 2003; Belsky, 1984).

        1.2.2 Trauma and maltreatment. Just as PTSD develops after a traumatic event,

maltreatment is thought to arise, in some instances, due to the caregiver's exposure to

multiple traumatic events. Such events commonly overwhelm an individual's

normal parenting capacity, impeding their ability to act in a protective manner towards

their child(ren) and instead they turn that energy toward self-preservation, with little to no

thought of the consequence (Amos, Fuber, & Segal, 2011; DeBellis, 2001; Goldfinch,

2009). Amos and colleagues (2011) developed a framework for understanding the

pathway from trauma to maltreatment positing that, for a woman, becoming a mother

interferes with one's ability to actively avoid trauma triggers. Behaviors, such as

maltreatment, which the traumatized mother often finds alleviates her trauma arousal, are

difficult to change (Amos et al., 2011). This difficulty arises because the mother's

primary goal is relief from arousal, which she finds she can achieve through maladaptive

parenting behaviors. Additionally, because relief from traumatic arousal is the primary

goal, the mother is unaware of and/or uncaring of the consequences to both her child and

her own well-being (Amos et al., 2011). The evidence implicating trauma as a key

component in the development of child maltreatment continues to mount indicating that

the field of child welfare should see the family in the context of their past and present

using trauma-informed care (TIC) asking "what happened to you"?; rather than the deficiency lens that asks "what is wrong with you"? (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).

With the knowledge that trauma is so prevalent in samples of mothers involved with child welfare and the role of trauma in the development of maltreatment, it would be prudent of child welfare to focus trauma-informed practices on the whole family, not just children. However, two elements impact implementation of trauma-informed practices. First, child welfare workers in the current workforce are expected to have a bachelor's degree; however, there is no requirement that the degree be in a socially based subject or equivalent and therefore, may not be trained as social workers or with a background in ethical social work.. Secondly, the three goals of child welfare: safety, well-being, and permanency place the priority on the child, which unfortunately creates an atmosphere that does not require a trauma-informed view of caregiving and labels the caregiver as deficient, rather than asking the question, "what happened to you?" When the caregiver is seen as deficient, research has shown that child welfare workers will often use coercive and oppressive practices to meet their dual responsibilities to the child and the parent, particularly when trying to balance the competing legal, ethical, and safety concerns involved in family life (Clark et al., 2005; Harris & Fallot, 2001; Watson et al., 2014). Practices that are coercive and oppressive ignore the impact of trauma in one's life, while also causing re-traumatization by using tactics that may mimic power dynamics characteristic of many traumatic events (Harris & Fallot, 2001). Harris and Fallot (2001) suggested that child welfare adopt trauma-informed practices to prevent re-

traumatization in caregivers that may be aroused by such power dynamics. Re-traumatization occurs through the trauma arousal process, in which an individual is exposed to a sensory reminder or "replication of dynamics" that triggers a trauma symptomology response as if experiencing the initial trauma event again (Harris & Fallot, 2001; Shelly, Hitzel, & Zgoda, 2016). Therefore, for caregivers with traumatic pasts, relationships that replicate power dynamics present during a trauma, have the potential to re-traumatize a survivor.

1.2.3 Trauma and child welfare. Rates of trauma experienced among caregivers involved with child welfare range from 80% - 91% (Bosquet Enlow et al., 2014; Chemtob et al., 2011; Gillespie et al., 2009; Roberts, et al., 2011). For many of these caregivers their experiences are not isolated to one traumatic experience, but rather they are characterized as chronic or cascading (Herman, 1992; Kira, 2001). As noted, child welfare involvement with families has the potential to re-traumatize the caregiver with a trauma history. The child welfare system operates on three primary goals: safety, permanency, and well-being (ACF, 2011; McGowan, 2005). The child welfare system is highly focused on achieving these goals for children and not the family system, which in of itself can cause conflict. Such as it is in the case of child removal, the impact of children being placed out of the home, although necessary, has traumatic implications. Research has shown that child removal, additional attachment disruptions caused by multiple placements, and lack of change in the home environment all have the capacity to be re-traumatizing for both children and their caregivers (Feletti et al., 1998, Gauthier, Fortin, & Jéliu, 2004; Rivera & Sullivan, 2015).

Agencies operate on the belief that the most effective way to achieve the goals of safety, permanency, and well-being is to provide services geared toward keeping families together by either preventing Out-of-Home Placement (OOHP) or facilitating reunification if OOHP occurs. Although reunification of child(ren) with their parent/ primary caregiver is the prioritized goal and most frequent outcome in child welfare when a child is removed, only 51% of OOHP cases nationwide in 2009 resulted in reunification (Children's Bureau, 2011). When a child is returned to the primary caregiver, social workers and child welfare professionals do so with the understanding that services provided during OOHP promoted safety, permanency, and well-being and that there will be no further family involvement with social services. However, it is reported that within the first 6-months after reunification, 13% of children reenter the system, another 14% reenter after 12-months, and 7% over the following 12-months; in all, 30% of children reunified reentered the system within 18-months. Such statistics bring to light the disconnection between the services families are receiving from child welfare and the services they need to overcome circumstance.

As demonstrated, understanding the caregiver within the context of their trauma experiences and applying a trauma-informed framework to all interactions could theoretically, improve the ability of families to maintain children at home, or at the least quickly facilitate reunification. However, child welfare involvement appears to have the potential to add to the caregivers cascading stressors, exacerbating their trauma by recreating traumatic contexts, rather than providing needed relief (Eskai et al., 2013; Harris & Fallot, 2001; Watson et al., 2014). Child welfare is in a unique position to

provide services from a trauma-informed paradigm that could encourage *power-with* caregivers and not *power-over* them, in hopes of reducing child maltreatment and maintaining the family of origin. Very little knowledge exists to help explain how caregivers perceive their involvement with child welfare. Theories have been posited regarding the re-traumatizing nature of child welfare, but no studies of rigor have been done to confirm such a theory. One qualitative study, which resulted in two articles by Dumbrill (2006, 2010) provided insight into the experiences of mothers involved with child welfare; however, the Dumbrill study did not approach this topic through a trauma lens. The purpose of this study is to explore the lived experiences of caregivers involved with child welfare through a trauma lens and to determine if further study should be conducted to examine the re-traumatizing nature of child welfare. Therefore, this study will attempt to fill this gap in understanding by asking the question: How do caregivers with a trauma history experience child welfare involvement?

1.3 Organization of dissertation

This dissertation is comprised of five chapters. Chapter One provides a discussion of the significance of the problem being explored to inform the purpose and goal of this research. The argument was made for asking the research question: How do caregivers with a trauma background experience child welfare involvement? In addition, it outlines the expected contributions to the overall body of literature. Chapter Two begins with a review of the historical development of the child welfare system and the rise of the deficiency narrative. Chapter Two will follow with a review of trauma symptomology and its impact on the brain and behavior. A review of applicable theoretical

explanations regarding the impact of trauma on behavior are included. Theoretical

explanations are all explored through a feminist lens, as this is a phenomenon that is

primarily experienced by women and mothers'. The theories used to better understand

this phenomenon will include: cumulative risk theory, including a discussion of complex

trauma theory, oppression, and poverty as cumulative stressors; the link between trauma

and maltreatment, and the re-traumatizing potential of the child welfare system. This

chapter will conclude with a review of current child welfare system interventions and

their efficacy within maltreating caregiver populations. Chapter Three provides an

overview of the research methodology including the research design, sampling, data

collection and the qualitative analytic process. Chapter Four is a review of the major

findings of the study and answers the research question posed in Chapter One. Finally,

Chapter Five reviews the major findings of the study through the lens of the existing

literature and the study limitations. Chapter Five concludes with the implications of the

findings and recommendations for policy, practice and future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

2.1 Introduction

The relationship between caregivers and the child welfare system is one with

historical significance that is difficult to understand without a basic comprehension of the

way in which child welfare came to exist in its current form. In addition, it is necessary to

understand the way in which the dominant narrative of dependency and poverty has been

equated with an inability to parent appropriately. Therefore, this chapter will review the

rise of child welfare in the US and the ways in which dominant narratives have informed

the development and direction of child welfare policy. This will lead to a discussion of

the theoretical underpinnings of trauma through a discussion of trauma and how

traumatic experiences can lead to a trauma diagnosis. Followed by a discussion of

cumulative risk theory, related to both traditionally understood traumatic experience and

exposure to insidious trauma. Next, the theory of intergenerational transmission of

maltreatment, which links back to cumulative risk and leads into a discussion of the

impact of trauma and trauma symptomology on parenting practices. Finally, a review of

feminist theory, child welfare re-traumatization, and oppression is provided. Although the

caregiving landscape is changing, women and mothers still provide a majority of

caregiving in the US, therefore the feminist lens is used to explore the impact of

oppression through three tenets of Young's (2000) *Five Faces of Oppression,* in regard to

the re-traumatizing potential of child welfare. This chapter will conclude with a synthetization of the literature outlining the impact of trauma on caregiving relationships that results in an increased risk for child welfare involvement, and finally the efficacy of the child welfare response.

2.2 Historical Background

Dominant social and political views that continue to shape our perceptions of poverty, mental illness, and parenting today find their roots in English poor laws, which were transplanted to the early American colonies (Cassiman, 2006; Trattner, 1998). The underlying belief of the English poor laws were that a lack of work ethic and adherence to strict religious values were the undeniable cause of an of an individual's poverty (McGowan, 2005). Because the primary focus of a life well lived in early colonial America was the ability to work in order to contribute to the family and society, the children of "paupers," or the poor, received special attention (McGowan, 2005). It was believed that the children of paupers would adopt the "bad habits" of their parents, and therefore required saving from such a fate (Cassiman, 2006; McGowan, 2005). During this time, if it was determined that a parent was going to lead their children down the path of a pauper, the right to raise their children was likely to be taken from them (McGowan, 2005). Prompted by the number of children who were orphaned and removed from parents the orphanage began to emerge in American cities. The goal of orphan programs was to instill a strong work ethic in children, supplemented by strict religious teachings (McGowan, 2005). While the focus was on the rehabilitation of the child, the parent(s) continued to be blamed and demonized as being responsible for their situation

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as a result of laziness and poor moral character, a characterization that continues to ring

true to this day (Caissman, 2006; McGowan, 2005). A characterization, which Val

Gillies (2013) argues changes the perspective of parenting expectations from provision of

"love and care" to one of "competence," guided by skills and proficiency that can only be

taught by "qualified professionals."

The late 19th century brought about two major developments in child welfare: the

recognition of child maltreatment as a social concern and the friendly visitor. Child abuse

and neglect were not prioritized as a social concern, possibly due to the perspective that

children were property (McGowan, 2005); however, that all changed with the case of

Mary Ellen, a child found to be the victim of horrific child abuse. When the abuse was

observed by social worker Etta Wheeler, Mary Ellen's adoptive mother was charged with

assault and battery, initiating the government's entrance into family life with the purview

of preventing maltreatment. As a result, the New York Society for the Prevention of

Cruelty to Children (NYSPCC) was started in 1874 and, fortunately, child safety became

a pressing concern. Unfortunately, the focus of the NYSPCC was solely on the

prosecution of maltreating parents, and therefore there were no resources or services,

which could improve family life (McGowan, 2005). As maltreatment became a public

health concern, other agencies arose that were concerned with the state of the family,

particularly families who lived in urban, poor, and immigrant communities (McGowan,

2005). The Charity Organization Society was established at this time, and gave rise to

"friendly visitors." Friendly visitors were groups of women who would go to the homes

of families in these communities working with them to improve their lives (McGowan,

2005). However, a duality existed in this relationship. The role of the friendly visitor was to seek out those in need of help and offer "moral and behavioral guidance" (McGowan, 2005), while simultaneously reporting back to their supervisors on the conditions of impoverished living (Astuto & Allen, 2009; Boyer, 1978; Mallon & Hess, 2005; Weiss, 1993). Astuto and Allen (2009) report that through this duality, "marginalized communities experienced a patriarchal, disempowering model of support, which would color their future engagement with social service programs" (p.4). Fortunately, despite this duality, the friendly visitors began to change the narrative that had dominated charity work and the social dialogue for centuries. The friendly visitors found it difficult to ignore that poverty was frequently the result of social and environmental factors, which prevented access to employment, and they began to argue that poverty should not be fully attributed to the moral character of the individual (McGowan, 2005). This gave rise to the Settlement House movement, started by Jane Addams. The Settlement House movement sought to provide "developmental" services in family's homes that included teaching skills meant to increase access to employment and setting the stage "for a complex system of child care" (McGowan, 2005, p.19). This complex system was comprised of three parts: orphanages and foster care for dependent children, a criminal justice system to prosecute maltreating parents, and organizations, which provided services in the homes of families (McGowan, 2005).

Major changes began to occur in the 1930s, both within the frameworks of understanding human behavior and with the passage of the Social Security Act of 1935. In the 1930s, psychoanalytic frameworks began to emerge, which were given life by the Charity Organization Society, and increased an understanding of behavior and led to improved therapeutic services (McGowan, 2005). However, the consequences outweighed the benefits, as this framework moved the child welfare field back to the belief that issues of poverty were the result of personal dysfunction, erasing the onus placed on social context that arose during the Settlement House movement. The personal responsibility narrative reemerged at this time and once again focused the conversation on a dependency narrative fueled by critics of "pensions," provided to single mothers, the precursor to modern day welfare. Opponents' against mothers' pensions commonly embraced a personal responsibility narrative, arguing that by simply using the word "pension" it is implied that the beneficiary worked to receive the benefit. In addition, it was purported that pension programs did not include an "element of prevention or radical cure for any recognized social evil… [and are] injurious to the character of the parent" (Devine, 1913, as cited in McGowan, 2005, p. 23). Despite the fears of providing monetary assistance to single mothers, pension programs continued and were expanded within the Social Security Act. Mothers' pensions laid the groundwork for the Aid for Families with Dependent Children program (AFDC), which expanded services to the permanently disabled and parents who were unemployed (McGowan, 2005). Although, the goals of AFDC were meant to provide widowed and single mothers the ability to stay home and care for their children, seen as their vital role (Berrick, 1997). Duality existed

within this program, with welfare workers reporting back on the condition of mother's lives, including work and romantic relationships, changing the message from deserving to undeserving, with eligibility being determined not by need, but by the "suitability of the home" (Berrick, 1997). The Social Security Act was instrumental in increasing the level of regulation over child welfare by offering Federal funds for child welfare to states who submitted plans for a "coordinated delivery of services" (McGowan, 2005). The changes and social programs that came with the Social Security Act led to progress in the child welfare field through the 40s, 50s, and 60s.

The progress was notable: the next few decades included lower placement rates, more focus on the provision of services in the home, and increased education and development of research which improved clinical social work practices (McGowan, 2005). Despite the improved statistical results, the reality for many families was not one of improved family life. The personal responsibility and dependency narratives continued to dominate how families were viewed. Unmarried mothers became a priority for social services at this time, which might have been a positive direction if not for the sole focus on child protection and maternal punishment. Unmarried mothers were characterized as, "multi-problem," disorganized," and "hard-to-reach…" (New York City Board, 1958; cited in Mallon & Hess, 2005, p. 28). As such, the services provided to these unmarried mothers were primarily focused on adoption planning and not parenting (McGowan, 2005).

As the 1960s came to a close, Lyndon B. Johnson introduced the War on Poverty. The War on Poverty had good intentions and programs that arose from this movement

have footprints on many modern social programs. Scholars agree that the benefits from this war have been far reaching; however, as pointed out by Edelman (2006), the legislation and programs born at this time did not address the core issue of poverty, finding work. Edelman (2006) states that for those who were disproportionately represented in impoverished communities, particularly people of color, the lack of available employment was further diminished by hurdles of racism and discrimination in hiring practices. Others have argued that the war on poverty, and the spending that came with it, forced back to the forefront the personal responsibility and dependency narrative, which moved the conversation from the war on poverty to a war on poor people (Orleck, n.d.). Programs introduced through the war on poverty led to more intrusive practices into the daily lives of the poor and established a new system of control (Berrick, 1997; Orleck, n.d., Roberts, 1999). McGowan (2005) reports that there are problems inherent in social control that are unavoidable when service provision is tied to public assistance. For example, Orleck (n.d.) reports that over two million Americans, not on parole or probation, must report monthly to government agencies on private details of their lives and submit to monitoring activities, such as drug tests and welfare checks, which could lead to criminal prosecution for any failure to provide timely and accurate information. The Sixth Court of Appeals has upheld such actions as they ruled that those receiving welfare benefits must expect "a somewhat diminished expectation of privacy," demonstrating that the poor who seek help have fewer civil rights protections than other citizens (Gustafson, 2002). As Orleck points out, these perspectives and rulings hurt the most vulnerable of our citizens; poor mothers and fathers, kinship families with little

resources, and those with mental health concerns. "As soon as they ask for government help in making it through the month, they become suspect… they are subject to constant government surveillance" (Orleck, n.d., para. 3). The war on the poor is fueled by a criminalization of poverty defined by strict and consistent review of eligibility, fraud investigations, and recouping of food stamp and Medicaid overpayments (Gustafson, 2002). Such policies echo the duality experienced by poor families during the friendly visitor movement.

As time marched on, public policy continued to follow trends that further marginalized young, single mothers, often disproportionately mothers of color. In 1974 the Child Abuse Prevention and Treatment Act (CAPTA) was passed, designed to provide funding for investigation, reporting, prevention and treatment of child abuse. However, as McGowan (2005) points out, the priority of CAPTA was on investigation and reporting, further punishing parents rather than providing support. This was followed by the passing of the Adoption Assistance and Child Welfare Act of 1980, which outlined provisions for permanency planning as a priority of care, requiring states to plan for in-home services, prevention of out-of-home-placement (OOHP) when possible, and promoting reunification; in addition, it established the benchmark of "reasonable efforts" (McGowan, 2005; Roberts, 1999).

Reasonable efforts were focused on maintaining children at home and when that was not possible, reunifying the child home as soon as possible. As reasonable efforts gained traction, the Family Preservation and Support Services Program was introduced in 1993 with the intent of using family support services in communities to prevent child

maltreatment. However, as research began to expose the flaws of family preservation models and the dependency narrative, which defined who was deserving of assistance continued to dominate social discourse, and attacks began to be levied against families in poverty and dependent on Aid to Families with Dependent Children (AFDC) as being unable to care for their children (Berrick, 1997; McGowan, 2005). The AFDC program is the pre-cursor to the modern day welfare program and provided economic maintenance for caregivers believed to be unable to work or who needed to be at home to raise children (McGowan, 2005). As the dependency narrative and criminalization of the poor continued to be exposed by "anti-welfare conservatives" the Aid to Families with Dependent Children (AFDC) program was influenced by public perception through the 1990s (Orleck, n.d.). The continued demonization of the poor as responsible for the poverty they experienced created an opening for the passing of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). The PRWORA eliminated the AFDC system and introduced Temporary Assistance for Needy Families (TANF), which imposed a five-year lifetime limit on receiving welfare funds and a ceiling on family benefits, and also instituted strict work requirements. McGowan (2005) writes that implementation of the TANF program made it increasingly more difficult for poor families to keep their children at home as families met their limits and did not have access to supplemental resources.

In 1997, one year after the PRWORA, the Adoption and Safe Families Act of 1997 (ASFA) was passed. This act established the trinity of safety, permanency, and well-being (McGowan, 2005). Within the rhetoric of the trinity, safety was and still is,

the overarching priority placed on child welfare services and workers, in particular the safety of the child. With the passing of ASFA and prioritization of safety, less focus was given to family preservation (McGowan, 2005; Roberts, 1999). In particular, timeframes were placed on family reunification, and for families who could not meet the expectations of their case plan the state would move quickly toward the termination of parental rights with the hope of "freeing" children for adoption (Roberts, 1999; 2002). The timeframes were constrictive and it was argued by child welfare agencies, that it was preventing them from truly determining what was in the best interest of the child and stalling progress toward successful reunification (Roberts, 2002). Another aspect of ASFA that has had a particular impact on families is the provision of concurrent planning. Concurrent planning allows caseworkers to consider all reasonable options for permanency concurrently, rather than sequentially. The priority is identified as reunification, but also requires that adoptions are planned simultaneously (Child Welfare Information Gateway, 2012). Therefore, caregivers dealing with environmental stressors, poverty, housing, and/or addiction would have difficulty meeting expectations for reunification, which would move to termination of parental rights (McGowan, 2005). Poverty is a primary concern, as it consistently places families in positions where they must make difficult decisions about prioritizing needs (Caissman, 2006). The family's priorities may not always align with the priorities set by child welfare policy, which may create a perception of the caregiver as difficult or defiant, reinforcing dominant perspectives on child welfare involved caregivers (Caissman, 2006; Schram, 2000).

