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Complex Trauma Among African American Mothers in Child Protective Services

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More than 90% of mothers who become involved with child protection have histories of complex trauma exposure. Influenced by complex trauma, mothers react to involvement with child protection in a variety of ways. The goal of this study was to identify common reactions mothers with complex histories of trauma use to manage involvement with the child protection system and to examine those responses using a trauma-informed lens. Using an embedded case study design, in-depth interviews and file reviews were conducted with 20 African American mothers who had histories of complex trauma. Data analysis revealed mothers with complex trauma managed involvement with the child protection system in four primary ways: (a) hostility and combativeness, (b) disappearing or intermittently disappearing and reengaging in services, (c) superficial compliance, and (d) immobilizing fear. Although there has been increasing awareness of the high prevalence of trauma among child-welfare-involved mothers, the majority of trauma-informed services have been directed toward children. Research has suggested individuals who have histories of trauma cannot benefit from services that are not trauma informed. More research needs to be directed toward mothers with histories of complex trauma.

Keywords: fight/flight/freeze/fright, trauma, child welfare, African American mothers

More than 90% of mothers[1] who become involved with child protection have histories of interpersonal trauma (Blakey & Hatcher, 2013; Chemtob et al., 2011; Schofield et al., 2011; Stephens, 2019; Stephens & Aparicio, 2017): Specifically, 60% of child-welfare-involved mothers experienced physical abuse as children; 34% reported being sexually abused as children by nonfamily members; 21% experienced incest as children; and 34% reported other traumatic experiences in childhood, such as neglect, abandonment, or entering foster care (Chemtob et al., 2011). As adults, 41% of child-welfare-involved mothers have experienced intimate partner violence, 6.3% of mothers reported histories of rape, and 22% of mothers had histories of physical assault (Chemtob et al., 2011). Almost 74% of mothers entering child protective services have experienced three or more traumatic events, often characterized as *complex trauma* (Chemtob et al., 2011; Greeson et al., 2011).

In addition to preexisting complex trauma histories, many mothers are further traumatized by involvement with the child protection system regardless if the intervention is warranted (Greeson et al., 2011). Mothers have described their experience with child protection as "traumatizing, humiliating, nerve-wracking, daunting, intimidating, [and] frightening" (Buckley et al., 2011, p. 104). Child protective services investigations involve making decisions regarding whether it is safe for children to remain in their mothers' custody. The removal or looming threat of removal of children from their mothers' custody traumatizes the parents and the children (Buckley et al., 2011; Dumbrill, 2006; Kletzka & Siegfried, 2008; Schofield et al., 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). When children are placed in foster care, mothers often are not allowed to know where their children are living, how they are doing day to day, or background information about the person caring for their children, all of which exacerbate trauma symptoms and add to many mothers' profound sense of loss (Schofield et al., 2011). When children are in foster care, mothers may only see their children once a week for an hour-long visit, provided the caseworker or foster parent can transport the children to the visit. Although studies have found children's mere involvement with the child welfare system is traumatizing (Greeson et al., 2011; Kletzka & Siegfried, 2008), there is a dearth of knowledge about how mothers with histories of complex trauma may be impacted by and react to their involvement with the child protection system. The purpose of this study was to identify common reactions mothers with complex histories of trauma used to manage their involvement with the child protection system and to examine those responses using a trauma-informed lens.

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[1] We refer to the parents as mothers, as they make up 97% of child welfare populations (Berger et al., 2009).

Literature Review

Trauma Is Multifaceted

The growing trauma literature has led to a repletion of trauma-related terms such as *adverse childhood experiences* (ACEs), *developmental trauma*, and *complex trauma*. Each type of trauma has unique features in which symptoms manifest differently depending on the population and varying degrees of treatability (Greeson et al., 2011). Trauma is the overarching term, which refers to an event, series of events, or experience that occurs over time, involving threats to life or encounters with death, and causing intense, lasting adverse effects on individuals' physical, social, emotional, or spiritual well-being and overall ability to function (SAMHSA, 2014).

ACEs are traumatic experiences often occurring in the first 18 years of life (Anda et al., 2006). There are nine types of ACES: (a) physical abuse, (b) sexual abuse, (c) emotional abuse, (d) mental illness of a household member, (e) problematic drinking or alcoholism of a household member, (f) illegal street or prescription drug use by a household member, (g) divorce or separation of a parent, (h) domestic violence toward a parent, or (i) incarceration of a household member. The more ACEs individuals have, the more likely they will experience chronic health outcomes, mental health challenges, and substance misuse in adulthood (Anda et al., 2006).

Developmental trauma disorder is another type of trauma created as a formal diagnosis to capture and account for the unique "cluster of symptoms that research has shown frequently occur in children exposed to interpersonal trauma" (D'Andrea et al., 2012, p. 188). Many children with histories of early childhood trauma have particular psychological, biological, and interpersonal sequelae of symptoms not fully captured by a PTSD diagnosis (D'Andrea et al., 2012; Schmid et al., 2013; van der Kolk, 2005). Therefore, developmental trauma disorder is a systematic way of describing severely maltreated, sexually abused, or neglected children who have experienced repeated traumatic events (Schmid et al., 2013).

Complex Trauma

Finally, complex trauma is another type of trauma that results from exposure to multiple, recurrent, and prolonged traumatic events that tend to be invasive, interpersonal, and have wide-ranging, long-term effects (Barbieri et al., 2019). The majority of people who have traumatic experiences rarely report a single incident (Cloitre et al., 2011). Studies by Greeson et al. (2011) and Saunders and Adams (2014) indicated that 48–70% of the individuals reported experiencing at least two traumatic experiences. These studies also revealed 11% of the individuals reported experiencing five or more types of trauma (Greeson et al., 2011), 15% reported experiencing six or more types of trauma (Saunders & Adams, 2014), 5% reported experiencing 10 or more types of trauma, and 10% reported experiencing 15 or more types of trauma (Saunders & Adams, 2014). Originally, the term complex trauma was created to describe long-term, coercive abuse individuals endure, such as torture, intimate partner violence, and severe physical abuse (Barbieri et al., 2019). These events often began in childhood (i.e., severe and pervasive abuse or profound neglect) and can compromise the developmental trajectory and long-term sequelae of symptoms (Kliethermes et al., 2014). Greeson et al. (2011) reported that individuals with complex trauma were more likely to have higher rates of internalizing problems, posttraumatic stress, and other clinical diagnoses. According to Courtois and Ford (2009),