Historically poverty, and the stereotypes and discrimination that come with it, has dominated the child welfare and social service narratives, dictating policies that outline how to best serve the poor. The way these stereotyped beliefs underlie negative perceptions about individuals based on group membership are continually perpetrated throughout history, which in turn impacts generation after generation, informing how they interact with systems that maintain power over their lives (Caissman, 2006). The dependency narrative, which serves to maintain the power of the dominant group, is dependent itself on individuals living in poverty being labeled dysfunctional and seeking to destroy the "American way of life" (Cassiman, 2006). Therefore, by seeing the child welfare involved parent as a dependent, the idea that she would rather collect welfare than work or that she would rather be homeless than be a caregiver, is reinforced (Berrick, 1997). Cassiman also notes that the dependent is characterized as a "pathological welfare recipient, [she] is the welfare queen, black, poor, and dependent upon an unearned income" (p.338). It is asserted that the dependency narrative has survived because there has not been a strong counter narrative to this dominant belief (Caissman, 2006; Kira, 2001; Schram, 2000). The lack of a counter narrative creates a lack of group identity, as adopting the identity of dependent means also adopting the pathology of poverty (Cassiman, 2006; Schram, 2000). Schram notes that living in poverty is, in and of itself, a traumatic experience, often informed by both physical and emotional violence. Cassiman (2006) argues that seeing poverty through a lens of trauma is necessary for establishing a counter-narrative to the dependency narrative:

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> …the dominant culture is creating the "culture of poverty" with behavioral modification policies (curing dependency and promoting marriage) that fail to address the political economy. Failure to acknowledge the devastating nature of poverty, allows the trauma to be perpetuated, and will lead to the intergenerational transmission of poverty, not as a result of inherent cultural deficits, but as a natural result of policy that fails to address the trauma induced by miserly policy responses. (p. 59)

Recognizing the traumatic nature of poverty is key to understanding and presenting a counter-narrative to the dependent welfare mother that, in essence, overshadows the narrative of all caregivers involved with child welfare as alleged perpetrators of maltreatment.

The National Center for Children in Poverty reports that one in every five (21%) children under the age of 18 live in poverty, while 44% live in low income families (Jiang, Ekono, & Skinner, 2016). Families living in poverty are disproportionally represented in child welfare (Lee & Goerge, 1999; Roberts, 1999; Fong, 2017). Research has demonstrated that families living in poverty are at higher risk for maltreatment (Drake & Pandey, 1996; Fong, 2017; Putnam-Hornstein & Needell, 2011) and at a higher risk for child welfare involvement (Dettlaff, Rivaux, Baumann, Fluke, Rycraft, & James, 2011; Pelton, 1994; 2015; Rivaux, James, Wittenstrom, Baumann, Sheets, Henry, & Jeffries, 2008; Turcios, 2009). The Federal National Incidence Study of Child Abuse and Neglect (NIS-3), found that, for families making $15,000 or less annually, physical abuse was 12 times more likely, emotional abuse was 18 times more likely, emotional neglect was 27 times more likely, and physical neglect was 50 times more likely when compared to families making $30,000 or higher annually (Sedlak & Broadhurst, 1996). In a follow-up study, using a follow up wave of NIS-4 data, Sedlak and colleagues (2010) did not

find such dramatic results, with much lower rates of risk for families making $15,000 or less annually. However, for these low-income families, the rate of physical and emotional neglect was 77% higher than physical or emotional abuse (29%) in families making $30,000 or more annually: this was a significant finding (Sedlak et al., 2010). The NIS-4 study showed a significant relationship between poverty and both, physical and emotional neglect (Sedlak et al., 2010). Material deficits, which impact the caregiver's ability to provide for basic needs, including housing and food, which are associated with poverty are often defined as neglect (Pelton, 1994). However, researchers have argued that viewing a lack of access to resources as neglectful behavior, ignores the social context and environmental stressors that could theoretically be solved through appropriate and effective services (Pelton, 1994; Turcios, 2009).

2.2.1 Summary. The intersections of poverty, the welfare queen, dependency and parenting have a long and complex history dating back to the establishment of the American colonies. This history has had its successes for children and families; in fact, it has been established that without the social and welfare policies that have shaped child welfare practices the consequences of poverty would be much farther reaching (Edelman, 2006; Gustafson, 2002). Unfortunately, help also came with problems. The narrative of dependency evolved, dominating the social discourse and creating policies that are oppressive, marginalizing, and dependent on society's willingness to accept a counter narrative. The adoption of this dominant narrative within federal, state, and local policy justifies the denial of basic human rights, by positioning the caregiver as undeserving.

2.3 Theoretical Underpinnings

Families can become involved with child welfare by requesting services, death or incarceration of a parent; however, the most common way in which families come to the attention of child welfare services is due to an allegation of abuse or neglect. This section will review the theoretical underpinnings of child maltreatment with a specific focus on trauma. Beginning with a discussion of trauma and how traumatic experiences lead to the development of traumatic symptomology, which then can lead to maltreatment, prompting child welfare involvement that in turn re-traumatizes the caregiver through discriminatory and coercive practices. To understand how trauma can lead to maladaptive parenting responses first requires a review of how a traumatic experience impacts the brain, leaving the survivor to struggle with real and perceived threats.

Research has shown that caregivers, primarily mothers, involved with child welfare experience trauma at a rate of 91.6% and report experiences of two or more traumas at rates between 15% and 74% (Briere et al., 2008; Karam et al., 2014; Kennedy, Bybee, & Greeson, 2014). Therefore, a discussion of cumulative risk theory and how the additive effects of cumulative, chronic, and complex traumas place caregivers at increased risk for the development of trauma symptomology, is provided. In addition, cumulative risk theory is expanded to include a brief discussion of insidious trauma, as experiences with discrimination and oppression enacted by helping professions have been shown to impact one's development of traumatic symptomology. The next section is a review of the major trauma theories which delineate how trauma can lead to child maltreatment. In addition, a review of the relationship between the expression of PTSD

symptomology and its' predictive relationship to parenting behavior and style is provided. This section will conclude using feminist theory and Young's *Five Faces of Oppression* to discuss the potential of child welfare policies and practices to contribute to experiences of insidious trauma.

         2.3.1 Trauma. Traumatic events are very common within the general US population. It is reported that up to 90% of Americans will experience at least one traumatic event in their lifetime (Gillespie, et al., 2009; Roberts et al., 2011). Trauma is defined as an invisible wound of the mind, which causes an individual to rely on distressed neural pathways learned during the event to alleviate the symptoms exacerbated by environmental reminders and stressors (Herman, 1992; Perry, 2001; 2006). The National Comorbidity Survey Replication (NCS-R) estimated the lifetime prevalence of PTSD in adults to be 6.8%; with lifetime prevalence rates for men at 3.6% and 9.7% for women (Kessler et al., 2005; National Comorbidity Survey, 2005). Studies which have specifically addressed mothers living in poverty have found that the lifetime prevalence of developing PTSD is slightly higher than that of the general population, ranging from 7.7% to 11.9% (Loveland Cook et al., 2004; Smith et al., 2006). Other studies have found higher rates of PTSD symptomology in populations of mothers and women with co-occurring disorders, defined as having a possible PTSD diagnosis, ranging from 26% to 54.3%, and is not comparable to the prevalence of those with a confirmed diagnosis (Bailey et al., 2012; Bosquet Enlow et al., 2014; Chemtob et al., 2011). These statistics are still concerning, as it has been shown that a full diagnosis of

PTSD is not necessary for individuals to experience a range of symptoms that impact daily functioning (Merlin & Mohr, 2000).

Trauma can be a single, one-time event (i.e. natural disasters, car accidents, rape, etc.), chronic (i.e. child abuse, domestic violence, etc.), or cumulative (i.e. experiencing multiple traumas over time), each with the capacity to result in the individual expressing traumatic symptomology, that can result in a PTSD diagnosis. A diagnosis of PTSD is given based on criteria in five main categories (APA, 2013). The first criteria define the precipitating event, exposure to actual or threatened death, injury or sexual violence either directly, as a witness, or due to repeated exposure to traumatic material and/or environments. The second category is intrusion symptoms, including flashbacks and intrusive memories, nightmares, "intense and prolonged" distress and physiological reactions to external reminders of the event. The next is avoidance, which are strategies employed to purposely avoid thoughts, feelings, and or external reminders of the event. The fourth category is, "negative alterations" in cognition and mood, and is the most extensive, including symptoms such as dissociative amnesia, persistent and exaggerated negative beliefs about the self and the world, distorted cognitions about the cause of an event (self-blame), persistent negative emotions (fear) and/or inability to experience positive emotion, and diminished interest in daily life. Finally, "marked alterations in arousal" are characterized by anger commonly expressed as aggression, risky behaviors, hypervigilance, exaggerated startle, concentration issues, and sleeping issues. For each category of symptoms an individual would need to endorse one to two specific behaviors, to qualify for a full diagnosis. However, as noted previously an individual does not

qualify for a PTSD diagnosis, they may still be experiencing a range of symptoms impacting their day to day life (Merlin & Mohr, 2000). The risk for development of trauma symptomology is present for survivors of one time traumas and those with a lifetime of traumatic events, but as research has demonstrated for decades, the risk increases exponentially for the latter, when there is little time for recovery from an ongoing onslaught of real and perceived threats (e.g. Appleyeard, Egeland, van Dulman, & Stroufe, 2005; Perry, 2001, 2006; van der Kolk, 2014).

Extensive research has shown that the path from a traumatic experience to traumatic symptomology, or a PTSD diagnosis, has a neurological basis (Perry, 2001, 2006; Evans & Coccoma, 2014; van der Kolk, 2014; Yehuda & LeDoux, 2007). This is important because the neurological basis for trauma explains how trauma impacts our brains, specific to the interpretation of incoming environmental information. These interpretations inform behaviors, which may be adaptive during a trauma, but maladaptive for day to day interactions (Amos, Fuber, & Segal, 2011; Goldfinch, 2009; Perry, 2001). In other words, the experience of having one's normal coping capabilities overwhelmed, which interferes with the brain's ability to fully integrate the experience, results in the development of new neural pathways which become entrenched in preparation for survival (Herman, 1992).

Research has shown that when a person is exposed to a threat the brain, which is instinctively wired for survival will prepare for action through the fight, flight, or freeze response (van der Kolk, 2014). Fight, flight or freeze is an autonomic process initiated by our brain's survival instinct in the amygdala, which informs the sympathetic nervous

system to prepare the body when threats appear in the environment. When the threat has been resolved, the bodies' parasympathetic system, initiated by higher order brain processes, stemming from the hippocampus works to bring the body back to a state of equilibrium through fear extinction (Evans & Coccoma, 2014; Yehuda & LeDoux, 2007). When the brain is overwhelmed in a situation of threat, the experience is not fully integrated within our brain pathways, compromising the parasympathetic nervous system response, making it difficult for the brain to extinguish the fear response.

PTSD is thought to occur because the sympathetic system becomes unable to effectively assess threat when sensory reminders of the event are present in the environment, causing one to be in a constant state of fear of encountering the trauma again (Herman, 1992; Perry, 2006). For the individual who experiences chronic trauma or multiple traumatic events, the potential for living in a constant state of arousal increases exponentially. The fear that the event will happen again is realized, making a compromised parasympathetic system an adaptive response to an unpredictable and dangerous environment (Herman, 1992; Perry, 2006). When surviving an environment that is consistently unsafe, a constant state of arousal is a functional coping strategy, but maladaptive and often disruptive in daily life (Evans & Coccoma, 2014). As Perry (2006) describes, when an individual's environment is fraught with experiences like child physical abuse, which are ongoing, fear inducing, and unpredictable, the brain remains in a permanent, low-level state of fear. When an individual remains in this low-level state of fear as their baseline functioning, it begins to impact their ability to appropriately assess threat.

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Threat is a relational construct that is assessed based on one's perceived ability to cope with the level of threat posed (Benight & Bandura, 2004; Chang & Fine, 2007). For the traumatized brain, the threat may be real or perceived. Either way the brain has a deficit in using context, and is therefore unable to register the lack of threat or when the threat has passed, remaining in an aroused state. The inability to extinguish threat arousal is an attentional bias, meaning the individual is unable to modulate what they pay attention to in the environment (Bar-Haim, Lamy, Pergamin, Bakermans-Kranenburg, & van Ijzendoom, 2007; Cisler, Bacon, & Williams, 2007). Having an attentional bias is only part of the equation. As noted, additionally, it is the inability of the individual to quiet their anxious state. These two factors circle around each other creating a perfect storm for the development of PTSD (Bar-Haim et al., 2007; Cisler et al., 2007; Herman, 1992). For the caregiver, threat arousal can occur during an interaction with their child, which creates an attentional bias toward the elimination of threat in the environment. If the child, is the source of that threat arousal, elimination of the threat may involve maltreating behavior (Amos et al., 2011; Goldfinch, 2009).

Bar-Haim and colleagues outline the development of PTSD. It is thought that because the trauma is often readily activated, any trauma-related stimuli can arouse a trauma response. When an individual is in an aroused state they will view the environment as high threat and the body preps for action, the fight/ flight/ freeze response, leaving the individual unable to access the cognitive information needed to alleviate their response and allow the fear to pass (Bar-Haim et al., 2007; Dayton, Huth-Bocks, & Bustino, 2016; Foa, Feske, Murdock, Kozak, & McCarthy, 1991). Although

any traumatic experience can lead to a trauma response, the impact of chronic and cumulative traumas is a more robust predictor of traumatic symptomology that is ongoing and difficult to change (Amos et al, 2011; Herman, 1992; Perry, 2006).

2.3.2 Cumulative risk theory & complex trauma. Experiencing multiple traumas is understood through Rutter's (1979) cumulative risk hypothesis which states that the greater number of risks one experiences, the more likely they are to have daily functioning concerns (Appleyeard et al., 2005). Rutter, through his work as a child psychologist, noticed that psychological disorders appeared to be more likely in children experiencing multiple risks and, as a result, proposed cumulative risk theory. Research based on this theory has concluded that cumulative risk is positively correlated with maladaptive day to day functioning and mental health diagnoses (Appleyeard et al., 2005; Briere, Kaltman, & Green, 2008; Herman, 1992; Karam et al., 2014; Kennedy, Bybee, & Greeson, 2014). Heightened risk exists for either cumulative independent stressors or ongoing chronic stressors (Kraemer, Lowe, and Kupfer, 2005).

Expanding cumulative risk to embody the impact of trauma, Judith Herman (1992) proposed the concept of complex trauma to describe how experiences of chronic traumas from which there is no escape may have a more profound impact on an individual than a single event trauma. Herman defines complex trauma as the accumulation of traumatic experiences that are all reflected within one's trauma symptomology, in contrast to symptoms being specific to the most recent or most severe trauma experience. As noted, traumatic experience can accumulate as multiple, single traumas or through chronic exposure. However, Herman (1992) focuses primarily on

what she refers to as "captivity," which is underscored by a power dynamic characterized by domination and subjugation, observed in traumatic experiences such as: domestic violence, poverty, and child maltreatment. Further, Van der Kolk and colleagues (2005) found that individuals who were younger age at the onset of chronic trauma that was perpetrated by someone they knew demonstrated more complex posttraumatic symptoms, than individuals who were victims of adult interpersonal victimization. Regardless of when in life the trauma is experienced, researchers found that the longer one is exposed to chronic trauma, the more likely one is to develop a trauma diagnosis (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). This is increasingly important to the discussion of trauma's impact on caregivers who become involved with child welfare since research has demonstrated that the prevalence of cumulative and complex traumas in child welfare populations has reached rates of up to 74% (Kennedy et al., 2014). At times, the cumulative risk within these populations are caregivers own experiences of maltreatment at the hands of their caregivers, this will be discussed in a subsequent section.

From 1995-1997, the Center for Disease Control, Kaiser Permanente, and the Emory University Department of Pediatrics sponsored the Adverse Childhood Experiences Study (ACES), a large, national, epidemiological study, which demonstrated evidence for cumulative risk theory. This study identified ten adverse childhood experiences (ACE), occurring before the age of 18, which had relationships with quality of life, mental health, physical health, and risk-taking behaviors (Centers for Disease Control, n.d). The adverse childhood experiences that were identified as most impactful

are currently included in the ACE screening tool and separated into two categories:

maltreatment and household dysfunction. Maltreatment includes verbal, physical and

sexual abuse and physical and emotional neglect. Household dysfunction includes living

in a single parent home, domestic violence, alcohol and substance abuse by a caregiver,

having a mentally ill caregiver, and having a household member in prison. Although,

such categories are identified as family dysfunction, many of those items are tied to

childhood maltreatment experiences (CDC, n.d.; World Health Organization, 2016).

Using the ACES data, Felitti and Anda (2014) found that 12.5% of participants reported

four or more ACES experiences. In a previous study by Anda and colleagues (2006), the

researchers found that for participants who reported four of more ACEs, the risk of

alcoholism was 7.2 times higher, impaired memory was 4.4 times higher, and risk for

perpetrating interpersonal violence was 5.5 times higher when compared with the rest of

the sample.

Emerging within this discussion is the cumulative risk that accompanies contexts

such as oppression and poverty. Nurius, Green, Logan-Greene, & Borja (2015) found that

a higher number of ACEs was not only positively correlated with mental health concerns,

but was also negatively correlated with socio-economic status and diminished access to

resources, meaning as ACE scores increased, socio-economic status and access to

resources decreased. Finklehor et al., (2015) took a deeper look at poverty and identified

it as a significant predictor of negative health outcomes, prompting researchers to

propose poverty as an addition to the ACE's screening. There is a wide range of literature

which provides evidence for a framework that adds poverty and oppression to the list of

traumatic experiences (Brown, 2004; Erikson, 1994; Kennedy et al., 2011; Kira, 2001; Finklehor et al., 2015; Young, 2000). This requires that one expand the traditional definition of trauma. Kira (2001) through the "taxonomy of trauma," suggest that the individual's perspective of an experience as traumatic should label it as such, rather than exclusively judging an experience as traumatic through the clinical standard outlined in the DSM-V. Similarly, Erikson (1994) posed this question, "what would happen if, instead of classifying a condition as trauma because it is induced by disaster, we would classify as event as a disaster it if had the property of bringing about traumatic reactions?" (p.20).

Oppression and poverty perceived as trauma are often referred to as insidious traumas. Insidious traumatization theory states that individuals who live in the margins (i.e. women, people of color, poor, mentally ill) experience daily traumas that include bias-based discrimination, negative and stigmatizing social images, and institutionalized systems of exclusion (Root, 1992). This is important to child welfare practice because we see high representation of poor, young, urban mothers of color within child welfare involved populations (Briere et al., 2008; Kennedy et al., 2014). Kira's trauma taxonomy further extrapolates through cumulative risk that accumulated insidious experiences have the potential to mimic traumatic symptomology. Kennedy and colleagues (2014) demonstrated this to be true in their study of the cumulative effect of stigma on trauma symptomology in parents involved with child welfare, which showed that perceived stigma was significantly associated with PTSD symptoms. Parents in the Kennedy et al., study reported feeling stigmatized regarding specific identities (i.e. being a person of

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color or survivor of sexual assault) and regarding their circumstances (i.e. housing insecurity or homelessness). Poverty also emerged as the area in which caregivers perceived the most stigmatization.

Iris Young's (2000) *Five Faces of Oppression* can help us further understand the concept of oppression and the ways in which oppression can result in traumatic experience and expression of trauma symptomology. Young describes oppression as, "the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions… the normal processes of everyday life." (p. 36-37). Young focuses on five areas of oppression; however, here we will only review the impact of three: marginalization, powerlessness, and cultural imperialism.

Young (2000) defines marginalization as an individual's expulsion from society due to a dominant view that they are undeserving often resulting in material deprivations associated with poverty. Young defines powerlessness in multiple ways including: "those who lack authority or power;" "those over whom power is exercised without their exercising it;" "[those who] must take orders and rarely have the right to give them" (p. 43). Finally, cultural imperialism is defined by Young (2000) as the dominant social narratives that stereotype individuals and pushes them to the margins, virtually silencing and making invisible their perspective. These topics will be explored more through a feminist paradigm in section 2.4, related to the potential for child welfare re-traumatization.

The evidence that both direct and insidious traumas lead to traumatic symptomology and a possible PTSD diagnosis is beginning to emerge more fully within the trauma literature. Research has shown that cumulative exposure to traumatic events, both direct and insidious, resulted in elevated symptomology among many trauma criteria (Briere et al., 2008; Kennedy et al., 2014). Karam and colleagues (2015), using a large, multi-national database of surveys collected by the World Health Organization, found in a sample of over 51,000 participants, that cumulative trauma resulted in increased symptomology, such as anxiety and hyperarousal for those who endorsed four or more traumatic experiences. An important commonality that these study results share is the emergence of insidious traumas as cumulative stressors in the lives of individuals.

2.3.3 Intergenerational maltreatment. For a parent, childhood trauma can have a profound impact on their parenting, particularly early experiences of maltreatment. The concept of intergenerational transmission of maltreatment is a cyclical process of maltreatment, in which an individual who is the victim of maltreatment as a child becomes the perpetrator of maltreatment as a parent. Studies have shown that mothers with chronic or cumulative childhood trauma, both measured as ACE categories or specific to childhood maltreatment, are at a significantly higher risk for using maladaptive parenting strategies (Dym Bartlett, Kotake, Fauthe, & Easterbrooks, 2017; Murphy et al., 2014). Many of the items on the ACE scale are risk factors for child maltreatment including, domestic violence, substance use/abuse, and parental mental health (CDC, n.d.; World Health Organization, 2016). It is theorized that the use of maladaptive parenting strategies may in part be due to the use of coping strategies that

often mimic traumatic symptomology, such as dissociation, self-blame, and avoidance, used during experiences of childhood maltreatment (Babcock-Fenerci, Chu, & DePrince, 2016; Bernstein, Laurent, Musser, Meselle, & Ablow, 2013). It is assumed that the child carries these coping strategies for dealing with their trauma into adulthood and are linked to maladaptive parenting strategies (Babcock-Fenerci et al., 2016; Bernstein et al., 2013).

Child maltreatment is primarily understood as a chronic or cumulative trauma for the child which increases the risk for their perpetration of maltreatment on their own children when they become a parent themselves. Murphy and colleagues (2014) found that for caregivers with cumulative trauma, 65% were at increased risk for using maladaptive parenting behaviors, such as physical abuse and neglect. Dym Bartlett, Kotake, Fauthe, and Easterbrooks (2017) found in a study of 417 adolescent mothers that the odds of perpetrating maltreatment against their children increased 72% when the mother reported experiencing childhood maltreatment at least once. In addition, for mothers with a history of neglect, their risk for perpetrating neglect increased 60%. Of note, it was reported that when mothers had a history of cumulative and chronic maltreatment, their risk of perpetration increased 300%. Despite the heterogeneous populations and measurements of childhood trauma and maltreatment, a link between childhood trauma and future maltreatment risk, particularly childhood trauma that is

chronic and/or cumulative in nature, has been established in the literature. However, the key to understanding the link between trauma and maltreatment appears to be found in traumatic symptomology one expresses, regardless of when the trauma occurred over the life span more than the type of trauma one experiences or when during their life span the trauma occurred.

Traumatic experiences across the lifespan, particularly those that are cumulative and lead to trauma symptomology, have been linked to frightening and neglectful parenting behaviors (Hesse & Main, 2006; Lyons-Ruth & Block, 1996). It is assumed that it is the arousal associated with trauma triggers and PTSD that are not effectively diminished through normal coping means, leads to maltreatment as a means of managing the arousal. Additionally, having a PTSD diagnosis and in some cases, just demonstrating specific trauma criteria such as dissociation, numbing and hypervigilance, has been associated with increased maltreatment risk.

2.3.4 PTSD symptomology and parenting. Maternal PTSD symptoms have been associated with greater impairments in: attachment, assigning responsibility for behavior and harsh parenting. Not all individuals who experience a trauma will develop PTSD; however, it is common for one to experience symptoms that will impair daily functioning (Herman, 1992; Merlin & Mohr, 2000). In a study comparing depressed mothers with and without a PTSD diagnosis Ammerman et al., (2012) report that for mothers with PTSD, when controlling for depression, a significant positive correlation existed between severity of trauma symptoms and parenting deficits. Therefore, as trauma symptomology increased the use of maladaptive parenting behavior, such as maltreatment, also

increased. Researchers have proposed that trauma symptoms, particularly avoidance and numbing, interfere with the parent's ability to pick up on their own internal cues of frustration allowing it to build, until they react with harsh parenting (Ammerman et al., 2012; Ruscio et al., 2002). Avoidance and numbing are the symptoms most often associated with parenting deficits. In a study on the impact of PTSD on parenting behaviors in female Vietnam Veterans, report that for veterans with PTSD dominated by avoidance and numbing, their propensity for psychological abuse increased (Gold et al., 2007). In a 2009 study by Ammerman et al. they found that PTSD symptomology was related to parenting, specifically avoidance and numbing symptomology was related to increased use of corporal punishment, criticism and scolding, and taking into account the child's needs.

To further understand the impact of PTSD symptomology on maltreatment outcomes Lyons-Ruth and Block (1996) proposed that the primary feature of one's PTSD symptomology can determine they type of maltreating behavior a parent will exhibit. For example, when a parent's trauma symptomology is triggered by their child, and that parent's primary PTSD feature is anxious or hyperaroused (i.e. hypervigilant for threat, easily startled by loud noise), they will parent in a hostile manner. Alternatively, a parent whose dominant trauma feature is avoidance (i.e. avoids people and places which may remind one of trauma, avoiding talking about arousal, ignoring signs/symptoms) will parent as emotionally withdrawn. Within this framework, Amos et al, (2011) further explored this theory and proposed that the fight/flight/freeze response is also implicated in maladaptive parenting, related to an inability to control attentional biases and then

extinguish fear. Meaning that when a threat is perceived and their attention is drawn to the threat, their autonomic processes for survival are activated.

The theory further proposed that the behavioral system which allows the parent to avoid her triggers is defined as the attachment-related dissociative personality (ARDP). When the ARDP is overwhelmed, the parent's ability to remain dissociated from triggers becomes compromised and her "fight/flight/freeze" response is activated through what Amos and colleagues (2011) define as the hostile/helpless dissociated personality (HHDP). For example, if a child's behavior (e.g temper tantrum, uncontrollable crying, etc.) makes the parent feel as if they cannot control or ameliorate their trauma symptoms they feel unable to ignore or dissociate from the trigger. Unable to maintain dissociation from the trigger, the HHDP is activated, causing the parent to move into "fight/flight/freeze" mode. If the fight response is activated, then the parent's response is violent (e.g. physical abuse) (Amos et al., 2011; Goldfinch, 2009). Whereas, if the flight / freeze response is activated than the parent will respond with avoidance (e.g. neglect) (Amos et al., 2011; Goldfinch, 2009). When the mother establishes coping behaviors that alleviate trauma arousal, such as maltreatment, those behaviors are difficult to change. The difficulty arises because the mother's primary goal is relief from arousal, which she finds she can achieve through maladaptive parenting behaviors. Additionally, because relief from traumatic arousal is the primary goal, the mother is unaware of and/or uncaring of the consequences, to both her child and her own well-being (Amos et al., 2011; Bugental & Johnston, 2000; Chemtob et al., 2011; Fluke, Shusterman, Hollinshead, & Yuan, 2005). As shown, trauma symptomology has the potential to impact parent–

child interactions that could result in maltreatment and subsequent child welfare involvement. Although these theories hold promise in understanding the pathway from trauma to maltreatment, little to no empirical data exists verifying them.

2.3.5 Feminist theory, child welfare, and oppression. Feminist theories of trauma tend to be highly focused on the oppressive nature of the environments and systems as additive stressors (Brown, 2004). In fact, feminist theories view oppressive structures, "…as not simply trauma, but as trauma for which special vulnerabilities were created by bias and unfair hierarchies of value in the culture." (Brown, 2004, p. 465). Therefore, feminist theory will help to explore the oppressive nature of the child welfare system through the ways in which it has been theorized to be re-traumatizing. Harris and Fallot (2001) outlined the potential of child welfare to be re-traumatizing through seven characteristics of traumatic events which have also been shown inherent in social service interactions. The seven characterizations are: betrayal, hierarchical boundaries, secrets, the silencing or denial of the victim's voice, feelings of coercion and powerlessness, being subject to the abuser's reality, and systemic protection of the abuser. The following two sections will review the ways in which child welfare systems enact practices and policies that have re-traumatizing potential, through the concepts of marginalization, the use of power, and cultural imperialism.

2.3.5a Marginalization and power: Stigma and the special circumstance of poverty. Social stigma is defined as a set of negative characteristics or stereotypes that are assigned to a group of people, which is often possible because the group assigning the characteristics hold the power (Corrigan, 2004; Link & Phelan, 2001). Stereotypes that

might incur the wrath of stigma, such as the "pauper" and "welfare queen" have dominated the social conversation becoming entrenched in how policy is written and implemented (Caissman, 2006). Understanding how stigma can result in trauma is abstract but well-established (Bernard, 2002; Brown, 2004; Ellis, MacDonald, Lincoln, & Cabral, 2008; Major & O'Brien, 2005; Gray & Montgomery, 2012). It is proposed that the ways in which systems reinforce stereotyped messages based on the dominant narrative, which creates a stigmatizing environment, exacerbates feelings of shame, guilt, and self-blame. These messages are internalized by the individual and they begin to accept that they hold the blame for circumstances, based on a personal flaw of character (Bernard, 2002; Ellis, MacDonald, Lincoln, & Cabral, 2008; Gray & Montgomery, 2012). Internalizing messages of oppression have shown that survivors often use attentional bias toward the source of the stigma, creating a sense of threat; leaving them feeling the need to be vigilant (Major & O'Brien, 2005).

Acceptance of the dominant stereotypes by the child welfare system, can lead to a slippery slope of decision making. For families experiencing poverty, Pelton (2005) points out the level of care that may be required to keep a child safe or to provide for their needs in dangerous and/or impoverished communities is much greater than in other communities, making these families more susceptible to allegations and substantiation of neglect. In a large, longitudinal study it was found that families experiencing material hardships, such as housing and food insecurities, were 2.2 times more likely and 2.03 times more likely to be investigated for maltreatment, respectively (Yang, 2015).

Caseworkers often make case decisions based on stereotyped beliefs about parental characteristics such as level of poverty, race and ethnicity, substance abuse, mental health, being a single parent, lack of social supports (Benbenishty et al., 2015; Johnson et al., 2008; Rivaux et al., 2008). To demonstrate this, Rivaux and colleagues (2008), interviewed case workers to determine what caregiver characteristics were being used most frequently to assess risk and make case decisions. These researchers found that families with low incomes were scored more frequently at higher risk. Despite the fact that white families were often scored as lower income and higher risk; black families scored with higher income and lower risk still experienced higher rates of child removal and engagement (Rivaux et al., 2008). The researchers proposed that this may be due to the perception that black families were at a higher risk for maltreatment, regardless of the other external factors, such as poverty (Rivaux et al., 2008). Similarly, Dettlaff and colleagues (2011) found that when controlling for income, race did not emerge to explain differences in substantiation; however, when controlling for risk, race became the strongest explanatory factor. Continually, it is demonstrated that families who have marginalized identities are judged based on the dominating social narratives. These dominant narratives can create a bias which is then applied to case decisions, leading to continued marginalization and discrimination.

2.3.5b Cultural imperialism and power: Coercion. Feminist theories have long recognized that an individual's suffering within oppressive structures is not a result of defunct moral character, but is about the way in which systems invalidate and silence the voice of the marginalized (Lerner, 1993). Discrimination is a primary example of one

being invalidated. Discrimination can occur in multiple ways including interactional

discrimination, direct discrimination, and structural discrimination (Goldbach et al.,

2015; Ravenell & Ogedegbe, 2014; Stuber, Meyer, & Link, 2008; van Ryn & Fu, 2003;

van Ryn & Saha, 2011). Interactional discrimination occurs during social exchanges,

where the person with power labels the individual with a stigmatized perspective

(Goldbach et al., 2015). Direct discrimination is defined as one of the most debilitating

for those involved with child welfare because this allows for one to use the stigmatized

perspective to provide or deny services to an individual which can create a fear in seeking

help or engaging with services (Goldbach et al., 2015). Finally, structural discrimination

is the use of laws and policies that favor the dominant narrative, with the goal of

maintaining the narrative (Goldbach, et al., 2015). Some qualitative studies have found

that mothers often describe their experiences with child welfare agencies as,

"judgmental" (Dumbrill, 2010), "fear inducing," "difficult," "humiliating,"

"intimidating," (Buckley et al., 2011) and "shaming" (Schreiber et al., 2013), indicating

experiences with discrimination, both direct and interactional. However, as Young

(2000) describes, it is structural discrimination, the use of power justified by policy and

practice, which can pose the most threat:

> Being a 'dependent' in our society implies being legitimately subject often to
> arbitrary and invasive authority of social service providers and other public and
> private administrators who enforce rules with which the marginal must comply,
> and otherwise exercise power over the conditions of their lives. (p. 42)

One of the ways in which to better understand structural discrimination, is

through the use of coercive practice. The use of coercive practices has been well studied

and has the potential to be traumatic (Clark et al., 2005; Cutcliffe & Happell, 2009; The

Substance Abuse and Mental Health Services Administration (SAMHSA, 2014)). When coercion or the use of power is exerted in any relationship there is often a corresponding "deprivation of liberty" that occurs (Clark et al., 2005; Cutcliffe & Happell, 2009). Clark and colleagues sought to understand how coercion was used in a social welfare setting, specifically with mothers who had co-occurring substance abuse and mental health disorders. The researchers found that mothers often felt pressured to comply, particularly when they felt the need for those in power to see them positively in order to maintain or regain custody of their children. This relationship becomes cyclical, with the worker using coercion to maintain child safety and to also balance the competing rights of parent and child. The parent completes this cycle by submitting to expectations in lieu of what they see as their real needs, in hopes of getting their child(ren) back (Clark et al., 2005; Hiday, 1992; Pescosolido, Gardner, & Lubell, 1998). Unfortunately, there is no achieved balance for the parent, as coercive practices create their own traumatic potential. Coercive practices use power dynamics to render one powerless to make autonomous decisions. For caregivers, this can include decisions about employment, treatment, parenting, and, at times, day to day living. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), released a statement noting that any use of coercion within social programs is detrimental to the psychological safety of individuals. Despite the warnings that such practices are detrimental and have the potential to traumatize or exacerbate symptomology based on past traumas, coercive practices are still used in cases of child maltreatment (Clark et al., 2005; Cutcliffe & Happell, 2009).

Bringing to light the effect of both stigmatizing and discriminatory practices can begin to address the dominant narrative and provide a counter narrative that recognizes the structural elements of oppression, which often render the individual invisible. As the dominant narrative prevails, one of the culminating results of continued stigma and discrimination is cultural imperialism. Cultural imperialism is the use of the dominant narrative or social meaning of a thing to render the marginalized in this case, *the pauper and the welfare queen*, invisible (Young, 2000).

In a large, international study of child welfare practices in six different countries, the one similarity found across all nations was the clear evidence that the parent's wishes for their family and children were not taken into account, regardless of the level of risk presented by the family (Benbenishty et al., 2015; Davidson-Arad & Benbenishty, 2008). Cultural imperialism enforces the dominant narrative and sets the bar by which all others are judged and when one cannot live up to that societal norm their experience is invalidated and therefore has no impact on moving the dominant narrative in their direction hence, they remain the devalued, the undeserving.

2.3.6 Summary. Using the concepts of cumulative risk and feminist theory researchers have outlined how, for marginalized groups, the cascading stressors, in which individuals are denied access based on group membership, manifest a response mimicking PTSD (Kira, 2001; Sotero, 2006; Root, 1992). The context and meaning of being stigmatized and discriminated against, "converge to create a traumatic stressor in instances in which standard trauma theory might see none" (Brown, 2004, p.466). Brown argues that if we can view people in light of their behavior and adaptive coping, we may

change how we view behavior and re-contextualize the problem as societal and not "situated in the character of the suffering" (p. 466). For caregivers who become involved with child welfare, particularly those who come in with already marginalized identities, the risk of re-traumatization and additive stressors and traumas is clearly aligned. Despite the research and consciousness about the realities of the ways in which this happens, the prevailing narratives and stereotypes continue to infiltrate systems meant to provide safety and assistance to families in need. By applying feminist theories and concepts of cumulative risk that challenge the dominant oppressive narratives, it is possible to move these discussions away from the moral argument for maladaptive behavior or circumstance and develop a counter narrative that views the caregiver within the whole of their experience; taking a first step towards dismantling the oppressive practices permeating the child welfare system.

2.4 Child Welfare Interventions

The goals of child welfare are to ensure the safety, permanency, and well-being for children. To achieve these goals child welfare uses interventions geared toward keeping children in their homes or facilitating reunification, when necessary. However, research suggests that services being provided to families involved with child welfare may not be appropriately meeting the parent's needs (Bolen, McWey, & Schlee, 2008). Several studies have examined the discrepancies between services requested from child welfare and services that are actually provided. Consistently across these studies, just over 16% of parents identified that they needed services for their own mental health concerns without receiving help (Chemtob et al., 2011; Marcenko, Lyons, & Courntey,

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2011). When looking specifically at mothers with a diagnosis of PTSD, 5.6% to 26.3%

report that they were not provided services related to their symptomology (Chemtob et

al., 2011; Loveland Cook et al., 2004). In further support of these findings, Bolen and

colleagues (2008) conducted a qualitative study to explore the parent's perspective of

child welfare interventions. The researchers reported statements from parents' that

services were not meeting their needs. For example, parents would report that they were

sent to a parenting class for infants or pre-adolescent children while they were parenting a

teenager. Another parent reported that they expected to be provided with effective

discipline techniques; however, she was taught how to "physically discipline" her child

without being "abusive" or being "founded for physical abuse." In addition, the

researchers reported that parents often felt that their day to day concerns were not

addressed, in particular the need for tangible resources to alleviate the pain of poverty

and help care for their child. Parents reported that their concerns regarding financial

needs including food, transportation, and utilities were not addressed and that attempts to

obtain resources were unsuccessful. Parents were adamant that involvement with child

welfare was not beneficial to them, added to their stress, and did not provide what they

felt they needed to overcome their circumstance.

   2.4.1 Parenting interventions. Parenting interventions are the most common

choice of intervention to help preserve and/or reunify families in child welfare (Barth et

al., 2005). Several studies have explored the efficacy of parenting interventions and the

impact of interventions on the reduction of subsequent maltreatment perpetration, with

mixed results (Barth et al., 2005; Bugental & Schwartz, 2009; Byrne, Rodrigo, &

Maiquez, 2014; Casillas, Faucheir, Derkash, & Garrido, 2016; Johnson et al., 2008).

Parenting interventions can be provided through many different modes, including parenting classes and services provided in the home. Parenting classes aim to provide parenting skills designed to deal with difficult child behavior with no real attention to the underlying causes of dysfunction and maltreatment in the family. Johnson and colleagues (2008) conducted a meta-analysis to review the efficacy of parenting classes, found that despite an increase in knowledge about child development no evidence existed for the prevention of further maltreatment (Johnson et al., 2008). In contrast, a meta-analysis conducted by Byrne et al., (2014) found that maltreating mothers, in primarily marginalized communities, when provided psychoeducational information regarding child development, were able to increase their use of reasoning and decrease their use of coercive or physical punishment. However, mothers also demonstrated what they called a "dissociated process of change;" as mothers gained changes in their understanding of child behavior, researchers observed a corresponding negative change in parenting self-efficacy. This could indicate that as parents gained more information on child development they less confident they were in responding appropriately. For mothers' also managing trauma, this lack of confidence could be exacerbated by the fears related to their child welfare involvement. Meaning if they don't act appropriately, they may not be reunified with their child or that their child may be removed.

Multiple studies exist that have evaluated the effectiveness of in-home services, with varied results. Many reasons may exist for the variance, including the diverse methods and frameworks for which home based services are provided, and the diverse

nature of research studies (Chen & Ling Chan, 2016; Duggan, et al., 2007; Filene et al., 2013; Nievar, VanEgeren, & Pollard, 2010). These recent meta-analyses have reviewed the effectiveness of in-home services with families in intervention groups showing significant, but small impacts on parental outcomes but no observable impact on the reduction of maltreatment potential (Duggan, et al., 2007; Filene et al., 2013; Nievar, VanEgeren, & Pollard, 2010). Duggan et al., (2007), reported that there were no overall program effects on maltreatment reports, abuse potential, or parental risk, regardless of the frequency or intensity of services. Although finding no significant impact on maltreatment potential, Nievar et al. (2010), noted that for families with higher rates of frequency and intensity of services mothers did show a slight, but notable improvement in parenting behaviors.

It is highly likely that the inability of these studies to find any areas of substantial impact on the reduction of maltreatment, is attributed to the immense diversity in the quality, intensity and frequency of provided in-home services. Understanding the variable nature of in-home programs, researchers note that a focused response to a family has more power than a generic approach (Casillas et al., 2016). One way in which in-home therapy may have a more focused approach is through the addition of a psychoeducational, trauma-informed component that helps parents resolve the gap between their environmental reality and their perceived coping abilities. The addition of this cognitive component has shown positive results with the benefits to parenting practices being significantly more effective than "unenhanced" programs. Enhanced programs were shown to lower the use of corporal punishment, increase adherence to

safety plans, and reduce reported child injury (Bugental & Schwartz, 2009). This preliminary evidence that adding a psychoeducational component to all parenting interventions may enhance outcomes, is promising. Despite the wealth of evidence regarding parenting interventions, the lack of consistent findings hints at there being no real consensus concerning what the main focus of parent training should be (Barth, 2009; Brook et al., 2012; Testa & Smith, 2009).

      2.4.2 Summary. The literature reviewed here as succeeded in demonstrating that the interventions employed by child welfare to serve maltreating parents are varied in effectiveness of such programs. This lack of consistency has left the child welfare field unsure of the best ways in which to serve at-risk families. However, the use of trauma-informed paradigms which challenge the dominant narrative of the dependent and deficient caregiver and give caregivers a way to understand their reactions, including maltreating behaviors are promising. It is clear that caregivers, particularly mothers, are experiencing trauma at alarming rates and that the resulting symptomology interferes significantly with effective parenting practices. Therefore, child welfare is in a unique position to change the way parents are characterized from "bad," "pauper," "welfare queen," and "dependent" to "survivors" who just need a little help.