> Complex traumatic stress disorders, therefore, go well beyond what is defined as the classic clinically significant definition of what is traumatic . . . and beyond the triad of criteria (intrusive reexperiencing of traumatic memories, avoidance of reminders of traumatic memories, and emotional numbing and hyperarousal) that make up the diagnosis of posttraumatic stress disorder. . . . Complex traumatic stress disorder tends to be difficult to diagnose accurately and to treat effectively. (p. 2)

Complex trauma has immediate, wide-ranging, and long-term effects and can impair virtually every aspect of individuals' lives. Studies have found a complex range of reactions often resulting in the loss of abilities to self-regulate, to relate interpersonally, impaired physical and emotional functioning and negative cognitions, poor self-concept, and symptoms, which tend to be more challenging to treat (Giourou et al., 2018). Complex trauma also affects attachment and familial relationships, social and interpersonal functioning, developmental delays, and motivation (van der Kolk, 2005). According to Kletzka and Siegfried (2008), "Long after they have ended, traumatic experiences continue to take priority in the thoughts, emotions, and behaviors" of individuals (p. 9). In an attempt to avoid experiences they believe could be traumatic, individuals attempt to regain control, or react with "hyperreactivity, aggression, defeat, or freeze responses" when faced with threatening situations (van der Kolk, 2005, p. 407).

Consequences of Trauma

Trauma often puts individuals at increased risk for myriad symptoms of which mental health disorders are a primary concern (Wu et al., 2010). Spinhoven et al. (2014) reported that of the 160 participants who had posttraumatic stress disorder (PTSD), 84.4% also had major depressive disorder, 55.6% social anxiety disorder, 42.5% generalized anxiety disorder, 41.9% dysthymia, 29.4% panic disorder, and 26.9% had agoraphobia. Almost 13% of participants had one other mental disorder. Eighteen percent had two additional mental disorders. Twenty-four percent had three additional mental disorders. Nineteen percent had four additional mental disorders. Thirteen percent had five additional mental disorders. Eight percent had six additional mental disorders.

Substance use disorders also commonly occur among individuals with histories of trauma, regardless of whether they have a PTSD diagnosis (Center for Substance Abuse Treatment [CSAT], 2014). Individuals who have co-occurring disorders of PTSD and substance use have more severe symptoms, shorter times they are abstinent, a greater chance of relapse, and more health problems (McCarthy & Petrakis, 2010). Moreover, different types of trauma can cause increased substance use, irrespective of whether the drug use rises to the level of a substance use disorder (CSAT, 2014). Studies also have found alcohol and illicit drug use increased significantly among individuals who experienced childhood maltreatment, physical and sexual assault, witnessed a life-threatening

accident, severe injury or death, unexpected death or loss, or learning that loved ones experienced trauma (Zweig et al., 2012).

Substance Use as a Coping Mechanism

There is significant comorbidity between trauma, PTSD, and substance misuse (Spinhoven et al., 2014). Three major hypotheses have been used to explain the relationship between trauma, PTSD, and substance misuse: high risk (substance use makes individuals more susceptible to revictimization), susceptibility (substance use may put individuals at increased risk for developing PTSD), and self-medication (Ullman et al., 2013). Self-medication hypothesis as a way to escape, avoid, or reduce reexperiencing and intrusive symptoms related to trauma is the most common hypothesis used to explain the relationship between trauma and substance use (Ullman et al., 2013). Studies have found that individuals with higher levels of PTSD symptoms had a greater propensity to engage in substance abuse to cope with trauma (Haller & Chassin, 2014).

Gaps in the Literature

Mothers' trauma stories have been marginalized and unexplored (Blakey & Hatcher, 2013; Stephens & Aparicio, 2017). The lack of information and understanding about individual trauma histories could lead to incorrectly pathologizing behaviors instead of viewing them as natural responses to trauma exposure (Kletzka & Siegfried, 2008). Limited research has focused on how parents with complex trauma histories react to the child protection system (Stephens & Aparicio, 2017). With increased awareness of the high prevalence of trauma among children and adults entering the child protection system (Chemtob et al., 2011; Greeson et al., 2011; Stephens & Aparicio, 2017), there needs to be a greater understanding of how complex trauma may affect mothers' abilities to navigate the child protection system. Failure to address complex trauma histories and trauma-related reactions limits mothers' abilities to benefit from services, effectively meet service plan mandates, and can delay or prevent reunification (Kletzka & Siegfried, 2008). Moreover, failing to address trauma also can result in missed opportunities to address the root causes of the problem, which could aid individuals' healing and recovery (Kletzka & Siegfried, 2008).

This article is part of a more extensive study that explored factors that contributed to whether African American mothers with histories of substance misuse retained, regained, or lost permanent custody of their children. Although many factors have influenced outcomes, trauma was a significant factor that consistently influenced mothers' involvement with the child protection system (Blakey, 2010). A previous study included an examination of externalized (i.e., anger and lack of trust) and internalized (i.e., negative view of self and guilt/shame) expressions of trauma-affected outcomes (i.e., whether parents retained, regained, or lost permanent custody of their children) of mothers' child protection involvement (Blakey & Hatcher, 2013).

This article focuses on parents who have histories of complex trauma (i.e., four or more traumatic events). Individuals with complex trauma have profound and enduring problems that are much more difficult to treat because the traditional sequelae of symptoms do not adequately reflect chronically traumatized peoples' experience (Courtois & Ford, 2009). This study aimed to identify the primary ways African American mothers with histories of complex trauma reacted to their involvement with child protection and examine those reactions using a trauma-informed lens. Parents who abuse and neglect their children are often villainized. Exploring the possibility that abuse and neglect may stem from parents' histories of trauma can highlight the root causes and more effectively direct child protective services' resources. The primary research question guiding this study was: What are the primary reactions child-welfare-involved mothers with histories of complex trauma used to navigate their involvement with the child protection symptoms?