2.5 Gaps and Weaknesses in the Literature

      Several gaps and weakness exist in the literature regarding the role, if any, trauma plays in how caregivers experience involvement in child welfare. Very little research exists which attempts to understand the caregiver's perspective of child welfare involvement, and none exists to understand this through a trauma lens. This presents two

major gaps in the literature: the lack of information on caregivers involved with child welfare and a lack of understanding the caregiver experience through a trauma lens. The majority of research that exists related to trauma, parenting and maladaptive parenting to child welfare, has always centered mothers, specifically biological mothers', in the conversation. Historically, mothers have been viewed within the dominant narrative as solely responsible for child rearing. However, we live in a time of changing demographics that recognizes many different forms of caregiving including: fathers, adoptive parents, foster, and kinship families. Therefore, virtually nothing is known about how these different types of caregivers, who have a trauma history and are accused of maltreatment.

Second, only five studies could be located that explored the biological mother's experience with child welfare involvement (Bolen et al., 2008; Buckley et al., 2011; Dumbrill, 2006; 2010; Schreiber et al., 2013). Despite the results of these studies demonstrating traumatic responses to child welfare involvement, they did not explore the traumatic nature of the experience. Therefore, a significant gap exists in understanding how *caregivers* with trauma describe their experience with child welfare.

Many studies reviewed here used strong research designs such as meta-analyses, randomized control studies, and longitudinal designs; however, the results must also be considered in light of the limitations of the research. Most often studies collected self-reported data, which can be limited by attentional and response biases; leading one to act in a specific way because you are being watched (Royce, Thyer, & Padgett, 2015). In addition, self-report measures are limited to the participant's ability to recall events over

the lifetime (Edwards et al., 2001) and what they are willing to disclose about their personal experiences (Anda et al., 2006; Babcock Fenerci, Chu, & DePrince, 2016; Chang & Fine, 2007). Individuals who are not willing to disclose certain life experiences, may underestimate the experience (Williams, 1995). Underestimation of an experience can also be impacted by selection bias often cited in the reviewed studies that used secondary data, limiting their access and possibly underestimating the true occurrence of variables, such as child maltreatment and trauma scores (Ammerman et al., 2012; Ammerman et al., 2013; Banyard et al., 2001; Dym Bartlett et al., 2017). However, within the large, national databases and studies with large samples sizes, researchers countered this limitation through the use of sample randomization. Finally, it is important to remember that the majority of caregivers in these studies were young, poor, traumatized, single mothers of color, who likely encountered confounding factors in their environments, which could impact study findings (Ammerman et al., 2012; Ammerman et al., 2013; Bosquet Enlow et al., 2014; Chang & Fine, 2007; Chemtob et al., 2011). Several intervention based studies, reported significant attrition from participants, indicating that positive findings were most likely result of study participants being engaged and involved willingly.

2.6 Chapter Summary

This chapter provided a review of the development of child welfare policy in the U.S. and how despite good intention unintended consequences of many policies and practice often hurt the most vulnerable. A review of relevant trauma theories was also provided including: 1. Trauma, 2. Cumulative risk theory and complex trauma, 3.

Intergenerational maltreatment, 4. PTSD symptomology and parenting, and 5. Feminist

theory, child welfare, and oppression. Finally, a synthetization of the literature on the

efficacy of child welfare interventions aimed at preventing child maltreatment was

provided. Chapter Three will provide an overview of the research methodology including

the research design, sampling methods, a description of participants, measurement

instruments used and the qualitative analysis process.

CHAPTER THREE: METHODOLOGY

This chapter outlines the research methodology beginning with the research design, followed by an overview of the instrumentation used to collect data. Next, an overview of the sampling design and a description of the study participants is provided. Finally, this chapter will end with an overview of the procedures used to recruit participants, collect data, and complete data analysis.

3.1 Research Design

This qualitative exploratory study used a phenomenological approach to understand the experience of caregivers involved with child welfare through a trauma lens, answering the research question: How do caregivers with a trauma history experience child welfare involvement? This study aims to understand the experience of these caregivers through a trauma lens; something that has not been done to date. Exploratory research by design is not aimed at providing conclusive evidence for an idea, but to explore if there is reason to conduct further research to confirm emerging hypothesis (Padgett, 2008). The goal of this research was to explore the assumption that child welfare is re-traumatizing to the caregiver from their perspective and to gain insight into their lived experience.

The phenomenological approach was chosen for this research for three major

reasons. First, a phenomenological design is used to understand the shared, lived

experiences of a group of people concerning a certain phenomenon, in this case child

welfare involvement (Padgett, 2008). Second, it was determined that the way to fully put

the caregiver experience within the context of their trauma was through the required

activities of phenomenological process. Specific to this process is providing textural

descriptions, structural descriptions, and a summary of major themes. A textural

description is used to tell the story of each participant through a narrative of their

individual experiences (Padgett, 2008). For this project, it was determined that the

caregiver's experiences could not be understood without also understanding the context

of their complex and cumulative traumatic pasts, making the textural description

necessary to answering the research question. Structural descriptions are defined as an

exploration of the "context and setting" of an experience (Padgett, 2008). An exploration

of the context and setting in some cases, allowed for the researcher to explore the

cumulative traumatic nature of poverty and past interactions with child welfare for some,

including stigmatizing interactions and oppressive practices that inform perspectives of

child welfare involvement. As the literature suggest, fear of child welfare involvement is

not solely informed by an individuals' involvement, but also by the community stories

and lore that identify child welfare as the enemy, that separates families, not as a resource

or help. Finally, the phenomenological process requires that a summary of major themes

that emerged through the analysis is presented. Considering the purpose of this

exploratory study was to explore the assumption that caregivers experience re-

traumatization through child welfare involvement, a summary of themes organized

through a trauma lens was believed to be the most efficient way to understand the

experience of child welfare involvement for caregivers with a history of trauma.

3.2 Measurement

Data for this study were collected through a demographic survey, two measures

designed to assess trauma experiences and traumatic symptomology, and a semi-

structured qualitative interview. Data which provides a description of the study

participants were collected through a basic demographic survey which asked participants

about their gender, ethnicity, educational attainment, annual income, number of children

and whether or not they received a parenting intervention.

In an attempt to provide a comprehensive picture of participant trauma and

symptomology, three assessments were administered. Multiple assessments were chosen

as the researcher wanted to be sure a complete picture of the caregivers' trauma was

provided, which included garnering information about early childhood trauma, trauma in

adulthood (after age 18), and trauma symptomology. Participant trauma experiences

across the life span were assessed using the Brief Trauma Questionnaire (BTQ).

Participants also completed a traumatic symptomology screener, the Trauma Symptom

Checklist-40. To further assess the caregiver's trauma experiences, specifically related to

adverse childhood experiences, an ACEs screen was applied to the participant interviews

by the researcher during data analysis.

3.2.1 Brief trauma questionnaire. Trauma experiences across the life span were

assessed using the Brief Trauma Questionnaire (See Appendix A). The BTQ was

developed using the Brief Trauma Interview, developed by Schnurr, Vielhauer, and

Findler (Schnurr, Spiro, Vielhauer, Findler, & Hamblen, 2002; US Department of

Veterans Affairs, n.d.). The BTQ is a 10-item self-report questionnaire that is most

commonly used as a screening tool and not as a measure of a subjective social construct,

validity and reliability are not reported in the literature. The BTQ provides a total score or

number of traumatic experiences from 0 -10. The BTQ was chosen specifically for its

ability to account for the possibility of cumulative risk of traumatic experience across the

lifespan, not just in childhood. Additionally, the BTQ was chosen due to its purposeful

assessment of traumatic experience through the definition of criterion A, in the DSM-V

for diagnosing PTSD, due to their being a correlation with a diagnosis of PTSD and

higher risk for re-traumatization.

        3.2.2 Trauma symptom checklist – 40. To assess trauma symptomology, this

project used the Trauma Symptom Checklist – 40 (TSC-40), developed by Briere and

colleagues (Briere, 1996; Elliott & Briere, 1992) (See Appendix B). The TSC-40 is a 40-

item self-report questionnaire with six subscales: anxiety, depression, dissociations,

sexual abuse trauma index (not being measured for this study), sexual problems, and

sleep disturbance, as well as a total score for overall symptomology (Elliott & Briere,

1992). The subscales are then further categorized as the symptomology being low,

medium, or high. Each item is scored according to the frequency it has been experienced

in the past two months and does not discriminate between childhood and adult trauma.

The TSC-40 has been shown to have good reliability with subscale alphas that range between .66 and .77, and full-scale alphas between .89 and .91 (Briere, 1996). Additionally, this measure has predictive validity for a wide range of trauma histories (Briere, 1996). The TSC-40 was chosen for its ability to assess a variety of current traumatic symptomology within the context of trauma experiences before age 18 and in adulthood.

      3.2.3 Adverse childhood experiences. As an additional measure of trauma experiences, the ACE screen was used as a coding tool and was applied by the researcher to the qualitative interviews during analysis (See Appendix C). As noted in the theory of cumulative risk, the higher the ACE's score the higher an individual's risk is for both physical and mental health concerns. Due to extensive research that demonstrates the utility of an ACE screen to understand traumatic symptomology and the context for maladaptive relational behaviors, it was determined that this additional assessment of traumatic experience was necessary to fully understand each participant's context. The ACE screen identifies ten (10) experiences, including maltreatment and other familial concerns such as, mental health, incarceration, and substance use (CDC, n.d). Similar to the BTQ, a total number of experiences is summed and provides a score from 0 -10. Because the ACE is a screening instrument and not designed to assess a social construct, no reliability or validity data is provided.

3.2.4 Qualitative interview. Finally, qualitative data were collected through an open-ended, semi-structured interview guide. The interview guide was developed with assistance from experts in qualitative research to ensure that I would be able to answer the research question. An open-ended, semi-structured interview was chosen for both the structure and freedom to more fully engage the participant regarding their response. This style of interview allows for a set of common questions which are proposed to all participants, but also allows the interviewer to ask probing and/or follow-up questions to gain a more inclusive understanding of the participant experience (Padgett, 2008). The questions for the qualitative interview were created specifically for this project by the researcher (See Appendix D).

3.3 Procedures

The following will outline the procedures for recruitment, data collection, and data analysis.

3.3.1 Recruitment. The population of interest for this study were caregivers who have involvement with child welfare due to allegations of abuse of neglect who had a trauma history. Individuals for this study were recruited through many different means including, in person recruitment at community events and parenting classes, paper flyers in human services buildings, libraries, and coffee houses, as well as both a Facebook and Twitter campaign. Participants were given a $20.00 cash incentive for completion of the assessment instruments and interview. In addition, snowball sampling (Royce et al., 2015) was employed to reach a sample of ten (N =10). Initial procedures of recruitment were solely focused on attendance at parenting classes in Adams County, Colorado. An

agreement of collaboration was reached with Adams County Department of Human Services and the researcher attended two parenting class meetings and conducted in-person recruitment. This method was not effective as caregivers did not follow through after initial contact. Therefore, additional methods were added. The next method was to attend community events, such as neighborhood BBQ's. An agreement was also made with a residential treatment facility in Denver, CO to attend Back to School Nights and conduct in-person recruitment.

In-person recruitment at both the parenting classes and community events began with the researcher introducing herself to potential participants and providing a flyer explaining the project (See Appendix B) and a brief verbal overview of the project and participant criteria. A follow-up contact method for the potential participants was secured and they were individually contacted by the researcher within 48 hours and provided a link to the demographic survey and trauma assessments and to schedule the interview.

To further increase participation flyers were posted in different community hubs including human services offices, libraries, and coffee houses. Next, Facebook and Twitter campaigns were initiated, which included posting a brief overview of the study with the link to the demographic survey and trauma assessments. Finally, snowball sampling was used. Snowball sampling includes asking participants to refer individuals to the researcher that fits the sampling frame and may be willing to participate.

Recruitment for this study was particularly difficult, possibly due to the sensitive nature of the study. Most caregivers approached were experiencing current child welfare involvement and it is possible that the researcher was perceived as yet another member of

the system. It was hoped that the use of multiple methods of recruitment would expand the reach of the researcher outside of her current community to overcome possible perceptions of further child welfare intrusion and meet the proposed sample size. In total 10 participants were recruited: six through community events, three through social media, and one as a result of snowball sampling.

3.3.2 Data Collection. Data were collected for this study through two primary methods. Participants were given the option of completing the demographic surveys online, through the Qualtrics site or in-person through a pen and paper format. In total, three participants completed the surveys on-line and seven completed them in person. All participants completed informed consent prior to completing the measures. In addition, participants were told that they could choose not to answer any question or discontinue participation at any time. The demographic survey and trauma assessments were completed prior to the participant interview.

Interviews were conducted using the semi-structured interview guide, either in the participant's home (n=7) or via the telephone (n=3). Interviews were audio recorded and transcribed verbatim by the researcher; however, one interview did not record as the result of a technology issue. Despite the loss of the recording, the researcher was able to take extensive notes during the interview. Additionally, immediately upon ending the interview the researcher made a personal audio recording of important elements she did not want to lose. The notes and researcher recording were used to approximate and partially recreate the interview for coding. At the conclusion of each interview, the researcher requested permission from each participant to contact them in the future with

any additional questions and to complete the member checking process. All participants agreed.

3.3.3 Data analysis. All qualitative data were analyzed using a phenomenological framework, which includes first and second cycle coding phases. First cycle coding processes resulted in textural and structural descriptions of participant experience and provided the framework for the second cycle coding (Saldana, 2009). Second cycle coding is where the themes regarding the caregivers experience with child welfare through a trauma lens began to emerge (Saldana, 2009).

3.3.3a *First cycle coding.* The first cycle of coding was completed in three distinct rounds of analysis. The first round was completed using descriptive coding, the second round was an open, initial coding process that included both descriptive and in vivo coding, and the final round consisted of a more in-depth review of the initial codes through emotion and values coding. Qualitative analysis is an iterative process that begins with data collection and continues through a thematic analysis to improve the understanding of a certain phenomenon.

The first round of first cycle coding was done using pre-determined descriptive coding. Descriptive coding is the application of a short word or phrase to a segment of data (Saldana, 2009). The goal of the first round of descriptive coding was to use a set of pre-determined codes to describe the textural (i.e. personal trauma story) and structural (i.e. history of child welfare involvement) experiences of study participants. Two pre-determined codes were created for the descriptive coding process; the first code was adverse childhood experiences, which allowed the researcher to seek out and identify

events that the participant named that fell within the framework of the ACES screen, adding to the textural description. The second code was child welfare experiences, which allowed the researcher to clearly denote any other involvement with child welfare, such as being placed in foster care as a child, adding to the structural description.

The second round of first cycle coding, was conducted using an initial coding framework. Initial coding is described by Saldana (2009) as a way in which the data are broken down into discreet parts and compared for similarities and differences. Therefore, the researcher read the interviews line by line and provided a set of initial descriptive and in vivo codes that allowed participants experiences to emerge naturally. As noted, descriptive coding is an application of a short word or phrase to a segment of data. Descriptive coding was applied during this round by allowing the words and phrases that described the data to emerge naturally as a result of the participant experience and not through the use of predetermined codes.

In vivo coding was also used. In vivo means, "in that which is alive," and when used as a coding method the goal is to capture the true essence of the data and to demonstrate ideas and perceptions in the language of the participant (Saldana, 2009). This is a particularly salient use of coding, especially when engaging with a population of individuals who have both been historically and currently marginalized, and have rarely had a voice in matters that primarily concern them. Therefore, in vivo coding allows the participant to tell their story in their own words, allowing their language to speak for itself. The second round of coding was a reiterative process that included returning to earlier interviews when new codes emerged to determine if the concept may have been

missed previously. When this process concluded, all codes were printed onto note cards and a table top sort was completed (Saldana, 2009). The table top sort was used to combine similar codes and identify differences in experiences. During this round, an understanding of the participant experience began to emerge, however it was necessary to also understand how participants were responding to child welfare through their trauma lens, which required a specific coding methods.

The third round of first cycle coding applied both emotion and values coding to the data, to explore how participants were responding to child welfare as the participant experience was emerging. Within the third round coding, it was important to maintain a trauma lens for reviewing the data. No pre-determined codes were used; however, the researcher did maintain a bias for language which depicted possible trauma symptomology and/or responses couched in participant emotion and value based statements.

Emotion coding is a method which is defined to be effective for understanding both intrapersonal and interpersonal experiences (Saldana, 2009). Emotion informs our actions, making this a salient method for exploring trauma within a narrative, providing a framework for determining if a participant's behavior or actions are tied to emotions which are also linked to trauma symptomology. Therefore, emotion coding was used to help understand the motivations behind actions.

Values coding allows for the application of value based codes that include values, attitudes, and/or beliefs that give insight into one's worldview (Saldana, 2009). Similar to the expectations for the utility for emotions coding, exploring one's attitudes and beliefs

should allow for the identification trauma related beliefs that can provide context for the participant's responses and reactions to child welfare involvement. Once the first cycle coding was completed, second cycle coding began with the goal of identifying the emerging patterns and develop the overarching themes that begin to explain the participants experience with child welfare systems.

3.3.3b Second cycle coding. For second cycle coding, theoretical coding was used due to the unique contributions the process makes to the coding process. Theoretical coding is considered, "an umbrella that covers and accounts for all other codes and categories formulated" (Saldana, 2009, p. 163). As the goal of an exploratory study is to begin to provide evidence for an emerging idea, it was determined to be the most effective way to organize the data. As theories have explored the potential for re-traumatization within child welfare, it was determined that using this idea as a theoretical basis, would the best method for establishing final themes. The process of theoretical coding begins with the development of the primary theme/theory from the data, this is clearly a beneficial method for this study, due to the exploratory framework, which states that the ultimate goal is to determine if the issue warrants further study. Once coding had identified the overarching theory from the data, the data was then organized to demonstrate that all patterns and themes are systematically linked back to that foundation. Table top sorting was used once again to complete the second cycle coding. The table top process allowed for organizing child welfare experiences within the context

of what was described through the emotion and values coding. This process established

the beginning framework for understanding the points of entry into family life that result

in the perception of threat, oppression, and control, arousing one's trauma.

3.4 Sample

Again**,** the population of interest for this study were caregivers who have

involvement with child welfare due to allegations of abuse of neglect who had a history

of trauma. The sample was purposive. Purposive sampling is "a deliberate process of

selecting respondents based on their ability to provide the needed information" (Padgett,

2008, p.53). Therefore, participants in this study were purposefully recruited using the

following criteria: being at least 18 years old, reading at a third grade level, had their

child removed or was threatened with child removal, and received or were receiving a

parenting intervention. This method was determined to be the most effective method for

identifying and recruiting individuals who could speak to the lived experiences of this

phenomenon.

3.4.1 Sample demographics. The final sample for this study included ten *(N=10)*

participants, which is an appropriate sample size for an exploratory, phenomenological

study (Padgett, 2008). All participants were the primary caregiver at the time that an

allegation of abuse or neglect was made, not necessarily the biological parent. The

sample included eight biological caregivers, one father and seven mothers. In addition,

there was one adoptive mother and one kinship provider, who identified as the child's

aunt. Most participants (7) came from the Metro Denver area, two were from the Metro

Kansas City, Missouri area, and one participant was from a small, rural town in Oregon.

Four participants identified as White, three as Latina, two as African American/Black, and one as multi-racial (Caucasian/Jewish). Five of the participants had a high school diploma, two did not graduate from high school, two had some vocational training, and one participant had a graduate degree.

The number of children in the families ranged from one to four, with family size ranging from two to six. Using family size, it was determined that eight study participants fell below the 2016 federal poverty guidelines, making $29,999 annually or less, two of those participants lived on fixed incomes of less than $10,000 annually. All participants received some type of parenting intervention, eight reported attending a parenting class and six (6) received in-home services. Lastly, all ten participants reported having a mental health diagnosis, with eight reporting being diagnosed bi-polar. Six reported a history of intergenerational abuse and child maltreatment, four reported being placed in out of home care and three reported having aged out of foster care.

3.4.1a Trauma experiences. Most participants in this study had high BTQ and ACE scores, indicating high levels of trauma exposure and cumulative risk. Results of the BTQ revealed that, three participants had a BTQ score between four and six, and four participants had a total score of eight indicating an endorsement of almost all events considered consistent with criterion A for PTSD. All of the participants endorsed at least one event on the BTQ, however as shown the majority of the sample, seven endorsed four or more events on the BTQ, consistent with an increased risk for development of trauma symptomology.

The prevalence of adverse childhood experiences in this sample was also high, with six participants reporting four or more. Three participants reported no adverse childhood experiences and one participant reported one. Within the six participants who experienced four or more, one participant each had a score of four, six, and nine, while three of the interviews indicated participants having ten adverse childhood experiences, endorsing multiple forms of child maltreatment and adverse home environments. For caregivers in this study, the rate of cumulative trauma both before age 18 and after is high and lends some understanding to the corresponding high rates of trauma symptomology.

3.4.1b Trauma symptomology. The majority of sample (8) demonstrated symptomology in each of the identified categories, with six participants reporting mild to high symptomology across all trauma symptom measures. Further breaking this down, six of participants reported mild to high dissociation symptomology, seven endorsed mild to high depression and anxiety, respectively, and finally eight of the participants endorsed mild to high disruption in their sleep. Unfortunately, there is no way to correlate this trauma symptomology to a specific traumatic experience. However, it is highly possible that the widely endorsed symptomology is the summation of accumulated traumatic experiences. Table 3.1 provides a snapshot of participant's traumatic experiences and demonstrated symptomology.

Table 3.1 – Participant Trauma

Trauma	*Number of Participants*
Brief Trauma Questionnaire Scores	
1	3
4	2
5	1
8	4
Adverse Childhood Experiences Scores	
0	3
1	1
4	1
6	1
9	1
10	3
Trauma Symptomology – mild to high	
Dissociation	6
Anxiety	7
Depression	7
Sleep Disturbance	8
Total Score (possible PTSD)	6

3.5 Rigor and trustworthiness

The following section will review the steps taken to increase the rigor of this qualitative study by addressing threats to the trustworthiness of the data and interpretation. One of the threats to the trustworthiness of this study is the solo nature of the dissertation, which included the principal researcher conducting, transcribing, and coding all interviews in isolation. In an attempt to preempt the threat, the researcher used the method described as peer debriefing and support (Padgett, 2008). A review of the data were conducted with two colleagues, one with knowledge and understanding of child welfare and the population and another with a minimal working knowledge of child welfare and the population. In addition, member-checking was conducted with three of the interviewees, in follow up phone calls, prior to final analysis and development of final themes. Member-checking is a process which re-engages the participant in validating the themes which emerged from the data as consistent with their experience (Padgett, 2008). In addition, to address concerns of trustworthiness and to ensure the rigor of the research design, the researcher used the bracketing process.

To understand the lived experience, phenomenological processes require that the phenomenon be explored by "bracketing" one's biases and analyzing the data without presuppositions (Creswell, 1998). Padgett (2008) goes on to note that the bracketing process should occur consistently during all phases of the research, to ensure the research is always exploring their own biases and personal experiences, in hopes of preventing personal experiences to encroach upon the participant experience. This element was crucial, as the researcher has had interactions with child welfare in her personal life and

also as a professional in child welfare for nearly 10 years. Therefore, the ability to use the bracketing process, including the use of memos and reflection, helped to set aside research bias and allow for an honest assessment of the participant voice.

3.6 Chapter Summary

Chapter Three included the details regarding the research design and methodology. The chapter began with a description of the research design, followed by a review of the demographic survey and trauma assessments that were administered. Next, the procedural steps that were completed including the recruitment of participants, collecting data and the qualitative coding process are reviewed. This chapter concludes with a review of the study participants, including a description of major characteristics. The next chapter will provide the results of the data analysis, giving a textural and structural description of each participant and then a comprehensive review of the thematic analysis.

CHAPTER FOUR: FINDINGS

This chapter will provide the textural and structural descriptions of caregivers' stories to provide context for understanding the impact of trauma on their lived experience of child welfare involvement. Next, a review of the major themes that arose during the coding process, designed chronologically to describe the many points of entry into family life with traumatic potential, including reports alleging abuse, intrusive and coercive levels of involvement, and oppressive practices, is provided. This chapter ends with a review of the emerging themes that indicate the traumatic nature of child welfare involvement. The emerging themes are not meant to provide a conclusive answer to the question, but rather to begin to clarify the nature of the problem, and explore the extent to which the issue should be further researched.

4.1 Trauma History

The trauma histories of participants were varied within this group of caregivers, ranging from one trauma in adulthood to chronic and cumulating trauma over the life span, which began in childhood. Caregivers were categorized as having either minimal trauma (n = 4) or cumulative trauma (n = 6). To further understand the participants, the following provides a review of the textural and structural descriptions of who the caregivers are and their trauma.

Julie – Julie is the mother of three children and identified her ethnicity as Latina. Julie's middle son is diagnosed as bipolar, which she says was the impetus for child welfare involvement. The family was reported twice by their son's school regarding allegations of physical abuse when he came to   school with bruises. Julie stated that her son's bruises were the result of his mental illness, where he would throw himself on the ground during tantrums. Neither of the allegations resulted in a finding of maltreatment and both were quickly discharged. The child welfare investigations were Julie's only reported contact with child welfare; she had no previous contact as a child. Julie only reported one adverse childhood experience, having a parent with a mental illness: her mother was also diagnosed with bipolar disorder. Julie did not report any personal mental health diagnoses, but did say that she had a short stay in a hospital psychiatric unit as a result of being overwhelmed with her son's mental health. Julie reported that she requested services to help with parenting her son during her investigations but, that no services were provided.

Gina – Gina is a single mother of two teenagers and identified as Latina. Gina and her family came to the attention of child welfare due to her children's truancy, which was reported by her children's school. Gina did not report any adverse childhood experiences and reported only one traumatic incident in adulthood. Additionally, she did not indicate any prior engagement with child welfare, as a child or adult. Gina did not report any mental health diagnoses. Gina reported that the child welfare investigation resulted in no findings of maltreatment; however, she was identified as at-risk for maltreatment and in-home therapy services were set up, to prevent further incident.

Melissa – Melissa is the parent of four boys and is in a committed relationship in which she is co-parenting. Melissa identified as Caucasian/White. Melissa and her partner adopted four boys from child welfare. The two older boys are now adults and Melissa described her experience parenting them as "normal." However, the two younger boys, both in pre-adolescence, have been diagnosed with Autism and in addition the youngest has also been diagnosed with schizophrenia. Melissa and her family came to the attention of child welfare a few years ago, when an in-home therapist reported them for neglect, which, according to Melissa, was due to poor housekeeping. Melissa reported that she went to court for the neglect charges, but that the case was eventually resolved as unfounded. More recently, her youngest son disclosed sexual abuse by his older brother, which resulted in the younger son being removed for a short period of time. Melissa reported no ACES or cumulative traumatic experiences, but did report one traumatic event in adulthood. She did not report any involvement with child welfare as a child, but did have prior involvement as a foster and foster to adopt parent. Melissa was recently diagnosed as bipolar. At the time of the interview, Melissa and her family had never been founded for any maltreatment and her youngest son had returned home. However, they were still under investigation for neglect stemming from the sexual abuse allegation. Child welfare worked with the family to set up several services including but not limited to: day treatment, in-home therapy, and psychiatry.

Sarah – Sarah has two children, an adolescent boy and a toddler girl. Sarah identifies as African American/Black. In addition, her sister, infant niece, and mother live with her. Sarah provides care for her mother who had a serious accident that resulted in a

traumatic brain injury and is now suffering dementia. Sarah's son has several mental health diagnoses and cognitive deficits including bi-polar disorder. Her daughter at this time has not been diagnosed, but Sarah said that she has some concerning behavior. Sarah has lifetime involvement with child welfare. Sarah reported being removed from her parents and living in both kinship care and foster homes, but spent most of her time in residential treatment and group homes, from the age of five. She was living in kinship care with her grandparents when she got pregnant with her son, who she describes as being "born into system." Sarah could not specify a time in which an allegation was made against her, but that "they [child welfare] had always just been there." She reports that she has not ever had a founded allegation against her and has never had her children removed. Sarah reported multiple adverse childhood experiences and has an ACES score of ten, endorsing each traumatic experience on the scale. Sarah entered the system due to sexual abuse by her brothers and physical abuse and severe neglect by her parents. Sarah stated that her parents both had mental illnesses and substance abuse problems and that one of her brothers went to jail for the sexual abuse. Sarah also endorsed multiple traumatic events in adulthood, including domestic violence and sexual assault. Sarah has her own personal mental health concerns, including diagnoses of bipolar and post-traumatic stress disorder, for which she takes medication. Due to Sarah's long and in-depth involvement with child welfare, she reports having received many different services over the years both for tangible (rent, utilities, food) and intangible (psychiatry, therapy, etc.) needs. Most recently she and her children are receiving in-home services and her son is in a day treatment program.

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Sandra – Sandra was the only kinship provider and identifies as African/American/Black. Sandra has biological children; however, they are all adults. Sandra was a kinship provider for her nephew, her brother's son. The allegations which brought Sandra's nephew to child welfare attention initially, were related to her brother's drug use and neglect. After a few weeks of providing kinship care, an allegation was made against Sandra; she is unsure of who made the accusation. Sandra stated that a worker came to her house and began to question her about physically abusing her nephew and that soon after he was removed from her care, with little explanation. Sandra stated that later she "heard" that the allegations were about her brother and not her. Sandra was never founded for maltreatment of any kind; however, she does not have visitation with her nephew and is not able to see him. Sandra endorsed ten ACES experiences. Sandra had lifetime child welfare involvement including foster care as a child, involvement and allegations while raising her own biological children, and then as a kinship provider. Sandra has her own extensive trauma history, including physical abuse and neglect at the hands of her parents. She also alluded to sexual abuse, but quickly refused to talk about it. Sandra was removed and reunified with her family several times, beginning around the age of six. Sandra also reported multiple traumatic experiences in adulthood, including domestic violence and sexual violence. Sandra has been diagnosed with bipolar disorder and takes medication. Sandra noted that when she initially took her nephew in, child welfare was providing some in-home services, but not any help with tangible needs, such as food or transportation costs.

Laurie – Laurie is in a committed, co-parenting relationship. Laurie is the mother of two girls, one pre-adolescent and the other is six. Laurie identifies as Caucasian/White. Both girls have an Autism diagnosis and other sensory processing disorders. Laurie reports at least 31 encounters with child welfare over the last 11 years, most often related to her oldest daughter. She reports being reported by schools, neighbors, and employees at local establishments where she shops. She has been founded for neglect twice, but has never had her children removed. Laurie endorsed ten adverse childhood experiences. Laurie was not involved with child welfare as a child, but reported extensive physical abuse and neglect at the hands of her mother and step-father. Laurie also reported several experiences with trauma as an adult including being in a violent domestic relationship, which almost resulted in the removal of her daughter and was her first experience with child welfare. Laurie has several mental health diagnoses, including bipolar disorder, posttraumatic stress disorder, and autism. She reports doing well on her current medication and feeling stable. Due to Laurie's extensive engagement with child welfare, she has received numerous services over the years aimed at addressing tangible and intangible needs. Currently, the family receives in-home therapy services.

Marcus – Marcus was the only father who participated in this study and identified as multi-racial (Caucasian/Jewish). Marcus was given custody of his four year old son, after being released from prison. Marcus was not forthcoming about why he went to prison, but stated that if he wouldn't have "done what he did, his father and sister would be dead." During Marcus's time in prison, his son was taken into child welfare custody due to the biological mother's drug use. Marcus's son has been diagnosed as

having attention-deficit hyperactivity disorder (ADHD). Marcus fought and was able to obtain custody of his son; however, at the time of the interview he was currently involved with child welfare due to allegations of physical abuse. Marcus admitted to pushing his son to the ground and causing bruises; the investigation began after his son went to school that day and reported the incident to his teachers. Marcus states that he called his social worker after it happened, but due to the school report child welfare had to investigate. Marcus's son was removed for a period of nine days before being returned home. The investigation was founded and Marcus has formally been charged with child abuse and is awaiting trial. Marcus reported four adverse childhood experiences, including physical abuse, neglect, having a parent with a mental illness, and domestic violence. He did not have lifetime child welfare involvement, as child welfare was not involved with his family as a child, but he did report significant abuse at the hands of his father. Marcus reported several traumatic experiences in adulthood including, physical abuse, assault, and sexual assault. Marcus has been diagnosed with bi-polar disorder and ADHD. Marcus reported that he has a team of people surrounding him and providing services, including parenting classes and in-home therapy.

Jordan – Jordan is in a committed, co-parenting relationship and identifies as Latina. She is the parent of two boys, one is now an adult and the other a pre-adolescent. Jordan did not report on any mental health diagnoses for her sons, although she suspected her younger son had attention-deficit hyperactivity disorder. Jordan has had allegations made against her on both boys. When Jordan's oldest son was a toddler, she was in a violent relationship that she said resulted in her son being removed and placed in kinship

care with her mother. Jordan never regained full custody of him on paper; however, when he was 15 he came to live with her when Jordan's mother felt she could no longer control him. At this time, Jordan's younger son was four years old. Jordan's older son was using drugs at school, which prompted a report by the school to child welfare and then a welfare check. When child welfare came to investigate they determined that the younger son was in danger, due to neglect and drug use, and removed him to foster care. Jordan was founded for neglect and her son remained in the system for nine months while she fought to regain custody. Jordan endorsed six ACES: she was involved with child welfare extensively as a child. Jordan was kidnapped by her father when she was six years old. Her father told her that her mother was dead and over the course of three years Jordan was sexually abused by her father and other men for whom her father provided access. When Jordan disclosed the sexual abuse, she was removed from her father. At this time, Jordan learned of her kidnapping and that her mother was still alive. Jordan was returned to her biological mother at the age of nine. However, Jordan reported that her mother did not feel as if she could "handle" Jordan. Jordan's mother relinquished her rights and Jordan went into foster care at the age of 11. Jordan stayed in group homes until she aged out of the system. Jordan has been diagnosed with bipolar disorder and at the time of the interview was not on any medication: she reported being unable to afford it. Jordan reported receipt of several services over the years due to her extensive engagement with child welfare. Jordan and her family are currently receiving in-home therapy services.

Lacy –   Lacy is the mother of one child, who is now an adult. Lacy identifies as Caucasian/White. Lacy did not report any diagnoses for her son. Lacy's son was removed by the police due to her arrest and assault charges resulting from domestic violence. Lacy was founded for failure to protect and her son was placed into his biological father's care. Lacy eventually regained custody of her son, but it took almost 18 months. Lacy's interview did not endorse any adverse childhood experiences and she reportedly had no previous child welfare involvement. However, she did report cumulative trauma in her adult life, including domestic violence. Lacy has been diagnosed with bipolar disorder and was currently on medication. Lacy reported that she received several services, including parenting classes, substance abuse classes, and outpatient therapy.

Melinda – Melinda is the mother of three daughters, two of which are now adults and one adolescent at home. Melinda identifies as Caucasian/White. Melinda did not report any mental health diagnoses for her children. Melinda had a report alleging neglect levied against her; she believes the investigated originated when a disgruntled teenager who she asked to leave her house anonymously reported her. She reports that she was investigated due to the use of marijuana in her house. The allegations were unfounded and her daughter was never removed from her care. Melinda has had lifetime involvement with child welfare. She endorsed nine ACES. Melinda's biological father committed suicide when she was six years old. When her mother remarried, Melinda reported that she was sexually abused by her step-father as a pre-adolescent. When she finally disclosed she reports that her mother refused to believe her and have the step-father leave the home. Therefore, Melinda went into foster care where she was in three

homes over seven years before running away and going back to her mother, where, she reports, child welfare allowed her to stay. As an adult Melinda also had a previous involvement with child welfare when her now adult children were three and four. Melinda said this investigation resulted from her mother and a new step-father calling in an allegation of neglect. Melinda reported this allegation was unfounded. Melinda reported two individual traumatic events in adulthood, a serious illness and car accident, although she also alluded to domestic violence in her interview. Melinda has a bipolar diagnosis and is not currently on any medication, as she does not feel it's necessary. Melinda reported receiving many different services over the years; however, most recently she received a diagnostic assessment and a urine analysis; she said she was offered therapy, which she refused.

4.2 The Child Welfare Experience through a Trauma Lens

The purpose of the exploratory design was to determine if current theory, that parents are re-traumatized by child welfare practices that mimic earlier traumatic experience, has support from the perspective of the caregiver. The findings from this study; however, demonstrate that child welfare involvement may in of itself by traumatic. There were multiple points of entry that child welfare has into family life which have the potential to elicit a traumatic response. The following will describe the shared experiences of caregivers who have a trauma history and involvement with child welfare, beginning with the initial allegation of abuse through the ongoing impact after a case closes.

4.2.1 Betrayal of trust. The ways in which caregivers became involved with child welfare are myriad; however, what was shared was that it began with an act of betrayal by a trusted person. Such betrayals were defined by Freyd (1996) as "betrayal trauma," occurring when an individual violates role expectations of protection and safety within a relational context. All participants were able to describe the circumstances that led to child welfare involvement. For some, the betrayal began with maltreatment at the hands of their parents in childhood. For a child, this may be viewed as a violation of the caregiver's role as protector. Caregivers who did not have childhood involvement, noted their involvement began with a call to child welfare by a mandated reporter who was, for participants in this study, a trusted professional they had allowed into their lives.

4.2.1a Betrayal of trust: Caregivers and child welfare. Six caregivers in this study reported maltreatment in childhood at the hands of a trusted caregiver. Child maltreatment was described by some caregivers in this study as events for which they blamed their parents for not protecting them. For example, Melinda stated,

> I remember telling my mom at one point when she didn't believe me and I was in
>
> foster care, that if she didn't believe me, when she had been through the same
>
> thing as a child, then I didn't want to see her ever again until she did.

Four of the six caregivers with child maltreatment were removed from their parents and were placed in foster care. For these caregivers, their introduction into the child welfare system began when they were children and continued throughout their life time, some with constancy and others more sporadically. The experience of childhood maltreatment that involved child welfare that involved child welfare appeared to cause the caregiver to

ascribe blame to the system, increasing feelings of betrayal. Blame ascribed to the system was two-fold, caregivers blamed child welfare for 1) causing disruption in their life, particularly breaking up their families and 2) not holding up their end of the bargain. Caregivers felt that child welfare's end of the deal was to keep families together and help the caregiver overcome their circumstance. A sentiment that they continued to use to describe child welfare involvement as the investigated caregiver. "When you can keep a child with their family instead of destroying their home then you need to make sure there is everything and anything possible that you can do" (Sandra). For Sarah, who noted being physically abused by her parents, saw child welfare as a group of people who kept snatching her from her family: "So, anything happened, or my mom made a call or anything like that, my dad, I was being snatched up right away." Sandra who also was placed in foster care as a child reinforced the idea that child welfare was not concerned with helping her family, "the only thing they [child welfare] are good for, is tearing families apart." Sarah, who reported, sexual abuse by her brothers, shared:

> As a child, the reason I ended up in the system is because I was molested by my
> two older brothers ... And once again, social services didn't help my brothers,
> they didn't fix our home, they didn't do anything. Everything I have seen social
> services, they have destroyed everything they have ever touched. Caregivers who
> had childhood involvement with child welfare experienced betrayal at the hands
> of many of those responsible for their care and safety. These betrayals caused a
> disruption in their ability to trust any individual given such authority in their lives.

That's a permanent scar that the state that done left on me, that my parents left on

me. And that's something I can't never take away, I can't get back. The only

thing I can do is make sure my kids don't have that issue and problems and

concerns (Sarah).

4.2.1b Betrayal of trust: Mandated reporters. All participants, except for one, at

some point had a trusted person call in an allegation of abuse and/or neglect. Most often

these reports were made by mandated reporters, which is usually someone who has a

level of power over the individual and their circumstance. Mandated reporters identified

in this study included clinicians, doctors, or their child's teacher. When caregivers came

to the attention of child welfare through a mandated report it often resulted in the

experience of feeling betrayed by someone that the caregiver believed they should be

able to trust. For example, Melissa felt betrayed when an in-home therapist who had been

coming to her home for over a year made a report seemingly out of the blue,

Um, well, I lost a lot of trust, I was really hurt that someone who had been coming

to our house for a year every week would walk in and decide one week that it was

so dirty that she had to make that report.

Melissa then stated, "… I can tell you [the interviewer], the only reason you [the

interviewer] are in here, is because of the therapist [current in-home therapist], because I

don't let people in my house because of that other experience, I just don't."

For Laurie, her betrayal came at the hands of her doctor. Laurie stated that her OB-GYN

reported her to social services for the use of pain medication, "my OB was prescribing

me Percocet for my back. My OB called social services on me and told them that I was

addicted to Percocet. I was a drug addict." Laurie expressed being confused and hurt that a person responsible for her care, who was providing the medication and telling her it was safe, could then construct her as the problem.

Lacy had a different experience than other caregivers regarding her initial involvement with child welfare; however, the elements of betrayal were still present. Lacy stated that she got into a physical altercation with her boyfriend and called police for assistance, however was arrested on drug and assault charges. Lacy stated:

> He [police officer] asked me "what happened?" and I was in a half hysterical
>
> mode but, he just looked at me and after I said about two and a half sentences, he
>
> looked at me and said, "I don't believe you, I'm arresting you."

Experiences of betrayal, for these caregivers, specifically those which were caused by an individual or system that they perceived as responsible for their well-being or safety, had traumatic potential. Melissa, in particular, spoke of the effect on her ability to trust professionals moving forward, "Um, well, I lost a lot of trust." Sarah was referred to child welfare after her son caught his bed on fire and ended up in the burn unit at a local Children's Hospital. She reported that the social worker stated she would provide resources to help bring her son home, but that the caseworker did not "hold up their end of the bargain." Sarah turned this inward and saw herself as the only one she could trust, I had to sacrifice, damn near, being put out of my home, just so my son could come home. Used up all my money, just so my son could come home, because they didn't hold up their end of the bargain.