Method

A case study approach was used (Stake, 1995; Yin, 2009) because of its potential to explore real-life experiences (Abma & Stake, 2014). Case studies allow for an in-depth understanding of a case (e.g., African American mothers who have complex histories of trauma) and explanations of particulars of that case (e.g., how child-welfare-involved mothers with histories of complex trauma navigate the child protection system) in real-world situations (e.g., involvement with the child protection system; Abma & Stake, 2014). Case studies provide opportunities to discover context-related knowledge and illuminate individuals' lives (Abma & Stake, 2014; Yin, 2009). Much of what is empirically known about the social world has been discovered by case studies (Yin, 2009).

Sample

A criterion purposive sampling method was used to select participants: African American mothers involved with child protection resulting from substance misuse. Participants were receiving substance abuse treatment at a women-only treatment center in a large, urban city. This study includes a subset of the sample (e.g., mothers who had histories of complex trauma, which consisted of four or more traumatic events) from the more extensive study. African Americans are disproportionately involved with the child protection system (McCarthy, 2011) and are more likely to be considered noncompliant or labeled in other negative ways (Mirick, 2012). African Americans also are more likely to have experienced childhood maltreatment, witness domestic violence as children, and be violently assaulted (CSAT, 2014).

Mothers were recruited from a substance abuse treatment center because when substance abuse results in substantiated child abuse and neglect, treatment participation is mandatory. Failure to participate in treatment virtually guarantees that parents will lose custody of their children (Kerbs, 2016). Focusing on mothers who participated in substance abuse treatment allowed the authors to identify other factors that seemed to contribute to whether African American mothers retained, regained, or permanently lost custody of their children.

The 20 African American mothers were between the ages of 19 and 43. The mean age of the participants was 36. Mothers reported a 3- to 35-year history of using alcohol and drugs (e.g., heroin, marijuana, and crack cocaine). The average length of substance use was 22 years. Mothers were as young as age 5 when they started using drugs and alcohol, and others were as old as 20 years

old. The average age mothers started using drugs was 14. Mothers were in substance abuse treatment from 33 to 122 days, with an average of 88.75 days of treatment. Mothers had from one to 10 children, with an average of six children. Ninety-five percent (19 out of 20 mothers) had at least one previous involvement with child protection. Mothers were previously involved with child protection anywhere from one to 13 times. On average, they had four previous involvement with child protective services. Nineteen mothers had mental health diagnoses, including depression (12 mothers), anxiety (five mothers), bipolar (one mother), auditory hallucinations (one mother), and PTSD (one mother; see Table 1 for demographics).

All 20 mothers in this study (100%) had experienced four or more traumatic events. Eight mothers (40%) experienced between four and six traumatic events. Nine mothers (45%) reported seven to nine traumatic events. Three mothers (15%) experienced 10 to 12 traumatic events. See Table 2 for the trauma exposure of participants.

Mothers experienced various types of trauma. Fourteen mothers (70%) experienced childhood sexual abuse. Eleven mothers (55%) reported physical abuse. Sixteen mothers (80%) reported being neglected or abandoned. Seventeen mothers (85%) were victims of domestic violence. Five mothers (25%) reported being sex trafficked. Ten mothers (50%) reported being raped. Thirteen mothers (65%) reported general violence, including watching family members being killed, kidnapped, or mugged. Finally, 16 mothers (80%) reported prostituting at some point in their adult lives. Nine mothers (35%) reported emotional abuse as an adult. Twelve mothers (60%) grew up with parents who had substance misuse problems. Four mothers (20%) were involved with the child welfare system as children. Two mothers (10%) were adopted as children through the public child welfare system.

There is a significant correlation between substance use and trauma (Spinhoven et al., 2014). As defined by reasons they entered the system, focusing on African American mothers who have histories of substance abuse was an indirect way of identifying mothers with possible trauma histories. Although parents' substance abuse histories were known to the child protection system, there was no documentation of parents' trauma histories (Greeson et al., 2011). Knowing the significant effects trauma can have on individuals' lives is the primary reason this study was intended to understand the primary reactions African American mothers with histories of complex trauma used to navigate their involvement with the child protection system.

Data Collection

Primary sources of data were documents from mothers' files and in-depth, semistructured interviews. Documents from mothers' files included psychological evaluations, correspondence with the Department of Children and Family Services (DCFS) and other collateral agencies, case notes, progress notes, and assignments mothers completed. Files were reviewed from Day 1 throughout the mothers' stay at the treatment facility. Interviews were conducted with 20 African American mothers. The women each received $25 for their participation in the study. Interviews lasted from 1 to 2 hr. Interviews occurred in private, secluded rooms, provided by a treatment facility. Interviews were recorded using a digital recorder. The semistructured interview questions related to the study were as follows.

1. Let us talk about your current child protection experience.
   a. What has this experience been like?

Table 1
Demographics of the 20 Mothers With Complex Histories of Trauma

Name of mother	Age	Number of years using alcohol/drugs	Age started using alcohol/drugs	Previous TX episodes	Length of time in TX	Number of kids	Previous DCFS involvements	Outcome
AHC (avg.)	31.75	18.125	13.625	3.75	84.75	4	1.5	
Dana	19	3	16	0	82	1	0	Lost custody
Candace	39	26	13	5	91	4	4	Lost custody
Tammy	43	25	18	4	33	7	2	Lost custody
Vickie	26	15	11	2	110	2	1	Lost custody
Darcy	20	6	14	1	86	1	0	Reunification
Lisa	37	30	7	13	101	5	3	Reunification
Mackenzie	39	22	17	4	90	8	1	Reunification
Natalie	31	18	13	1	85	4	1	Reunification
WD (avg.)	39.4	27.8	11.6	3.8	86	7.8	2.8	
Barbara	38	27	11	6	95	10	5	Reunification
Darla	43	29	14	3	95	10	2	Lost custody
Harriet	39	25	14	3	90	8	3	Lost custody
Kai	40	35	5	4	39	7	2	Lost custody
Victoria	37	23	14	3	111	4	2	Lost custody
SC (avg.)	37	21	16	2.8	96	6.2	2.8	
Tabitha	37	18	19	1	96	5	1	Reunification
Tonia	34	21	13	3	71	4	2	Reunification
Vivian	33	19	14	1	122	10	4	Reunification
Lashaun	41	21	20	5	86	6	3	Reunification
Vanessa	40	26	14	4	105	6	4	Lost custody
IF (avg.)	40.5	25	15.5	6	93.5	7.5	3	
Dawn	39	24	15	3	102	7	2	Reunification
Edith	42	26	16	9	85	8	4	Lost custody

Note. TX = treatment; DCFS = Department of Children and Family Services; AHC = anger hostility, combativeness; WD = withdrawing and disappearing; SC = superficial compliance; IF = immobilizing fear.