4.2.2 Coercion. Coercion for participants in this study is understood as the caregivers feeling that they had no choice but to comply with child welfare, particularly because they were working to maintain or regain custody of their child. Coercion for caregivers was commonly related to feeling threatened, which is known to increase a traumatic response (Brown, 2004; Clark et al., 2005; Cutcliffe & Happell, 2009). In this study parents experienced threat in different ways. First, threat arose in relation to child removal. This was enacted by either threatening to remove the child or by threatening not to reunify the child unless the parent adhered to specific expectations. Secondly, some caregivers noted feeling threats to their safety, including involving children's fathers. Threats to safety were also related to caregivers' use of mental health medications, particularly during pregnancy, when caregivers were told to discontinue medications they needed to feel "in control." Finally, parents often felt that they were given impossible choices, often relayed in the form of ultimatums, which forced them to make choices they often feared would cause more problems.

4.2.2a Threats of removal or not reunifying after removal. Threats of removal or not reunifying a child with their caregiver occurred frequently throughout caregiver narratives. Such threats were perceived as coercive primarily because caregivers did not agree with case worker assessments of their abusive behavior and saw expectations, such as drug classes, parenting classes and therapy, as unnecessary. Lacy stated, "I didn't consider myself to be an alcoholic, I'm sorry, but I'm not going to sit there and admit to something I'm not." Lacy later stated that she was told she would not be reunified with

her son, if she did not successfully complete treatment. In response, she reports admitting to being an alcoholic simply to pass the class and get her son back.

Jordan, who reported being unable to pay for her bipolar medication, stated that her case worker told the court, "Because I wasn't on my medication that she didn't feel that I should get him back." As Jordan noted, this would have been fair if she had been given access to resources to help with her medication. Instead she felt that she was left on her own to navigate the system and believed if she couldn't find the solution she would never get her son back. Similar comments were made by Lacy:

> I had housing and I got kicked off housing and they told me without housing I couldn't get my son back…I know that there are programs out there to help people in these situations to help them get back on their feet, but nobody would tell me about them.

Sandra, although speaking on behalf of her brother, stated that he was put on a time line for achieving expectations, but ended up being waitlisted for drug treatment. However, while he waited for an open bed, child welfare continually threatened that they would have his son adopted if he didn't get into treatment. "It's, it's horrible, the way we have to wait for services. And the social services wants to take your kids, because you're on a waiting list for services." Sandra further expressed her frustration, seeing child welfare as manipulating parents by using their children as chess pieces, "but, I would not sit there and hold em' over your head like little pawns in a chess game and use them [children] like that. You don't use children like that."

Jordan reported the use of concurrent planning when her son was removed, which she perceived as a threat to reunification with her son. Concurrent planning allows child welfare to work simultaneously on reunification and adoption, just in case reunification is not possible. Jordan stated, "Like they wanted to take him, they wanted him to be adopted by another family. By the family he was living with … they told me he was going to be adopted." Jordan was reunified with her son; however, she noted that the case worker told her at the reunification, "… if I ever had to deal with social services again, that they would take him and not ever give him back." This statement stuck with Jordan, as a few years later when her son was acting out (it was later discovered he had been molested by a neighbor child), she struggled so extensively with going to social services for help that she reported, "I wanted to hurt him and I didn't want to hurt him, but I was worried that I was going to because I just couldn't handle everything that was going on." They did eventually seek help. Jordan stated that she overcame her fear when her son threatened suicide and she took him to the hospital, stating "it wasn't about me, it was about him."

Fears of having a child removed and never reunified was common, even for those families who did not have a child removed. For most caregivers, this appeared linked to the perception that child welfare could decide to take their children and compel specific actions for which they may not have the resources to meet, resulting in permanent loss of their parental rights.

> I'm ashamed that if I couldn't have complied with it, and I couldn't have paid for it, um, who's to say she [my caseworker] would've offered to pay for it through the state … I mean, say the parent couldn't take the test because they couldn't

afford it or couldn't find a ride there, then they would lose their child. Because, they weren't able to follow through with the wishes, you know what I'm saying, and I've heard that happened before (Melinda).

4.2.2b Threats to safety. Caregivers experienced what they considered threats to their own safety from child welfare in two different ways: 1) requirements that non-resident parents be involved, and 2) being told to discontinue the use of medications for mental health during pregnancy. Six caregivers were told that they had to involve the child's non-resident caregiver with their cases. This was done in spite of caregivers reporting to case workers that their children's non-resident parent had serious and persistent mental illnesses, illicit drug use (i.e. crack, heroin, etc.) and/or a history of interpersonal domestic violence. Five of the non-resident caregivers eventually had their parental rights terminated due to drug use and/or domestic violence, according to the caregivers in this study. This did not change the affect reported by caregivers that the initial involvement with non-resident caregivers often caused them angst and anxiety.

Sarah's son's father is a convicted sex offender, whom she stated was abusive when they were together, "Social services had also forced me to involve my son's dad back in his life, after I had cut my ties with him." Sarah reported that at the time child welfare became involved she had moved and her son's father was not aware of where they were living. However, she stated that child welfare "forced" her to let him know where she lived, which made her feel consistently unsafe. In fact, she reports that she ended up in court getting a restraining to prevent further contact after an incident where she stated, "My son's dad was threatening me, to kill me, to kidnap my baby, all type of

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stuff. Now my son is out of control, now I'm ready to beat him, because ya'll done violated me."

Threats to safety also extended to the caregivers' children. The perceived threat to their child's safety was often because of previous risky behaviors that caregivers believed would put their children in danger from the non-resident caregiver:

> They were going to give him to bio-dad who lives in another state and I
> recommend that if that ever happens to anybody that you make sure you make
> them do a background check on bio-dad, because once they realized, they put a no
> contact order, yea, so, they were contemplating giving *my son* to him, and they
> didn't realize that he's a sociopath and has bi-polar and schizophrenia and would
> take him without any... (Jordan).

For caregivers in this study, fear regarding the safety of their children from a non-resident parent was consistent. For Marcus, his son entered child welfare while he was in prison, due to what he reported was his son's biological mother's drug use. He reports that at one point during the case, his son was reunified with his mother,

> Back to mom he went. And her compliance completely and totally shattered after
> that, started to break apart and then shattered and then was just gone. Nothing left.
> She, there was no compliance what so ever. And when she did try to pass a couple
> of drug tests she failed them for meth and heroin and different things.

Marcus noted that after that, he did not trust that the system would not reunify his son again with his mom and put his son at risk; therefore, he entered into total compliance with child welfare, "It finally got to the point where I did everything I was supposed to,

everything. And I even took the extra initiative to innovate my own ideas to speed up the process for child protective services."

Caregivers who were prescribed medications for bipolar disorder during pregnancy, reported feeling as if their and their child's safety was threatened by child welfare's demand that they discontinue medications. This experience was present for two caregivers, Laurie and Sarah.

> I was medicated before I found out I was pregnant with my daughter, then throughout most of my pregnancy with her, I was on my medications. When I found out I was pregnant, the social worker told me if "I was going to be a good parent, and if I was going to keep my children, I could not be on any kind of medication at all." Once more my kids are being impacted by people who are forcing on me to do (Sarah).

This was difficult for Sarah as she reported feeling good when she was on her medications, more "in control." Laurie was more direct in noting her tendency to be out of control when she did not have her medication, "When I had my baby in 2011 these people were so insane, they made me get off my medication for my bipolar. Look, I'm staying on my mental meds because if I don't I'm liable to slap somebody."

4.2.2c Threats to financial security. Four caregivers reported feeling that they experienced threats to their financial stability. This emerged in two ways: 1) the impact of child welfare involvement on background checks for employment; or 2) as ultimatums related from child welfare and judges, perceived to be given because the caregivers work schedule interfered with their ability to meet child welfare expectations, such as

visitation, therapy, and doctor's appointments. Melissa noted that she experienced a lot of anxiety when she submitted an annual application for her nursing license,

> I was scared to death that it was on my record … as it was I have to renew my
> nursing license every, every other year and they ask you questions on there and I
> had to put on there that yes, that had happened to me [being investigated for child
> neglect] and I had to write them a letter as well, of explanation of what had
> happened. So, that was fine, that wasn't a problem, but it was humiliating, it was
> really humiliating.

In the end, Melissa did not have any problems obtaining her licensure, but she reported going through the same fear and humiliation each year, even though she knows her license won't be denied.

More frequently caregivers felt that they were given ultimatums regarding employment. For example, Laurie stated, "It was my child or my job." Caregivers reported that expectations of being at visitation, therapy and court often interfered with their work schedules.

> I had to take a lot of time off of work to be available to at first go to the meeting
> or the visitations, because if I didn't show up to one then that would be held
> against me, it would mean that I didn't want to see my son and that's not the case
> (Jordan).

However, the time off work caused a loss of income, which for most caregivers caused increased fears about not being able to provide for their children,

[I didn't work a lot] for those few months as I was fighting to try and get him

back. And yea, the first thing the judge told me is that I had to quit my job. I was

like, and yea, that kind of defeats the purpose of trying to keep a family together

because, if I was the only sole provider then if I had to quit my job, how am I

supposed to provide for my children. But, he didn't care, he said that (Jordan).

Laurie reported that her social worker told her she would need to quit her job to meet her

girls' needs. Laurie stated that she told the social worker that she needed her income and

could not quit her job, to which the social worker responded, "'I don't care', he says,

'You'll figure it out'." Laurie said in response, "sure enough I did [figure it out]"; she

quit her job and states that they have been living on her husband's minimum wage

income, paycheck to paycheck.

The loss of financial security was most often linked to child welfare perceiving

employment to be a barrier in the caregiver meeting child welfare expectations. Whereas

the caregiver saw the loss of employment as a barrier to being able to meet their

caregiving expectations. Particularly, the expectations of material needs, including food,

rent and bills, also required by child welfare. It felt like a catch-22, leaving the caregiver

to make difficult decisions regarding work and employment guided by the fear that either

choice would result in the loss of their child(ren).

4.2.2d Walk a mile in my shoes. For many caregivers, it seemed that the affects

that feeling coerced and threatened could be overcome, if they felt that they were

understood and that they had someone on their side advocating for them. Sandra stated,

"But for them to be effective, I think they have to walk a mile in somebody else's shoes

that's been in this situation." Laurie further expanded on this theme stating, "Social workers need to get outside of their utopian ideas of how the world should work… you've gotta live in reality." This sentiment was consistently present; all caregivers at some point expressed wanting someone to just understand. Sarah noted that her need for understanding could be traced back to her past abuse and her desire to be better a parent to her own children,

> My passion is my kids versus the hate and wanting to get rid of my kids and hurt them and be unnecessary abusive, because I was abusive [abused], and all I want to, all [I] wanted was somebody to understand me, and love me and care, and show me these things, I didn't have these things.

Other caregivers who experienced childhood abuse often felt the same way. There was a common message among caregivers Melinda, Sandra, Laurie, Sarah, Jordan and Marcus that they were "trying to parent the way they wish they were parented" (Sarah), that raising kids "doesn't come with a manual" (Sandra & Laurie) and although they were not perfect, they were doing the "best they could with what they had" (Jordan).

> None of us [parents] are perfect. And they [child welfare] need to realize that. They really need to come in with an open mind. Not shut down with archaic views of crap, they really need to be open-minded and willing to accept families as they are and help the family build themselves up (Laurie).

Caregivers rarely denied the allegations of abuse against them: rather, they suggested that they often felt so overwhelmed that they made mistakes. For example, Jordan said, "I kind of understand why they did [placed her son in foster care];" Lacy shared, "I made a

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bad choice;" and Marcus stated, "that was like my breaking point and I, I just, boom, and I pushed him down." Therefore, these caregivers were not trying to deny their responsibility, but hoped that social workers would demonstrate some understanding of the role that external circumstance was playing in their situation and give them the tools to overcome and improve on that situation. For example, Sandra stated, "Social services doesn't, they don't really care, I think. I don't feel like they care enough to dig under and figure out why things are going on and then figure out a solution."

Eight of the caregivers in this study were able to name at least one social worker whom they felt "understood" them. Examples of feeling comfortable with a social worker were often accompanied by an example of that social worker taking the time to listen to the caregiver's circumstance. For example, Julie said:

> She [social worker] really made a point to explain this is why I'm here, um you
> know she wanted to know about his full diagnosis, and whether he was in therapy,
> on medication, you know I felt comfortable letting them in and to let them know
> what was really going on.

The caregivers described these workers as "non-judgmental," taking the time to listen and to address environmental stressors or culturally specific practices. For Laurie, she finally had a social worker she liked, "I wanted him to stay cause, he understood the way that southerners raise children."

Caregivers also described the social workers whom they felt understood them as "advocates" who protected them when the system seemed to attempt to railroad them. Sarah said her "advocate" who responded when asked by the court, "Who are you to be

speaking up on this girl's behalf? Why are you here?" Sarah recounted the following

response from the advocate,

> … and she [the advocate] just completely shut things down like, 'no, cause there
>
> are some things this girl [Sarah] don't understand and you not bout's to walk over
>
> her, you're not bouts to trick her.

Caregivers felt they were more supported and less targeted by the system when they

perceive their social workers as understanding, caring, and willing to act as an advocate.

Stories told about advocates in the system often animated participants who would sit up

straighter and talk with enthusiasm and smiled frequently with something akin to pride:

caregivers found hope in these stories of effective support.

    4.2.3 Powerlessness. Powerlessness in this study emerged as caregivers expressed

feeling as if they did not have power over their own lives. Powerlessness was expressed

by caregivers in this study through two contexts: a loss of control, intrusion, adapting to a

new normal. When considering their powerlessness, caregivers used expressions of fear,

panic and anger. For example, phrases such as "fits of rage," being in "pure panic mode,"

"screaming," and "throwing things" were used by caregivers to describe their response to

child welfare involvement. Lacy stated, "I was really resistant … I was really angry and I

mean they came in and they snatched my baby [*her son was 15*] from me and I was

really, really mad."

    For Sarah, this was better understood as her feeling that her life was never her

own; several times during her interview she stated, "the state owned me," expressing a

lack of any power; by invoking a visual image of slavery with her language. She later

expanded on this stating, "Y'all got my life, from the time I basically was born until I was an adult, you got half my fucking life. The least you can do is give half of it back." Such statements indicate her desire to recapture her lost power.

   4.2.3a Lack of control. A lack of control was understood as temporary states of mind when caregivers did not feel like they had a voice in decision making. Sandra experienced this lack of control when her nephew was removed from her care regarding allegations of abuse due to child welfare not informing her why they were removing or where he would be placed.

   A *caseworker* called me one day and says, uh, "have you ever hit *your nephew,* or

   have you ever beat him?" and I thought that was very unprofessional and I told

   her, no, I haven't and I said, why are you asking me these questions? She said,

   "Well, we have a case open." She didn't say what it was for, or if it was against

   me.

Sandra said that she later "heard" that the allegation was against her brother, yet she reports that her brother was in jail at the time and that her nephew was removed from her care soon after the call, with no explanation from the social worker. At the time of the interview, Sandra had been trying to set up visitation with her nephew but had been unsuccessful.

   Lacy reported that she felt a lack of control when completing expectations, including therapy and parenting classes. Lacy indicated that she never felt like she could get ahead because she had no voice in the process and the expectations changed frequently.

I believe that the courts and child welfare came up with what I had to do, I mean it was a kind of list I suppose, but they would keep adding things so I never knew if the list was complete.

A lack of control was often accompanied by the caregiver feeling like their voice was not honored in child welfare interactions, using language such as "forced," "no choice," "felt like I had to," and "make us go." For some this included attending parenting classes or treatment they didn't feel was needed. Laurie said, "the worst thing they've [child welfare] done is make us go to a parenting class." Laurie felt the class was not necessary because it didn't make sense for her, and she explained that they didn't listen to her concerns, "I'm an autistic parent, parenting autistic children. There is no class for that." Sarah, she reported that she was, "forced into opening a voluntary case versus them just leaving my house and leaving me alone, after they came into my house." Sarah said that she did not want to open a case. Later Sarah made this comment regarding child welfare involvement, "I'm tired of fighting, I'm tired of talking to therapists, I'm tired of getting on the meds and everything," but she pointed out that she did not feel as if she had the option of saying no, "they demand it, they just demand it."

4.2.3b Intrusion. Caregivers in the study frequently talked about how child welfare was a constant intrusion in their lives. Intrusion was described in several ways, from the initial investigator showing up unannounced, to continual visits from social workers and other professionals, ending with caregivers adapting to the constant intrusion as a normal part of life.

4.2.3b1Unpredictability. Caregivers described their initial contact with child welfare as an unexpected knock at the door, which came with a sense that this could happen at any time. "So, they came to my home whenever they want, I mean they came in twice" (Julie). Although Julie corrected her exaggeration, there is still the sense that she felt that they could come back anytime they wanted. Other parents provided similar sentiment, "Just like me, being popped in on by some [social worker] because a teenager that I pissed off called the state on me." This unpredictability was difficult on parents, to the extent that most of them used hypervigilant coping strategies to prevent that unexpected knock at the door. For example, Julie stated that anytime her son throws a tantrum and bruises himself, "I would probably give them [the school] a call and let her [child's teacher] know what happened the night before, so they won't be so quick to make a judgement." Similarly, Marcus also called his social worker when he pushed his son down,

> I called and told *caseworker* before she had even heard anything from anyone
>
> else, I told her, *'my son* and I had problem this morning and I pushed him down'.
>
> And, am I glad that I did that? Cause I called and told her very first. And then
>
> luckily, I've still got my son and that mistake will never happen again.

Notably this was not true for all caregivers. Particularly for those with prior child welfare involvement. These caregivers instead lived in constant fear of what would happen if child welfare was ever involved with them again, "That's my constant fear that if anything happens and if they ever get called they're going to take him and not give him back. Cause that's what they told me."

4.2.3b2 Constancy. For some families, the intrusions became constant, a revolving door of social workers and other professionals constantly involved in the lives of these caregivers. Caregivers felt like they were under surveillance at times, hinting back at the historical perspective of the friendly visitor duality-- there to help, but also reporting back on their parenting. "They were just involved, like in every little thing. I mean anything that happened at my house, or whatever, it got leaked out and they were involved" (Sarah). Melissa noted that she feels like she has to act as if, "someone is always watching," because someone usually is.

Laurie, in contrast, challenged this duality stating, "With all the mandated reporters I've got coming in, bring it. Please bring it. Because I've got people's been with us almost 3 years now, constantly in here every week." It seemed that Laurie was aware of this duality and believed that although the mandated reporters were there to help her family, she was not disillusioned by the fact that they would report her if they felt she was using maladaptive parenting behaviors. However, she still felt that the constant involvement from social workers was an intrusion, describing child welfare as "invad[ing] my house 3 or 4 times a week." Marcus described the constant intrusion into his family by sharing that he has "a lot of women" around him all trying to help but, "There's so many people I work with right now. I can't even remember her name…"

4.2.3b3 Adapted to a new normal. The families who experienced the constancy of intrusion appeared to adapt to this just being their life, to the extent that they could identify a social worker when they came to the door, "I do, I remember these social

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workers; she smelled like a social worker. She came to the door, and, you could just smell her, like, oh, there's a social services, why are you here?" (Laurie).

For others, it just became their day to day expectation that social services would always be there, making the intrusion into daily life something they came to accept. "Like, I go through this, this is something that I deal with social services every single month this is like a daily routine for me" (Sarah.). For some the adaptation to this normal confounded their understanding of why they were reported for maltreatment again, speaking to a child welfare duality. "That had been the thing, you know what, we had caseworkers out to our house every week for the last 10 years" (Melissa).

4.2.4 Stigma. All caregivers experienced some form of stigma. Stigma in this study emerged as stereotypes that reinforced oppressed identities that were often shared, such as poverty including the trope of the welfare queen, prior child welfare involvement, and criminality, which caregivers felt was often linked unfairly to their parenting. However, for some caregiver's their experience with stigmatization led to a heightened internalization of these identities, leading to perceptions of being judged, which caregivers believed led to caseworkers extending punishments that caregivers felt were beyond what was deserved for their crime.

4.2.4a Reinforced oppressed identities. Reinforced oppressed identities are understood as caregiver's experiences in which they felt that child welfare reinforced a stereotype about who they were. For example, Marcus who had recently been released from prison for a violent crime, recognized that the case worker, judge and guardian ad litem, initially only saw him as a criminal.

They're [child welfare] like, pshhh, obviously this dude should not have this kid.

That's it, case closed… I understand everyone's approach and everyone's even

stereotypical bullshit, you now, which is, that's what it is.

Marcus also noted that there was a stigma attached to fathers. Marcus wanted to be seen than more than a stereotype; he wanted to be seen as a good father. "One out of a hundred of us actually do turn around and become a good father and a good person. I was always a good person, I just didn't do good things."

Caregivers often believed that social workers reinforced stereotypes associated with poverty.

… They do look at poverty, families in poverty, they look at us a lot different than

say, somebody living in a million dollar home … They really do look at us

differently and they treat us differently (Laurie).