Table 2
Various Types of Trauma by Category

Name of mother	CSA	PA	Neglect	EA	WDV	VDV	Rape	ASA	GV	PROST	Trauma total	AEA	AL	PSA	CWI	P DV	ACE total	Cum total
AHC																		
Dana	1	1	1	1		1	1	1	1	1	9	1		1	1	1	3	13
Candace	1	1		1		1		1	1	1	7	1	1				2	9
Tammy	1		1	1			1		1	1	6			1			1	7
Vickie	1		1			1			1	1	5			1	1		2	7
Darcy	1		1	1							3	1	1		1		3	6
Lisa	1	1	1	1		1	1	1	1	1	9	1	1	1		1	3	13
Mackenzie		1	1	1	1	1			1		6	1		1		1	2	9
Natalie		1	1	1	1	1		1		1	7	1	1				2	9
	6	5	7	7	2	6	3	4	6	6	52	6	4	5	3	3	18	73
WD																		
Barbara	1		1			1	1		1	1	6		1		1		2	8
Darla	1	1	1		1	1	1			1	7	1	1	1			3	10
Harriet	1	1				1	1			1	5						0	5
Kai		1	1	1		1	1		1		6		1	1			2	8
Victoria	1		1			1			1		4		1	1		1	2	7
	4	3	4	1	1	5	4	0	3	3	28	1	4	3	1	1	9	38
SC																		
Tabitha						1			1	1	3			1			1	4
Tonia	1		1				1			1	4			1			1	5
Vivian	1		1	1		1	1			1	6	1					1	7
Lashaun			1	1		1			1	1	5						0	5
Vanessa			1			1				1	3			1			1	4
	2	3	4	3	1	4	2	0	2	5	21	1	0	3	0	0	4	25
IF																		
Dawn	1				1	1			1	1	5			1			1	6
Edith	1		1	1		1	1		1	1	7	1	1				2	9
	2	0	1	1	1	2	1	0	2	2	12	1	1	1	0	0	3	15
Total	14	11	16	12	5	17	10	4	13	16	113	9	9	12	4	4	38	151

Note. CSA = childhood sexual abuse; PA = physical abuse; EA = emotional abuse; WDV = witnessing domestic violence; VDV = victim of domestic violence; ASA = adult sexual abuse (sex trafficking); GV = general violence; PROST = prostitution; AEA = adult emotional abuse; AL = ambiguous loss; PSA = parental substance abuse; CWI = child welfare involvement as a kid; PDV = arrested for beating up their partner; CUM = cumulative; AHC = anger hostility, combativeness; WD = withdrawing and disappearing; SC = superficial compliance; IF = immobilizing fear.

   b. What has been the hardest about this experience?

   c. What has been the most rewarding part of this experience?

2. How did you become involved with child protection?

   a. Where are your kids currently placed?

3. Is this the first time you've been involved with child protection? How many other times have you been involved with child protection?

4. Thinking back, tell me about the first time you became involved with child protection.

5. If this is not your first time, how does this time compare to that experience?

6. What do you have to do to get your children back or maintain custody of your children?

7. Thinking about the most recent experience, what do you think are the most significant things that will affect your case's outcome?

8. Thinking about the most recent experience, what things might get in the way of you accomplishing your goals?

9. Can you describe your relationship with your child protection caseworker?

10. What has been the most challenging part of your relationship with your caseworker?

11. What has been the most rewarding part of your relationship with your caseworker?

12. Is there anything else you think I should know about your involvement with child protection?

The study was approved by the DCFS and university institutional review boards. The IRB protocol required a discussion of what we would do if women were upset by the interview and how the information would be protected. In the approved protocol, we indicated that we would talk with them and ask their permission to share any difficulties with their treatment counselors. During the interview, we also reminded the mothers that they did not have to answer any question they did not feel comfortable answering. Many of the women indicated it was cathartic that someone was

asking about their lives. Author Joan M. Blakey is an African American woman who was a child protection social worker. When she introduced the study, she indicated she wanted to tell their story. Additionally, she spent Monday–Friday at the treatment center for 14 months, so she checked on women who became emotional during the interview. In terms of protecting information, pseudonyms were used to protect participants and the treatment agency's confidentiality. All audio files and transcripts were kept in an encrypted computer or a locked file cabinet at the university.

Data Analysis

Data analysis is a continuous process when researchers are in the field. Data were analyzed through a series of steps. The first step consisted of reviewing transcribed interviews to ensure the accuracy and quality of the information collected. The second step involved organizing documents collected from participants' files. Interview transcripts and documents were uploaded into NVIVO 12, a qualitative software program that helps researchers organize, code, and categorize narrative text. The third step involved coding interviews and documents. Initially, data were coded using open coding, in which the researcher codes data line by line (Miles & Huberman, 1994; Padgett, 2008) to develop a list of codes. Salient themes were then identified by grouping codes (Miles & Huberman, 1994). Words and phrases such as "anger," "hostility," "denial," "fearful," "disengagement," "left treatment against medical advice," "playing the game," "telling them what they want to hear," and "dissociation" were identified. These words were grouped into four major categories. Grouped responses were examined using thematic analysis to find succinct labels. Thematic analysis involves reviewing salient themes to identify and understand plausible explanations across cases to answer the research question (Miles & Huberman, 1994).

Once the themes emerged from the data, they were narrowed down to four categories. Interviewees' transcripts and documents associated with each case (e.g., progress notes) were then reviewed to ascertain the mothers' processes and behaviors. Case notes spanning mothers' stays in substance abuse treatment were reviewed. Mothers were in treatment from 33 to 122 days, with some mothers having over 300 pages of case notes and other documents. Using the four categories, the primary author looked for every time the category was mentioned. In many cases, participants used most, if not all, of the methods. Nonetheless, mothers were placed in categories in which they primarily responded or employed, as identified by the mother, documents in her file, her substance abuse treatment counselor, child protection caseworker, and other service providers.

The trustworthiness of the findings was established by peer debriefing and triangulation (Padgett, 2008). Initially, the primary author and a doctoral student coded the data. The primary author reviewed the case notes and documents. After grouping, similar codes and sample passages within the four categories, the preliminary findings were presented and discussed with five qualitative researchers who met monthly to discuss and provide feedback on their work. Peer debriefing allowed for the refinement of categories and feedback on the interpretation of the data. Triangulation of the data was another method used to increase the rigor of the study. Each mother's file was reviewed. Mothers were placed into one of four categories based on the case notes and other documents in the mothers' files. Reviewing the mothers' files confirmed groups in which mothers initially were placed, except for one mother. Based on the transcript, this mother was placed in the withdrawing/disappearing group. After reviewing case notes and documents in her file, she was placed in the angry/hostile/combative group because her words and behaviors were egregious, violent, and hostile, ultimately leading to her dismissal from the program. All mothers in the withdrawing/disappearance group left treatment against medical advice, so this mother was placed in the angry/hostile/combativeness group.

Findings

This study aimed to identify the primary ways African American mothers with histories of complex trauma reacted to their child protection system involvement. Data analysis revealed that participants reacted in four primary ways. Findings indicated 40% (n = 8) of mothers reacted with anger, hostility, and combativeness; 25% (n = 5) of mothers withdrew, disappeared, never resurfaced, or intermittently disappeared and reengaged; and 25% (n = 5) mothers complied superficially, disbelieving the validity of maltreatment findings. Superficial compliance resulted in virtually no movement or meaningful change taking place. Finally, 10% (n = 2) were grief-stricken and fearful of their involvement with child protection and were immobilized or had long periods of immobilization.

Anger, Hostility, and Combativeness

The most common response African American mothers with histories of complex trauma used to manage child protection involvement consisted of anger, hostility, and combativeness. This response most often was directed toward professionals (e.g., child protection caseworkers, treatment counselors, and parenting workers) involved with their cases.

For example, Tammy's substance abuse counselor wrote, "Tammy is very angry and won't listen to feedback from anyone. After almost a month of being in treatment, she continues to fight anyone who tries to help her." David, Tammy's child protection caseworker, commented on Tammy's hostility:

> So, it can be pretty risky when you're dealing with mental illness, period. Because you do not wanna say the wrong thing because when Tammy would get hostile, you know, the voice increases. She would stand up. I got excellent at getting her to sit down. So, this particular time, I was not working alone. I was working with an investigator. I kept telling the investigator, you know, trying to signal her to bring this down because you can hear her getting worked up. . . . She was so hostile all the time that I just gave up trying to help her. . . . She acted like she knew everything and didn't need any help from anyone. So, I decided to stand back and watch her fail, which eventually she did.

Tammy confirmed she got most angry when people tried to tell her what to do or corrected her:

> Who doesn't get angry when someone is telling them something they do not want to hear? Everyone keeps telling me I'm angry or hostile, but they shouldn't give me a reason. Two different times I was kicked out of treatment because they said I was the aggressive one. . . . I'm always the one that has to leave, but they said I couldn't come back

> because I was choking somebody or something. . . . My child protection worker always got something smart to say. . . . I do not want to hear anything any of them got to say. . . . They need to shut up talking to me.

The above quote illustrates that Tammy was angry with most of the professionals trying to help her. The quote also indicates that Tammy used anger, hostility, and fighting as she was kicked out of two other treatment centers for fighting and choking someone. Vickie, a 26-year-old woman with an extensive history of sexual abuse, neglect, and intimate partner violence, also had a problem with anger and often was unsure of who or what would cause her to become combative. She described her experience:

> Today I could be fine, and then like while we're sitting here talking I can get real upset . . . I feel like they're [child welfare caseworker] against me. They're waiting for me to mess up. I'm not going to let that make me leave. . . . I got a real problem with anger but ain't nothing I can do. . . . Next time somebody tries to talk to me, I might just snap. It depends, you know, on what they're saying. . . . We all try not to, but all of us are liable to just snap and cuss somebody out in a minute because, like, we're already going through a lot. We've been through so much.

Vickie, like many of the women, had problems with anger. Sometimes it was clear what set them off. Most of the time, they were not aware of the trigger. Although all 20 mothers had anger problems, anger was eight (40%) mothers' primary response to involvement with child protection. Four mothers (20%) were reunified, and four mothers (20%) lost custody of their children. One explanation for why 50% of mothers were reunified with their children was, at some point during their involvement, they stopped directing their anger at people who were trying to help them and used their anger and hostility as motivation. Lisa confirmed this:

> I have a history of getting by and going off on people when they do not respond the way I want them to. . . . I ain't going to lie. When I first became involved with child protection, I fought them on everything. . . . I realized that this put me at dangerous risk of losing my son. But when I stopped focusing on DCFS and my primary motivation became getting my son back is when I started getting out of the way and using everything I feel to get my son back. . . . So, my thing is to focus on me, so I'm better for him. . . . Now I can appreciate her [DCFS caseworker] input.

Anger, combativeness, and hostility were the most common reactions to mothers' involvement with child protection. However, when they no longer directed their anger at service providers and used it as motivation, many regained their children's custody.

Withdrawing and Disappearance

Withdrawing and disappearing was the second most common reaction African American mothers with complex histories of trauma used to navigate their involvement with child protection. Five mothers (25% of mothers) withdrew, disappeared, or disengaged from services for long periods during child protection involvement.