This idea of being treated differently often associated with poverty and the caregiver feeling as if they were being categorized as a bad parent for not having the resources to provide for needs. After Sarah's son caught his bed on fire, child welfare told her that if she wanted to bring him back home, she first has to purchase a safe to lock up any dangerous household items. However, Sarah stated she could not afford a safe and could not find assistance in purchasing one, "It's like their view is, well you're broke because you pay your bills on time, so you can't take care of your children." Similarly, Lacy stated, that reunification was denied for over a year, "Because I didn't have the finances to fulfill his [her son's] needs."

4.2.4b Heightened internalized oppression. For some caregivers, continued exposure to oppression and stigma resulted in the internalizing of dominant social narratives that they began to accept as true about themselves. For caregivers, stigmatization came through cultural stereotypes of the poor, including the welfare queen and poverty's relationship to bad parenting. Some, like Sarah, internalized these stereotypes. Sarah identified with the welfare queen stereotype and saw her need for welfare meaning she was a bad person,

> Like I tell everybody, I have been on welfare for a long time, and, I'm not proud of that, because if I didn't have all my disabilities and somebody was actually there to help me and mine. I would be a better person.

> For Sandra, her internalized oppression was linked to her experience as a black woman, which she noted feeling judged for,

> Because we're [black people] not really affected in society, you know they see your skin color and if they are going to help you, then they see what color you are, you are not getting that help.

Marcus had also seemed to internalize the stereotype of his criminality by recognizing that he did not look good on paper, "if I was the one making the judgement, I'd be like, hey, no this dude, hey look at this record."

4.2.4c Perceived judgement. All the caregivers in this study experienced feeling as if they were being judged, most often for their parenting behaviors, whether they accepted responsibility for the allegation of maltreatment or not. For Melissa, who denied any wrongdoing on her part as a caregiver stated:

It was the experiences of being blamed that drove my guilt. Because the things

she [social worker] was saying to me I could think through intelligently and know

that I disagreed. She was not right. She was not correct. So, but in her saying

those things to me, I did start to doubt myself, and say, oh man, maybe I am doing

things all wrong….

In contrast, Jordan who accepted full responsibility, felt that child welfare was so

entrenched in judging her as a "bad mom" that they did not provide her son what he

needed drug treatment, "I feel that they kind of overlooked the fact that he [older son]

was on drugs because I'm a bad mom." Gina had a similar experience, sharing that she

often felt that her children were able to manipulate their in-home therapist, because the

therapist was convinced she was a "bad mom."

There was also a sense that caregivers felt that case workers did not do their

homework, leading the case workers to make judgements about them that were not based

in fact, making the caregivers feel targeted. For example, when Julie experienced the

second investigation she said, "When you figure, it's on the record about kid's behavioral

disorders, you know, I mean, they knew the history." She went on the state that no one

took the time to find the truth, needlessly putting her family through a second

investigation. Sarah expressed a similar sentiment, though very different experience,

… because my biggest issue with social services is when they pull my record, the

first thing they come in my house and say to me is, and they think they know

everything, 'well, you got 13 child abuse cases'. Let me stop you right there,

that's how I know you didn't read my case, those 13 child abuse cases is on my

mother, for us. Rude.

The examples of perceived judgment were frequent throughout the caregiver's

stories and most participants made statements about being judged: "Just cause, we're

judged by everything we do (Sandra);" "So we, that would be a help, to see, getting us

help, instead of being so damn judgmental. It's like they've got us condemned before

they walk in the door" (Laurie). Feelings of judgment were often associated with the

caregivers' poverty, "They'll [child welfare] be like you don't have a home, you don't

have this, or this, how can you raise a kid?" (Jordan).

Again, the idea of caregivers trying to do their best was stressed within feeling

judged, this comment is from Sarah, who saw child welfare as the root of all of her

problems and that they still couldn't see her as trying to do the right thing.

And once again, social services and everybody else makes it the parent's fault.

It's not our fault. See everybody needs to take their own blame and their own

responsibilities for things, because you can't always blame the outside people.

Especially the ones that are actually trying to work.

4.2.4d Loss of privilege. Caregivers in this study who enjoyed a level of privilege

(i.e. white, middle class, and/or no prior child welfare investigations) expressed feelings

of being treated as member of a group that they did not identify with. This was identified

as a loss of privilege. A loss of privilege could be seen when caregivers would

differentiate themselves from an oppressed identity. For example, when Laurie, a White

parent, was discussing how she felt discriminated against for being poor she said this,

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They, they treat us, I'm trying to find the right word that doesn't sound racist, but

I can't, they treat us like the 'n' word. They really do. And it's like, really? You

know, cause they do, they do look at poverty families a lot different.

Laurie appeared to feel that she was being treated like a person of color just because she

was poor as if to say: I may be poor, but I am not black. Laurie is reinforcing the

dominant social narrative of the poor, urban, woman of color: the welfare queen, likely to

prevent her own perceived loss of privilege and maintain a sense of superiority.

In contrast to the experience of poverty, Melissa was one of the two caregiver's

who did not live below the poverty line, and the only caregiver to have a graduate degree.

Melissa saw the allegation as the possible end to her career. Melissa's concerns were very

far removed from the other caregivers in this study. This appeared to be, in part, related

to Melissa having a graduate degree and the loss of class privilege that could occur as she

stated,

Once it was dropped and I was assured it doesn't go on your record in that case,

its kept in a file someplace so Social Services would know if another complaint

was ever made, that kind of thing. I was still scared, the next job applied for,

which is the one I have now. And, um, I remember doing my background check

and thinking, god, please god, don't let it be on there (nervous laughing). Um, it

would have totally destroyed my career.

Julie's expressed a loss of privilege that captured both class and race privilege,

specific to the allegation of maltreatment. This loss of privilege was more pronounced

when she referred to the second investigation. Julie expressed that she did not believe she

should be grouped with caregivers out there that are hurting their children, for which she

thought child welfare should be using their resources; as if the time spent on her could

have be used to prevent another child from being abused.

> I don't know, you know after the second time, I think that they need to be more
>
> selective. Because there are other children out there that are being abused or
>
> neglected… maybe they should have taken more time on someone's else's child.

4.3 Child Welfare as a New Trauma

Through an exploration of caregiver's experiences with child welfare, what

emerged that child welfare is a new trauma. The traumatic symptomology expressed

during the interviews, in some cases were able to be linked to specific child welfare

experiences, as addressed when this could be done throughout *The Child Welfare*

Experience through a Trauma Lens. Commonly, it was the caregivers who had minimal

trauma that a symptom could be linked to a child welfare experience.

> "I don't let people in my house because of that other experience [allegation report
>
> by clinician]" (Melissa).

> "I would probably give them a call and let her know what happened the night
>
> before, so they won't be so quick to make judgement" (Julie).

However, what was more common was reported trauma symptomology that could

not be attributed to one traumatic experience or child welfare experience, reported by

caregivers with cumulative trauma. Leading to the assumption that child welfare is a new

trauma, which compounds previous trauma. This overarching theme was further

understood through the lens of cumulative risk, such that multiple trauma experiences

results in symptomology that is also cumulative, not being specific to one event or the

most recent experience (Herman, 1992). Therefore, the majority of trauma

symptomology expressed by caregivers was seen through this lens.

The following are examples of traumatic symptomology taken from caregiver

narratives.

Intrusion:

"It's also made me to the point where I'm stuck a lot of the time, I'm stuck. Like,

with cleaning my house, this is overwhelming for me, I'm stuck" (Laurie).

Avoidance:

"I was not agoraphobic until social services started fucking with me, and it's the

truth" (Laurie).

"I was hesitant in contacting anybody for therapy for him, but it wasn't about me,

it was about him" (Jordan).

Negative alterations in cognition and mood:

"Being a young mother I was terrified that they were going to come in for some

reason, you know, to come get my kids. So, I had to prove to them that there was

no reason to do that" (Jordan).

"I have a pretty intuitive sense of people, um, and just my environment around

me, people that are close to me" (Sarah).

Marked alterations in arousal:

"I have to find ways not to lash out and yell" (Laurie).

"I was, I was mad because I didn't know. I wasn't able to stop it. And I was mad

because I was worried" (Jordan).

4.4 Discussion

Using the exploratory approach, it was assumed that support for the re-

traumatization theory would emerge; however, it was determined that this was not able to

fully explain the phenomenon. Rather, what did emerge was that child welfare

involvement has the potential to on its own, be interpreted as a traumatic experience.

This conclusion was reached due to the fact that all caregivers interviewed expressed

traumatic symptomology, regardless of the extent of trauma in their background. For the

caregivers with low BTQ and reports of adverse childhood experiences, particularly those

without prior child welfare involvement, the relationship between their trauma responses

and child welfare involvement had a more direct path. For example, the level of

hypervigilance for who may be watching therefore, leading to them become their own

informant (i.e. calling teachers and caseworkers to assuage concerns about covert abuse,

video recording interactions, etc.) when something goes awry at home. In addition, high

levels of avoidance were present, which was understood in this study as the ways in

which families succumbed to what was interpreted as coercion, shaming, and being

marginalized; therefore, falling into line with expectations with the ultimate goal of

removing the traumatic stimulus, child welfare. For families with extensive child welfare

involvement and high BTQ and reports or adverse childhood experiences, this

relationship was more difficult to pull apart and in fact, could not entirely be done. As

pointed out by Herman (1992), when an individual has cumulative or chronic traumatic

experiences that often the expression of symptomology is not able to be traced to the most intense or the last traumatic experience, but rather the symptomology is expressed through the sum of all of those experiences. It is so proposed that for this sub-sample of caregivers in this study that the trauma was so extensive that their symptoms could only be understood as a summation of experience across the lifespan. Despite this conclusion, caregivers who had their own involvement with child welfare as children and who spent time in foster care, were able to clearly articulate the impact that the child welfare system had on their lives and saw child welfare as the primary source of their problems and trauma.

Taken together, these findings provide support for the revised hypothesis that child welfare involvement has the potential to be a traumatic experience through different pathways. As the hypothesis began to change and a comprehensive understanding of this phenomenon took form. For families, regardless of the level of intrusion, whether it was minimal or constant, the traumatic symptomology emerged. Child welfare has points of entry into family life at many times, which can traumatize a caregiver from the initial contact often viewed by the caregiver as beginning with a betrayal by someone they placed trust in, which snowballs from there into intrusive and coercive practices, which tend to blame, shame, and oppress caregivers who are not seen as adhering to social norms of good parenting. Understanding that a child welfare has this potential, may be a first step in developing a counter-narrative to challenge the ways in which policy structures and organizational culture may be creating barriers to successful reunification.

4.5 Chapter Summary

Chapter four provided a review of the major themes that emerged through data analysis. The major themes included the individual narrative of each participant through a textural and structural description of their trauma. Next, there was a review of the child welfare experience through the trauma lens, outlining the points of entry that were shared by caregivers with traumatic potential. The next section demonstrated the overarching theme to emerge from the data: child welfare as a new trauma. Finally, a discussion of the major themes is given, setting the stage for chapter five. Chapter five concludes the dissertation with a review of the major themes within the context of the literature and the limitation. The final section will give recommendations for policy and practice, as well as future research needed to further explore the emerging information.

CHAPTER FIVE: CONCLUSIONS AND IMPLICATIONS

Chapter Five will conclude the dissertation with a summary of the overall findings from the study. The summary of findings are discussed both within the context of the literature reviewed in Chapter Two and the research limitations. Finally, implications for policy and practice will be presented, followed by recommendations for further research.

5.1 Summary of the problem

In 2015, there were 683,000 verified cases of child abuse and neglect in the United States and 91.6% of those children were maltreated by one or both parents (USDHHS, 2017). Child maltreatment has been a social issue of concern for centuries in the US and although progress has been made, there is still work to do. The impact of child maltreatment and child welfare involvement has been widely studied in the literature as it impacts the child. Much less studied is how child welfare involvement impacts the family as a whole, in particular the caregiver experiencing allegations of child maltreatment. What research has demonstrated is that the level of trauma in populations of mothers involved with child welfare is extensive, with over 70% experiencing multiple traumas during their lifetime (Chemtob et al., 2011). In addition, the relationship between trauma exposure and child maltreatment has strong support, indicating that caregivers attempting to manage traumatic arousal may use maltreatment

to dampen that arousal (Amos et al., 2011). Despite the wealth of information about these concerns, virtually nothing is known about how that traumatic background and arousal impacts caregiver's perceptions of and engagement with child welfare. This study employed an exploratory design with a phenomenological approach to initiate an understanding into how caregivers view their child welfare involvement through a trauma lens. Ten caregivers, representing different types of parenting were asked to complete assessments of trauma exposure and trauma symptomology. Additionally, a qualitative interview was completed that was then coded through several cycles in hopes of expanding current knowledge by giving voice to caregivers, an understudied population. This study was guided by the theory that caregivers would be re-traumatized by child welfare involvement and therefore sought to understand this phenomenon by asking, how do caregivers with a trauma background experience child welfare involvement?

5.2 Conclusions

Overall, it emerged that re-traumatization theory may not comprehensively explain the caregivers' experiences. For caregivers with extensive traumatic backgrounds and child welfare involvement, their traumatic symptomology was more pronounced and overt but, distinguishing between the symptoms that indicated re-traumatization and those arising from direct trauma was not possible. Supporting Herman's (1992) theory that experiences of chronic and/or cumulative trauma present with symptomology that has no direct link to a specific traumatic event or the most recent cumulative trauma. However, for caregivers with minimal trauma exposure and little to no prior child welfare involvement, trauma symptomology was present and relationships to specific child welfare experiences could be drawn. Because all participants demonstrated a level of

symptomology regardless of trauma history, it was determined that the re-traumatization theory may miss the potential of directly being traumatized by involvement. Within the participant's stories several interactions with child welfare emerged with traumatic potential. However, it was not possible to tell the story without beginning at the report of alleged abuse. The allegation was the impetus for the entire interaction and was discussed by participants as an incident which impacted trust in relationships and created feelings of betrayal.

The concept of betrayal trauma was developed by Jennifer J. Freyd in 1996 and is based in feminist theories of trauma. Freyd (2008) states that a "betrayal trauma" occurs when the people or institutions on which a person depends for survival significantly violate that person's trust or well-being" (p.76). Further, research has found that when an individual experiences betrayal by a trusted figure or institution they will use trauma informed style coping to maintain the relationship (Babcock & DePrince, 2012; DePrince & Freyd, 2014). This is most often applied to children who have been maltreated by their caregiver, where the children will use coping skills such as avoidance or self-blame. Although the caregivers in this study were not attempting to maintain a relationship, they did appear to use coping skills in an attempt to have the case worker see them favorably, or enter into a relationship (Clark et al., 2005). This was particularly seen when caregivers felt coerced to comply with child welfare because of the perception that not complying could result in the loss of their child. The threat of removal or threat of not having a child reunified was present, even for parents who were not threatened with removal.

Clark and colleagues (2005) found similar results, such that parents often felt that they did not have a choice to comply, particularly in cases where they were trying to regain custody of their child(ren). It has been found that coercive practices used by social welfare systems are meant to ensure the paramount concern: the safety of the child (Clark et al., 2005). However, these coercive practices have been found to be detrimental to caregivers by enforcing practices that are informed by dominant narratives of the "bad" mother. These practices result in the use of trauma informed coping by the caregiver to prevent the reinforcement of the dominant narrative on themselves (Clark et al., 2005; Hiday, 1992; Pescosolido et al., 1998). This only works to continue parenting stress not to alleviate it, as was found in this study, particularly when the use of threat was applied.

Research which has aligned traumatic experience with the use of trauma symptomology to promote survival in situations of threat is well-established (Evans & Coccoma, 2014; Yehuda & LeDoux, 2007; Perry, 2006; van der Kolk, 2014). For caregivers, removal or the possibility of not being reunified was perceived as a threat. Caregivers who had their child removed recounted feeling responsible for the maltreatment; however, they did not see what they had done as warranting having their child removed, therefore furthering their feelings of betrayal. When the child was not removed, the threat of removal was often used to garner compliance from the caregiver. Regardless, coercion often resulted in caregivers perceiving that they were being asked to compromise their safety or employment, leading to caregivers complying with all requests whether they agreed with the expectation or not.

Although this study could not make definite claims about the use of trauma symptomology, the impact of continued threat including the removal of children, caregiver and child safety, and financial well-being was reported. As shown in other qualitative studies assessing the experiences of caregivers with child welfare, threats were described as "fear inducing", "humiliating" and "intimidating" (Buckley et al., 2011; Dumbrill, 2006; 2010; Schrieber et al., 2013). Language used to assess threat in this study was similar to language used in the reviewed studies, which hints at traumatic symptomology related to child welfare involvement. However, if practices of trauma-informed care were used to minimize coercion and minimize cumulative risk in child welfare then, it may be possible to minimize caregivers' use of trauma symptomology.

> The traumatized person is often relieved simply to learn the true name of her condition. By ascertaining her diagnosis, she begins the process of mastery. No longer imprisoned in the wordlessness of the trauma, she discovers that there is a language for her experience. She discovers that she is not alone; others have suffered in similar ways. She discovers further that she is not crazy; the traumatic syndromes are normal human responses to extreme circumstances. And she discovers, finally, that she is not doomed to suffer this condition indefinitely, she can expect to recover, as others have recovered. (Herman, 1992, p. 158)

It is then possible that caregivers could begin to understand the underlying causes of maltreatment, and effectively begin to change the behavior, creating a counter narrative.

It is proposed that changing the counter narrative of the maltreating caregiver may also rely on changing the dominant narrative surrounding the child welfare system. The perspective that individual's hold regarding the child welfare system are informed by more than their own experiences. Rather, individuals also consume information from their families', their communities', and social media, which lead to a lack of distrust even when their own reality does not support that perspective (Schreiber et al., 2013). As noted

in literature and in this study, the perspective of child welfare was overwhelmingly negative (Bolen et al., 2008; Dumbrill, 2010; Schreiber et al., 2013). Caregivers in this study used words like "horrible," "terrible," "the worst thing that ever happened to me," which were echoes of language reported in other studies. Despite this negative view, all caregivers were able to identify a positive influence, a social worker that understood them, that advocated for them. This was also reported by mothers in the Dumbrill (2010) study, such that participants reported more positive views of social workers they perceived as ''on their side,'' including understanding their problems and attempting to help solve them. Unfortunately, both studies found that it was more common for caregivers to feel that their social workers were working against them, not with them. If a trauma-informed framework can help formulate a counter narrative to the maltreating parent; maybe the advocate can help formulate the counter narrative to an uncaring child welfare system.

Powerlessness was used in this study to describe the use of power by child welfare that effectively silenced the caregiver and allowed for child welfare involvement to become a part of daily life. Experience of powerlessness are understood through Young's (2000) *Five Faces of Oppression,* in particular powerlessness, marginalization, and cultural imperialism. For caregivers in this study, feelings of powerlessness contributed to perceived oppression. Although themes of marginalization and cultural imperialism did not arise specifically, the ways in which caregivers felt marginalized and silenced were. When power is exerted in relationships it often comes with a corresponding "deprivation of liberty" (Clark et al., 2005; Cutliffe & Happel, 2009), which causes the individual to feel as if they have lost control. This loss of control often

resulted in caregivers feeling like their needs were not being met because they did not have a voice in their case planning. Caregivers reported having to meet numerous expectations, including parenting classes, therapy, visitation. It was further perceived by caregivers that if they could not afford to attend, find transportation to attend, or didn't want to attend they would be judged as uncaring and not viewed as actively working to maintain and regain custody of their children. This has been shown in other studies, which have demonstrated that case workers often make decisions without considering the concerns, cares or needs of families (Benbenishty et al., 2015; Davidson-Arad & Benbenishty, 2008).

Interventions such as parenting classes and in-home therapy were not explored with much breath or depth in this study, but overwhelmingly caregivers reported that the services received were not applicable to their situation, were repetitive, or were unnecessary. Providing support that the caregivers' voice in this study was perceived as silenced by what the social worker thought was best for the family. This is similar to findings in several studies, which found that both tangible and intangible needs of caregivers were not met, including services needed for the parent's own mental health, such as PTSD diagnoses (Bolen et al., 2008; Chemtob et al., 2011; Loveland Cook et al., 2004; Marcenko et al., 2011). Although, in the current sample parents were not as concerned with their own mental health, several parents felt that the parenting services

they received were not effective for them. Several caregivers in this study were trying to figure out how to parent a child with a mental health diagnosis and did not feel like services were sensitive to that. In addition, caregivers reported that parenting classes were "good," however they felt that the information provided was not relevant, specified as not being applicable to their child's age.