Withdrawing was the first step in the process. Mothers were physically in treatment but appeared preoccupied and distant. Relapse was usually the second step in the process. Four of the five mothers relapsed while in treatment. Harriet and Victoria relapsed while on approved passes to go to doctors' appointments or shopping trips. After each relapse, they came back to treatment.

Kai also relapsed while on a shopping trip to Walmart. She had her drug dealer meet her at Walmart and used drugs in the store. She then brought drugs back to the unit. The drugs were confiscated, but she was not kicked out of treatment because she had her daughter with her, and they did not want her to lose custody. Kai left treatment a couple of days later, leaving her daughter behind. Her daughter was placed in foster care.

Barbara relapsed after a court hearing because she was frustrated with the child protection system. She confirmed her experience:

> I guess I left treatment to get high because it was like they [judge and caseworkers] didn't even acknowledge me. I went to court. All they focused on was where is the father at. I'm like, why does he need to be here? At the time, all I could think about was getting high. . . . Now I realize the court hearing made me feel hopeless. . . . It was just that they didn't see me. They didn't acknowledge all the progress I was making. It was not about anything but where is the father. . . . When I left, all I could think about was using.

Barbara left for days and came back to treatment a second time during the study period. She continued to be withdrawn, which the counselors believed led to her relapse. They gave her an ultimatum. Barbara reported her response:

> I'm just going to try to work harder at my treatment this time because it's difficult for me to participate in the group setting. . . . It seems like since I relapsed, it's been hard. Because it seems like they treat me a little different now. . . . They are like, if I do not talk in 10 days, I'm going to have to get out. I'm on contract now because I keep to myself and do not want to talk. . . . They are just telling me well you know how to ask the dope man for dope. But they do not understand the group thing is difficult for me.

Throughout Barbara's second treatment episode, she continued to be withdrawn in group settings but did talk to her counselor in one-to-one sessions. The second time, Barbara completed treatment and eventually regained custody of her sons. Barbara was the only mother who successfully regained custody of her children. She attributed her success to her child protection caseworker and stated the following:

> This time I ended up with a cool caseworker. I never had a caseworker like the one I have now, who you know talks to me, doesn't look down on me, doesn't treat me badly, because the rest of the caseworkers they look at my past and seems like they look at my past and they already treat me a certain way. This caseworker, he doesn't do that . . . you know he's been; he's been really nice to me.

According to Barbara, because the caseworker believed in her, she felt she had a chance to get her twins back. The remaining 80% (four of five) of mothers whose primary response was to withdraw or disengage from services and disappear lost custody of their children.

Superficial Compliance

Superficial compliance was the third most common reaction African American mothers used to manage their child protection involvement. For mothers in this study, superficial compliance primarily involved participating in services to appear compliant

with their case plans. Mothers who superficially complied were primarily stuck in denial around drug use, which caused them to remain unchanged throughout their substance treatment services engagement.

Tonia was a 34-year-old woman who had a history of childhood sexual abuse, neglect from parental substance use, and rape. After 4 weeks in treatment, she continued denying her drug use had any effect on her parenting or led to her child protection involvement. She discussed this:

> I'm the kind of mom where I could be in my room getting high because I do not hide anything from my children. . . . All I smoked was laced blunts. . . . They could have a problem with their homework. All they have to do is knock on the door, and I'm gonna stop what I'm doing. I always take time to sit down and go over their homework or anything else they need. . . . That's how I've always been. I'm a functional addict, very functional. . . . The only reason I'm here is to give birth to a drug-free baby.

Tonia came to treatment because she continued "dropping dirty" in her outpatient treatment program. She came to treatment to give birth to a drug-free baby to avoid involvement with child protection. However, her daughter was born substance exposed, so Tonia had to complete treatment as part of her child protection case plan. Throughout treatment, Tonia refused to discuss issues or identify the causes of her drug use. Instead, she claimed that her children were unaffected by her drug use and that she was the perfect mom. Tonia focused on checking "treatment" off her list rather than changing. After 58 days in treatment, Linda, Tonia's substance abuse treatment counselor, confirmed her lack of commitment to change in her progress notes:

> Tonia looks at treatment as days and not getting better. She's the same as she was when she came to treatment. There are issues that Tonia doesn't want to explore, particularly those related to child abuse and family issues. She shows no indications that she's serious about getting better. She had her mind made up from the beginning, that she was going to come, do her time, and leave. It doesn't matter the number of days, whether it was 60 or 90 days. She's complacent, in denial and grandiose. . . . Her coming here was purely to satisfy DCFS, nothing more.

Like Tonia, Tabitha, a 37-year-old woman with a history of domestic violence and a violent attack, primarily responded to child protection involvement with superficial compliance or denial. She avoided dealing with her history of substance abuse by avoiding depressing topics; instead, she spent much of her time in treatment, trying to make people laugh. She explained,

> I am here, ain't I? I do not remember much of my childhood, what led to drug use, or how old I was when I started using. . . . They keep trying to make me think about bad things, but I do not want to . . . I like to make people laugh. That's my thing. Group can be so depressing. So, I try to lighten treatment up and make people laugh.

For mothers who superficially complied, their extensive traumatic histories often kept them stuck, as it was too overwhelming and painful for them to process the past. Vivian, a 33-year-old with a history of childhood sexual abuse, neglect, rape, and domestic violence, described this:

> My mom hasn't been in my life for 15 years. She left me in the ninth grade and then left again when I was pregnant with my fourth child. We were living together, and I came home, and all my stuff was gone. I haven't seen her since. My baby's father beat me so bad that I had to have 67 stitches on my face. They want us to talk about all this stuff. They say that it's related to my drug use, but it's too painful to think about my past.

Four of five mothers whose primary reactions to involvement with child protection were to comply superficially were reunified with their children. Many of these mothers completed treatment, which satisfied their case plan requirements. Smith (2003) found that when parents who enter child protection because of substance abuse complete treatment, they are more likely to achieve reunification, regardless of whether they show substantive change due to their participation in services. Child protection has no real way to gauge the impact of services other than participation, which is a loophole in the system (Mirick, 2012; Smith, 2003). Tonia remarked on her experience:

> This time, DCFS is a little bit harder on me, which made me panic a little bit because I kinda took them for granted. I ain't trying to hear them. I really ain't. I'm just gonna do what they tell me so I could get on with my life because after this baby I'm not planning on having any more children. . . . I do not understand why I have to do parenting and all that because I'm a great parent. My only problem is using it while I'm pregnant. Other than that, I have everything else under control.

The fact that Tonia and other mothers did not see their substance abuse as a problem kept them stuck in denial. Mothers who superficially complied focused on tasks that had to be completed instead of the intended changes that resulted from participation in substance abuse treatment. They were unchanged by involvement with child protection.

Immobilized by Fear

Immobilizing fear was the least common reaction to mothers' involvement with child protection. Only two mothers (10% of mothers) were immobilized by fear resulting from their child protection involvement. Many parents who become involved with child protection fear the possibility of losing custody of their children. For mothers with complex trauma, fear can be irrational. For example, Edith, a 42-year-old mother with a history of childhood sexual abuse, rape, neglect, domestic violence, and other violence, believed child protection abducted her baby. She was never going to see him again. She reported her feelings:

> I haven't heard from her [DCFS caseworker]. I've been calling her. She's not telling me nothing, not returning my calls . . . I do not know what to do. I'm wondering if the lady skipped town with my baby. Is she mistreating my baby? He just had open-heart surgery. . . . I need to know where he's at. . . . I need to know something. I cannot get a person to call or tell me nothing. . . . I've been here a month. I talked to her every day when my baby was in the hospital. Now she cannot call me. I'm so sick. I cannot even function. I cry all the time every day because I do not know how my baby is doing. I'm afraid that she ran off with my baby and I'll never see my baby again. . . . They keep telling me to focus on treatment, but how can I when I'm afraid I may never see my baby again?

Edith's fear stemmed in part from not knowing where her son was placed. Other times she was involved with child protection, Edith's children had been placed and adopted by relatives. Edith believed

child protection intentionally "passed over" her relatives and placed her son with a stranger so they could take her son. She believed her child protection caseworker was capable of killing her son. She stated,

> You know, family gets first priority. . . . I do not know where he's at. They act like they do not want to give him back to me. What am I supposed to think? I never went through nothing like this. I'm thinking they done took my baby and probably skipped town or killed him. I do not even know who he's with . . . what kind of person they are. . . . I'm just in a bad state of mind all the time wondering and worrying all day long. Every time I look at his picture, I'm crying and I'm just depressed. . . . I'm battling every day trying to hang on and praying to God that I do not snap out my mind, you know.

Thoughts someone had skipped town with or killed her baby consumed her. Edith's fear was so immobilizing that she could not focus on anything else. She paced, cried, or slept her way through treatment. Consequently, she lost custody of her son.

The other mother, who was immobilized by fear, used her fear as motivation to comply with her case plan's conditions. Dawn, a 39-year-old mother of seven who had a history of childhood sexual abuse and was a victim of domestic violence, replied, "I might be afraid—and worried out of my mind that they're going to try to take my kids, but I use that to do what I gotta do. Ain't nobody taking my kids." Dawn also was motivated because if she did not do what she needed to do, her children would be placed in foster care. Dawn's mother, who was caring for Dawn's children, told her if she did not do what she needed to do, she would let her children go into the child welfare system. Dawn had been involved with child protection two other times, but those cases were closed quickly. This instance was the first time she feared she could lose custody of her children. Consequently, Dawn's fear motivated her to do what was necessary to regain custody of her children.

Discussion

Terms such as "hostile," "combative," "uncaring," "shutdown," "in denial," "irrational," "withdrawn," "grandiose," and "unconcerned" were some of the words child protection caseworkers used to describe mothers in this study. These behaviors often were used as evidence to substantiate the termination of mothers' parental rights. Previous studies also found that mothers involved with child protection reacted in similar ways: (a) with anger, aggression, and fighting the system; (b) with passivity or "playing the game"; (c) by pretending to cooperate until they successfully regained custody of their children; and (d) with psychological immobilization due to fear, grief, or profound sadness (Dumbrill, 2006; Horejsi et al., 1992; Mirick, 2012). Using a trauma-informed lens would suggest mothers' primary reactions (i.e., anger/combativeness, withdrawing/fleeing, superficial compliance, and immobilizing fear) resemble physiological reactions (i.e., fight, flight, freeze, and fright), which mothers enlisted to protect them from perceived or actual threats (van der Kolk, 2005).

Studies have shown mothers' histories of unresolved complex trauma can impact their ability to engage and work with service providers, contributing to increased rates of out-of-home placements and termination of parental rights (Chemtob et al., 2011). Hernandez-Mekonnen and Konrady (2017) reported, "Had a trauma focus been part of the [child protection] service delivery a decade ago, those children that are now parents may have had better chances to become healthy adults and parents" (p. 237).

Additionally, parents' ability to trust the child protection system is limited (National Child Traumatic Stress Network [NCTSN], 2011a, 2011b). Consequently, during interactions with child protection caseworkers, parents often refuse to reveal anything that might be used against them, so their complex trauma history often remain unaddressed (Douglas & Walsh, 2010; NCTSN, 2011a). Additionally, participants reported being traumatized by their involvement with the child protection system. The history of child protective services in communities of color, coupled with unresolved trauma, resulted in intense responses of anger, hostility, rage, withdrawal, resignation, dissociation, defeat, avoidance, and intense fear (Buckley et al., 2011; Horejsi et al., 1992; van der Kolk, 2005).

In this study, we discover that these participants' primary reactions closely resemble fight, flight, freeze, and fright trauma responses. When traumatized people see images, hear sounds, or are reminded of situations related to or reminding them of traumatic experiences, fight, flight, freeze, and fright are activated (van der Kolk, 2014).

Fight: Anger, Hostility, and Combativeness

The fight response was the most common reaction African American mothers had to their involvement with child protection. When triggered, fighting is a typical response often intended to intimidate or protect from threats that may be real or perceived (Blakey & Hatcher, 2013; van der Kolk, 2014). Although many parents, regardless of background, may think their involvement with child protection is unjustified and react with anger (Mirick, 2012), traumatized parents often remained intensely hostile, resistant, and uncooperative for long periods or throughout their entire involvement with child protection (Horejsi et al., 1992).