Experiences of powerlessness were also informed by caregiver's reports of intrusive practices. Intrusion in this sample was characterized by the unpredictability, constancy, and an evolution to normalcy. As noted by Herman (1992), the unpredictable nature of abusive relationships is one of the cornerstones that leads to consistent low levels of arousal in victims of chronic and complex trauma. In this sample, experiences of intrusion and unpredictability appeared to increase caregiver's use of trauma coping such as, hypervigilance and avoidance. Additionally, caregivers reported negative emotions, such as fear and anxiety, which impeded their ability to experience positive emotions. Leading to the conclusion that the intrusive and unpredictable nature of child welfare involvement is a traumatic event in the lives of caregivers. When caregivers perceived the intrusion as constant, the element of unpredictability did not diminish. However, there was an acceptance by caregivers that this is the new normal, for which they had no control over, resulting in feeling their own power diminished. It appeared that this was accepted because the caregiver believed that rejecting the intrusion increased the risk that their child would be removed or not reunified. Diminished power has been implicated as the goal of many complex traumatic perpetrators, ensuring that the ultimate power remains with them (Herman, 1992; SAMSHA, 2014; Harris & Fallot, 2001). This diminishment of the individual leaves them with no options but to submit to the new

rules, their new normal. Herman (1992) describes this as "captivity," or being under coercive control. Feeding further into the deprivation of liberty tied to coercion (Clark et al., 2005; Cutcliffe & Happell, 2009). Evidence also exists that an individual's power can be diminished through the reinforcement of oppressed identities that then become internalized by the individual, leaving them without the ability to form a counter narrative.

Identities which have been widely understood as oppressed in the literature (i.e. persons of color, victims of sexual assault, women, the poor, etc.) are often reinforced by the larger social narrative and those who hold power. In turn eliciting a traumatic response from that individual when feeling stigmatized as result of identifying with the larger group (Bernard, 2002; Ellis et al., 2008; Gray & Montgomery, 2012; Kennedy et al., 2011; Major & O'Brien, 2005). Stuber and Schlesinger (2006), found that the most salient predictor of feeling stereotyped in a welfare interaction is poverty, seen frequently in the caregiver's narratives in this study. In this study poverty emerged as the most often stigmatized, but it is possible that this is due to poverty being the most commonly shared identity among participants. For caregivers who had oppressed identities that were not commonly shared among the sample, such as being a person of color or having a criminal record, stigmatization also emerged. Of note, stigmatization that has been shown in previous studies regarding Latino caregivers feeling increased stigma in child welfare interaction (Stuber and Schlesinger, 2006), did not emerge from this study. One of the ways in which stigma that reinforces oppressed identities can lead to traumatic symptoms includes the caregiver internalizing the dominant message.

When systems or agents of systems reinforce stigmatized or stereotyped messages based on the dominant narrative, this can exacerbate feelings of shame, guilt, and self-blame in the target of that message. These messages become internalized by the individual and they begin to accept blame for the circumstance as a result of a personal character flaw, without incorporating the whole of their experiences that inform behaviors (Bernard, 2002; Ellis, MacDonald, Lincoln, & Cabral, 2008; Gray & Montgomery, 2012). Internalizing messages of oppression have shown that survivors often use attentional bias toward the source of the stigma, creating a sense of threat; leaving them feeling the need to be vigilant (Major & O'Brien, 2005). Many caregivers in this study demonstrated the internalization of oppressed identities, believing that something was inherently "bad" about their character. Interestingly, the caregivers who held privilege in this study experienced the reinforcement of dominant narrative, however they seemed less likely to internalize the message. Instead, these caregivers pushed back against the dominant narrative as applied to them, while simultaneously maintaining the narrative as applicable to parents they perceived as the "other" (i.e. the real child abusers and welfare queens). When caregivers perceived the reinforcement of an oppressed identity, they often responded with feelings of judgement.

Several caregivers in this study expressed feelings of judgement. Caregivers felt judged regarding their parenting practices, their ability to provide for their children, and their housekeeping. This is consistent with the findings of the Dumbrill (2010) study. There was consensus among most participants in the Dumbrill study that workers were trying to protect children. However, a predominant perspective emerged that workers tried to protect children, by reinforcing the dominant narrative that these mothers were

bad. Mothers' believed that because they were perceived this way that they were unable to the get the help they needed. One mother in the Dumbrill study explained, "No matter what books they've [workers] read they don't understand, they're not in the situation, and they need to realize that somebody is looking for their help not their judgement." Another mother reiterated, "What they do is they judge you ... Right from the get-go, the judgement is on." Sentiments also heard throughout the narratives of the caregivers in this study. When exploring the experiences of caregivers including the betrayal, threats, intrusive and unpredictable social workers, and experiences of stigma and discrimination and the demonstrated links from such experiences to traumatic symptomology, the conclusion was that child welfare is a new trauma. It is proposed that the threat for experiencing trauma through child welfare involvement, is relevant and important to consider as the possibility for re-traumatization.

Both the level of trauma in this sample for Adverse Childhood Experiences (ACES) and traumas in adulthood were high, for most caregivers. Additionally, the caregivers in this study who experienced childhood abuse was high, with the majority of those caregivers going into foster care and not being reunified with their family. Although, this is a qualitative study, it can be said that the rates of multiple traumas and intergenerational abuse among this sample was consistent with large, multi-national studies, showing that mothers involved with child welfare experience cumulative trauma at a rate of up to 74% (Bosquet Enlow et al., 2014; Briere et al., 2008; Chemtob et al., 2011; Karam et al., 2014; Kennedy et al., 2014). Additionally, the rates of intergenerational abuse were consistent with the literature, which range from 65% to 72% (Dym Bartlett et al., 2017; Murphy et al., 2014). It was not possible to diagnose post-

traumatic stress disorder (PTSD) for caregivers in this study, however two participants did report having been diagnosed, also consistent with rates found in studies for child welfare involved caregivers (Bailey et al., 2012; Bosquet Enlow et al., 2014; Chemtob et al., 2011; Loveland Cook et al., 2004; Smith et al., 2006). Regardless of caregivers having a PTSD diagnosis, they did experience a high incidence of traumatic symptomology, demonstrated both on the Trauma Symptom Checklist - 40 and throughout their interviews. Trauma symptomology can impact parenting, whether or not the individual has a PTSD diagnosis (Herman, 1992; Merlin & Mohr, 2000). Trauma is linked to maltreating parental behaviors. For example, Ammerman and colleagues (2012) found that avoidance symptoms were associated with parenting deficits, as shown avoidance was a relevant symptom for explaining physical abuse and frightening parental behavior. However, those findings were not supported here. Although avoidance was a relevant trauma symptomology expressed in this study, the majority of caregivers in this study were investigated by child welfare for neglect or failure to protect. Three caregivers were reported for physical abuse in this study, one was the father; who accepted responsibility and was eventually charged with child abuse. The other two caregivers, both reported that the allegations were false and that child welfare ruled them unfounded, with no further action. Although for one caregiver, the child [her nephew] was removed from her custody. The trauma background of each of these caregivers was incredibly varied, leaving no room to speculate about the relationship between trauma symptomology and specific maltreating behaviors.

The findings reported here are the result of an exploratory study with a phenomenological approach, therefore they are not meant to provide a comprehensive explanation for the emerging results. Rather the goal was to begin to explore the emerging data from caregiver's stories who shared experiences of trauma and child welfare involvement for allegations of child maltreatment, to determine if further investigation was warranted. Although more investigation is needed before fully conceptualizing this emerging idea, there are implications that can be taken away. First, the experiences of the caregivers tell a story that is often silenced. The stories told represented caregivers who wanted to be seen as more than a child abuser, they wanted the social worker to know they were doing the best that they could with what they had. The caregivers did not want to be silenced any longer, they wanted to be heard, and more specifically they wanted to be understood. These caregivers cannot be separated from their past, instead they have to be viewed within the context of that past, particularly when that past is fraught with cumulative risks and/or traumas. In addition, the child welfare system must be seen within the context of it's past.

The child welfare system has a long history in the United States, one which has fluctuated through periods of viewing the caregiver as an underserving dependent and periods in which societal ills were blamed. Despite these fluctuations, the narrative of the poor, urban, single, and/or mother of color as an underserving dependent has flourished. As demonstrated in this study, particularly through the themes which outlined the oppressive nature of child welfare practice that left caregivers feeling discriminated against, judged, and without help, the underserving dependent narrative persists. It has often been said, those who don't know their history are doomed to repeat it; inspirational

author Cynthia A. Patterson added, "You have to expose who you are so that you can determine what you need to become." Therefore, the adversarial nature of child welfare systems which have existed in the US should have their nature exposed. This is not to say that child welfare systems are not philanthropic on the surface, however the message of help is often clouded by the dominant social view of the caregiver, which deems them undeserving of help. Such ingrained beliefs can result in moving caseworkers in those systems to use method of coercion and power to remind these caregivers of their place in the social order. For families who identified as having a marginalized identity such as being poor, a person of color, or a women, experiences with discrimination occurred frequently, through interactional discrimination as Sandra experienced as a person of color or as Laurie reported she experienced related to her poverty. For Sarah, particularly as the caregiver with the most extensive and long history with child welfare felt both interactional and direct discrimination as a woman, single parent, abuse victim, being a person of color and being poor. And as noted, when the dominant narrative serves to enact structural discrimination, using dominant stereotypes to write and enact social policy and practice (Goldbach et al., 2015), as was Jordan's experience. Jordan, who after having her son removed lived in constant fear, as she recounted a social worker making her feel as if they did not want her son reunified with her, which was directly related to her experience with concurrent planning. Concurrent planning was a policy developed through the Adoption and Safe Families Act, with a goal of increasing adoptions and preventing children from languishing from care (McGowan, 2005). However, as Roberts (1999) reported the real goal was moving quickly parental termination of rights in order to free children up for adoption. If rights were terminated, adoptions could not move

forward. This is just one example of how child welfare policies are enforced by the ideas of who is deserving and who is not. The maltreating parent with the drug problem (i.e. underserving) should be moved out of the way to make room for the salvation of the sacrificing adoptive family (i.e. deserving). Being made to feel as a member of the underserving group, has been shown to be linked to traumatic symptomology (Brown, 2004; Erikson, 1994; Kennedy et al., 2011; Kira, 2001; Finklehor et al., 2015; Young, 2000). Therefore, understanding the bias that is existent with the system for certain caregivers should be exposed so that changes within value systems, cultural practices and written policies no longer rely on the long held beliefs born out of the late 19th century "pauper" or the 1980s welfare queen, but to view these caregivers through the "what happened to you?" lens.

5.3 Implications

This study demonstrates that there are several interactions between maltreating caregivers and the child welfare system that have the potential to be traumatic or to re-traumatize the caregiver who has a history of traumatic experience(s). Considering the high likelihood that caregivers who maltreat have a history of trauma, particularly cases of cumulative and chronic trauma within this context, important study implications must be highlighted. As the social science field continues to debate the best way to engage with maltreating families, one valid and current framework is Trauma-Informed Care (TIC). The framework of TIC, at its core, is a philosophy which recognizes the impact of trauma in an individual's life and seeks to change the perspective from, "what is wrong with you?" to "what happened to you?" (Hopper et al., 2009; SAMSHA, 2014). There are several principles of TIC that are meant to be applied in any social service setting from

the frontline staff to the Chief Executive Officer, which minimizes the likelihood that an individual will be re-traumatized during engagement with the system. The principles of TIC are meant to validate the individual's experience and response to their trauma, while empowering them and helping them to identify ways to regain control (Elliott, Bjelajac, Fallot, Markoff, & Glover Reed, 2005). Elliot and colleagues note that it is necessary that TIC practices openly acknowledge power differentials and set them aside, promote strengths over pathology, and welcome the individual's voice as an expert on their life. Despite the wide understanding of the benefits of employing TIC principles across child welfare agencies and programs, the evidence of successful implementation is promising. However, movement to a TIC framework often requires that we challenge the dominant narrative of personal responsibility and dependency. As shown, these beliefs are deeply ingrained in the fabric of practice and policy making the creation of a counter narrative a challenging and difficult undertaking. Two important elements of the trauma-informed approach are 1) cognitive attention in identifying, and 2) not engaging in institutional practices and processes that may exacerbate trauma responses and ignore client empowerment by excluding them from participation in the development and evaluation of services (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).

It is proposed that the most effective way to prevent cumulative trauma and new trauma in the lives of caregivers would be to fully implement trauma informed care in the culture of child welfare agencies. A call for this to be a part of agency culture has existed for a while (SAMHSA, 2014); however, problems exist with implementation. There is no manual, there is no test for fidelity, and this is a cultural shift. It is a shift in the way

caregivers are perceived by those in positions of power, to provide help or harm. In 2008, The National Child Traumatic Stress Network (NCTSN) Child Welfare Committee worked to develop the "Essential Elements of trauma-informed child welfare practice" (TICWP). Although beneficial, the essential elements of care focus on the care of children and not the family including but not limited to, maximizing a child's sense of safety, comprehensive screening measures of trauma for children, and continuity of care. In 2011 the NCTSN applied these principles to determine if foster care placement could be improved with the use of TICWP, and conducted a study to better understand how trauma informed child welfare practice could improve foster care stability. It is proposed that the recommendations from that study which are aligned with trauma-informed care be expanded based on findings from this study and an emphasis be placed on using the principles of trauma-informed care with the entire family system. Additionally, it is recommended that child welfare workers should be trained in trauma-informed care not only for the child, but also for the caregiver. This knowledge should then be applied to the case plan and to identify appropriate services that will meet the tangible needs of their clients and the role this plays in their trauma.

The use of trauma-informed care has been demonstrated as an effective method for helping social workers to prioritize experience over behavior; however, caregivers in this study rarely felt that social workers were concerned with their well-being or safety, inconsistent with the use of trauma-informed practice (Harris & Fallot, 2001). More training and incorporation of trauma-informed principles at the least into practice and at its best into the organizational culture of child welfare, could change the dominant

narrative. And, in turn change the traumatic potential of child welfare into a potential impetus for a counter narrative that challenges normative stereotypes. Although, the evidence for the traumatic nature of child welfare did emerge, these findings should be reviewed with caution, due to study limitations.

5.4 Limitations

Several study limitations existed that warrant consideration when interpreting the findings. First, this is a qualitative exploratory story, for which it met its goals. However, the nature of an exploratory study presents limitations to interpreting the major themes. The themes that emerged are preliminary and should be used as such, until further evidence of the findings can be sought. The sample size for this study, although appropriate for an exploratory study (Padgett, 2008), is still relatively small and it is the determination of the researcher that data saturation was not achieved (Saldana, 2009). Data saturation is the point at which no new codes or ideas emerge from participant interviews (Saldana, 2009); however, in this sample the new themes continued to emerge through the tenth interview. In addition, despite the efforts of the researcher to reach a diverse sample of caregivers, the end sample was still primarily represented by biological mothers, with one father, one kin provider, and one adoptive mother. Although, it is difficult to determine if experiences for caregivers with little to no representation are truly a shared experience, the evidence of trauma symptomology is promising. It is possible that for alternative caregivers that their experience is different, but was unable to be explored here due to the lack of diversity. Additionally, the theme of privilege was unexpected and therefore was not more fully explored, making the assumptions about privilege important for further study.

Secondly, the trauma screenings also present limitations. Considering the importance that oppression and stigma presented in this study, the lack of a screening to assess stigma and or discrimination prevents a true accounting of these experiences. In addition, completing the ACE screen using the participant narratives likely resulted in the underreporting of adverse childhood experiences. Reasons for underreporting could be the result of the interviewer not asking questions that probed into childhood trauma and/or the caregivers not wanting to disclose their own childhood trauma. In addition, the lack of recording for one caregiver likely impacted the researcher's ability to fully account for this caregiver's experience.

Reporting on the BTQ, TSC-40, and qualitative interviews are subject to self-report and observations biases. Although this was identified as a weakness of most reviewed literature, it was still chosen for this study for two reasons. First, the quantitative screenings were meant to provide a description of participants and not for any variable analysis. Second, the nature of qualitative research is allowing an individual to self-report their own story. Despite the limitations this method for data collection was deemed as most appropriate. Most screenings were done in person with the interviewer sitting with the caregiver and the test instruments were relatively long. This could have resulted in caregivers rushing through and not really reading the questions. Plus, with the in-person format there was no way for the caregiver to be divorced from their responses

both on the screenings and during the interview. As with many traumatized individuals, caregivers may have responded in a way that they believed was favorable to the researcher who was perceived as having power in the interaction. Despite the many limitations, the findings of this study are promising and warrant further research to fully develop the emerging themes.

5.5 Future Research Agenda

The exploratory nature of this study provided enough evidence to warrant further investigation of the emerging themes, in particular child welfare as a new trauma and the emergence of privilege. To further investigate the traumatic potential of child welfare involvement, it is proposed that a large, mixed methods study should be conducted. A study which employs both quantitative and qualitative measures would help provide a more comprehensive picture of caregivers and provide some background statistics to support the experiences of trauma, level of trauma symptomology and whether those two variables have any relationship with caregiver's maltreatment potential and subsequent child welfare involvement. A study of this magnitude would require more specific measurements of cumulative trauma and oppression. In addition, it would be important to include a number of diverse caregivers to determine if the shared experiences of these caregivers do indeed share traumatic characteristics. The qualitative interviews in such a study would help to make that determination and further expand on the themes which emerged in this study, reaching a level of saturation not met here.

Second, the emergence of the theme of *loss of privilege,* was unexpected but should be more fully explored. To explore this topic, it is proposed that a similar study using an exploratory framework with a phenomenological approach, to begin to explore the utility of such an idea. Since the exploratory framework is designed to being to explore the beginnings of an idea, it would be prudent to first explore whether this is a common shared experience for caregivers who also share a level of privilege. However, it is suggested that a sample for this type of study would consist of only caregivers with a trauma history, who are white, middle to upper middle class, and had at least a bachelor's degree.

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APPENDIX A: BRIEF TRAUMA QUESTIONNAIRE

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

	Has this ever happened to you?		Answer these questions for each event that has happened to you.	
			Did you think your life was in danger or you might be seriously injured?	Were you seriously injured?
1.	Have you ever serviced in a war zone, or have you ever service in a noncombat job that exposed you to war-related casualties?	No Yes	No Yes	No Yes
2.	Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3.	Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4.	Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc?	No Yes	No Yes	No Yes
5.	Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6.	Not including any punishments or beatings already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone including friends, family members or strangers?	No Yes	No Yes	No Yes
7.	Has anyone ever made or pressured you into having some type of unwanted sexual contact?	No Yes	No Yes	No Yes
8.	Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	No Yes	No Yes
9.	Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attach?	No Yes	No Yes	No Yes
10.	Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?	No Yes	No Yes	No Yes

APPENDIX B: TRAUMA SYMPTOM CHECKLIST-40

How often have you experienced each of the following in the last two months?

1. Headaches	0 1 2 3
2. Insomnia (trouble getting to sleep)	0 1 2 3
3. Weight loss (without dieting)	0 1 2 3
4. Stomach problems	0 1 2 3
5. Sexual problems	0 1 2 3
6. Feeling isolated from others	0 1 2 3
7. "Flashbacks" (sudden, vivid, distracting memories)	0 1 2 3
8. Restless sleep	0 1 2 3
9. Low sex drive	0 1 2 3
10. Anxiety attacks	0 1 2 3
11. Sexual overactivity	0 1 2 3
12. Loneliness	0 1 2 3
13. Nightmares	0 1 2 3
14. "Spacing out" (going away in your mind)	0 1 2 3
15. Sadness	0 1 2 3
16. Dizziness	0 1 2 3
17. Not feeling satisfied with your sex life	0 1 2 3
18. Trouble controlling your temper	0 1 2 3
19. Waking up early in the morning and can't get back to sleep	0 1 2 3
20. Uncontrollable crying	0 1 2 3
21. Fear of men	0 1 2 3
22. Not feeling rested in the morning	0 1 2 3
23. Having sex that you didn't enjoy	0 1 2 3
24. Trouble getting along with others	0 1 2 3
25. Memory problems	0 1 2 3

26. Desire to physically hurt yourself	0 1 2 3
27. Fear of women	0 1 2 3
28. Waking up in the middle of the night	0 1 2 3
29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3

APPENDIX C: ADVERSE CHILDHOOD EXPERIENCES ASSESSMENT

Prior to your 18th birthday:		
1. Did a parent or other adult in the household often or very often… swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?	No	Yes
2. Did a parent or other adult in the household often or very often … push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?	No	Yes
3. Did an adult or person at least 5 years older than you ever … touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?	No	Yes
4. Did you often or very often feel that … no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?	No	Yes
5. Did you often or very often feel that … you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	No	Yes
6. Were your parents ever separated or divorced?	No	Yes
7. Was you mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at here? Or sometimes, often or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	No	Yes
8. Did you live with anyone who was a problem drinker or alcoholic, or used street drugs?	No	Yes
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	No	Yes
10. Did a household member go to prison?	No	Yes

APPENDIX D: QUALITATIVE INTERVIEW GUIDE

Tell me about your experience with the child welfare system.

Tell me about the services that you received.

Do you feel like you learned anything through those services?

What skills did you learn that have helped you to parent your child(ren)?

What did you need from those services that you did not get? What suggestions do you have for service providers? How could they have better met your needs?

You Are Invited. . .

Have you ever been referred to a service because someone questioned your parenting? Have you ever talked about that experience and shared what it was like? Would you like to? You are being invited to share this experiences and help other parents in the future by talking about what you need today.

If you are interested in more information about how to participate, please contact **Erin Boyce at** eboyce1205@gmail.com **or 303-301-4679.**

All we ask is that you are atleast 18 years of age, a parent, and receiving services that are directly related to parenting and/or child behavior.