Flight: Withdrawing and Disappearance

Participants whose primary response was to flee described their responses as being automatic. After they relapsed, they realized what they had done and the possible consequences of their actions. van der Kolk (2014) suggested that flight is a preprogrammed physiological response developed and set into motion without thought or planning. Interestingly, fleeing often happened before or after court dates or other anxiety-provoking experiences, which was often used as evidence to support parental rights termination.

Freeze: Superficial Compliance

Many mothers involved in treatment escaped the threat (real or perceived) by escaping mentally through *dissociation*. According to Farley (2018), "Dissociation is a response to overwhelming and uncontrollable traumatic events in which the mind detaches from one's current emotional or physical state" (p. 99). According to van der Kolk (2005), "The goal of the freeze response is to avoid engaging in activities or tasks that may unexpectedly trigger a person" (p. 7). All of the mothers had extensive histories of trauma they were unwilling to discuss or process. The mothers superficially complied with services. They were physically in treatment but mentally were unwilling to do any work that would help them

get to the root causes of their substance misuse. Therefore, they left treatment nearly the same as they entered.

Fright: Immobilizing Fear

Fright often stems from feeling helpless and out of control (Vaiva et al., 2003). Participants' fright resulted in irrational fears that child protection might kill their child or that the system was conspiring against them. Mothers whose primary response was fright cried at the mere thought of losing custody of their children. Their fear was immobilizing. They had trouble sleeping and struggled to get through each day. One mother seemed to give up trying to regain custody of her children out of exhaustion, which allowed her to focus on becoming a better mom, finding housing for her children, and satisfactorily regaining custody of her children.

Mothers with histories of substance abuse often are believed to lack motivation to regain custody of their children (Tullberg, 2013). Using a trauma lens, however, these behaviors are common responses to traumatic events (i.e., danger, threat, or perceived threat) known as fight, flight, freeze, or fright (van der Kolk, 2014). Using a trauma lens requires rethinking assumptions about these mothers and understanding that their child protection involvement may trigger these physiological response in mothers with complex histories of trauma.

Limitations

Several limitations should be noted. One limitation is that the study focused on mothers' primary reactions to involvement with child protection. Many mothers displayed multiple responses. However, the focus was on the primary response, which was determined by responses parents most often displayed throughout involvement with child protection.

Another limitation is that mothers could have had different responses based on their caseworkers. For example, studies have found caseworkers who are more confrontational create different outcomes than caseworkers who are more empathetic (Forrester et al., 2012).

Finally, the findings included only African American mothers. African American mothers were chosen because they have higher rates of involvement with the child protection system and a higher prevalence of trauma (Roberts et al., 2011). Mothers from other racial groups and ethnicities may have different experiences concerning the prevalence and types of trauma, which could have changed their primary responses. Hatch and Dohrenwend (2007) found differences in the types and prevalence of trauma-based on different racial, gender, and socioeconomic groups.

Implications for Practice

This study makes several contributions that may shift how caseworkers and social workers assist parents who have histories of complex trauma and are involved with the child protection system. First, this study's findings focused on mothers with histories of complex trauma involved in the child protection system. Only a handful of studies have focused on child-welfare-involved parents with histories of trauma (Blakey & Hatcher, 2013; Chemtob et al., 2011; Horejsi et al., 1992; Stephens, 2019; Stephens & Aparicio, 2017). Only two of those studies focused on parents with histories of complex trauma (Stephens, 2019; Stephens & Aparicio, 2017). More studies are needed to explore the prevalence of trauma among child-welfare-involved parents, the types of trauma parents have experienced, and how trauma can affect interactions with caseworkers and the child protection system. A greater understanding of trauma experienced by children entering the child welfare system has created a tremendous amount of knowledge and trauma-informed resources (i.e., NCTSN), resulting in more effective interventions with children (Klain & White, 2013).

A second contribution of the current study is it provides evidence of pragmatic coping, which posits that although certain behaviors (i.e., hostility, lack of cooperation, lack of motivation, resistance, resistant, or disengagement) would be considered maladaptive under normal circumstances, they are adaptive following exposure to traumatic events (NCTSN, 2011a; Westphal et al., 2008). According to Westphal et al. (2008), "Pragmatic coping may promote resilience to extremely aversive events but can carry enduring social costs and other liabilities as well as have potentially maladaptive consequences when exhibited in less acute circumstances" (p. 226). When parents act in extreme ways, the reactions are often trauma responses in which parents are trying to gain some sense of control over a process that makes them feel powerless (NCTSN, 2011a).

Notably, results of this study support the importance of acknowledging that mothers have unresolved trauma and that how the current child welfare system is set up, mothers often are made to feel like they are "bad" mothers and consequently do not feel they can ask for help without stigma or judgment (Douglas & Walsh, 2010; NCTSN, 2011a). According to the NCTSN (2011a), when working with parents who have histories of trauma, a trauma-informed approach involves a series of steps, including referring parents to trauma-informed services and organizations that use trauma-informed interventions. Trauma-informed, strength-based approaches can lead to more empathic responses, improve engagement, and facilitate a deeper understanding of the ways trauma can affect parents' ability to respond to child protection involvement effectively and, at the same time, help workers meet safety and permanency goals (NCTSN, 2011a). Additionally, effectively identifying and addressing mothers' histories of complex trauma "will result in improved outcomes, less need for more extensive and expensive services, and reduce long-term costs" (Hanson & Lang, 2016, p. 96).

The vast majority of efforts to understand how trauma might affect individuals' involvement with child protection have been directed primarily toward children (Hernandez-Mekonnen & Konrady, 2017). Rarely do child protective systems assess whether parents have histories of trauma (Blakey & Hatcher, 2013; Chemtob et al., 2011; Tullberg, 2013).

The child welfare system has failed to provide appropriate services to mothers with histories of complex trauma. The perpetuation of providing inadequate services not only contributes to further harm of mothers and their children but also maintains a cyclical pattern of division, especially among the African American mothers and children who are disproportionately involved with the child protection system.

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