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Original Research Article

The lived experiences of biological mothers parenting with a history of complex trauma in the Govan Mbeki Local Municipality, South Africa

Sekelo Atalia Shube[1] and **Eugene Lee Davids**[1]

Abstract

Complex trauma is experiencing a traumatic event, in the form of abuse, which is chronic, interpersonal, and begins in childhood. Limited knowledge exists regarding the impact of complex trauma on parenting. The current study, therefore, aimed to explore the lived experiences of biological mothers parenting with a history of complex trauma in the Govan Mbeki Local Municipality, South Africa. Using purposive sampling, the study included 10 biological mothers. Data were collected using semi-structured interviews and analysed using Interpretative Phenomenological Analysis. The data tell the story of how mothers with a history of complex trauma prioritise the well-being of their children while neglecting their own needs. In addition, their experiences of complex trauma result in protecting their children from potential traumas, leading to overprotective parenting. The findings highlight the role of complex trauma on parenting, particularly among biological mothers in South Africa, and provide recommendations for society, practice, and research.

Keywords

Biological mothers, complex trauma, overprotective parenting, parenting, psychological well-being, trauma

Introduction

South Africa ranks as one of the countries with the highest levels of trauma exposure globally (Nothling et al., 2023). Zyl et al. (2017) highlight that 73.8% of the general population reports lifetime exposure to at least one potentially traumatic event, with women being the most affected.

[1]Department of Psychology, Faculty of Humanities, University of Pretoria, South Africa

Corresponding author:
Eugene Lee Davids, Department of Psychology, Faculty of Humanities, University of Pretoria, Lynnwood Road, Hatfield, Pretoria 0002, South Africa.
Email: eugene.davids@up.ac.za

Blaustein and Kinniburgh (2019) define complex trauma as repeated exposure to traumatic events, typically occurring in childhood within the caregiving system. This recurring exposure often involves various forms of abuse, including emotional, sexual, and physical abuse, collectively referred to as complex childhood trauma (Blaustein & Kinniburgh, 2019). South Africa's socioeconomic and cultural landscape, shaped by historical injustices such as apartheid, continues to fuel poverty, inequality, and emotional distress, disproportionately affecting mothers with trauma histories. Traditional caregiving roles, coupled with limited access to support, further contribute to their isolation (Kim et al., 2022). Additional challenges, including unemployment, community violence, and restricted services, can exacerbate the impact of trauma (Hatcher et al., 2019; Seedat et al., 2009).

Existing research on complex trauma provides evidence of its significant impact on child development, particularly during childhood and adolescence (Banyard et al., 2003; Buller et al., 2020; Ingolia & Barrett, 2019; Mason et al., 2020). Yet, little is known about how early-life experiences of complex trauma shape parenting among biological mothers (Ingolia & Barrett, 2019). Studies indicate that parents with unresolved trauma may experience impaired parenting abilities, leading to periods of neglect (Arnold & Fisch, 2011) or the projection of their own distress onto their children. This, in turn, can contribute to heightened hypervigilance in children (Arnold & Fisch, 2011; Mal-Sarkar et al., 2021) and increase their risk of developing psychological ill-health (Gibbs et al., 2018). South African mothers from low-income communities who have experienced multiple adversities often face significant challenges, such as a lack of access to health care and food security in their parenting capacity (Christie et al., 2020; Davids, 2025). However, there are generally few interventions to address the sociocultural factors influencing complex trauma or the psychological and emotional functioning of adult survivors and their children (Briere & Spinazzola, 2005; Christie et al., 2020).

Although no direct associations have been established between early-life exposure to complex trauma and poor parenting ability, DeStone et al. (2016) found that structural disadvantages, such as poverty and stigma, negatively impact parenting quality. In contrast, Banyard et al. (2003) emphasise that increased trauma exposure is linked to lower parenting satisfaction, higher instances of child neglect, greater reliance on physical punishment, and an increased number of protective service reports. Moreover, Banyard et al. (2003) highlight that these associations are partly explained by the link between trauma exposure and increased maternal depression.

The current study is guided by the *developing a mothering self* framework, which was developed by O'Dougherty Wright and colleagues (2012) using a grounded theory approach to understand the perspectives of women on mothering as survivors of trauma. The framework presents four phases, which are cyclical in nature. The framework captures the perspective of mothering as survivors of trauma and their process of developing a mothering self. Mothering self within the context of the framework refers to mothers as survivors of trauma who are able to love, protect, and nurture both themselves and their children. The cyclical nature of the model makes provision for mothers who might go back to a previous phase or who are still stuck in a current phase, either due to changes in their children's development, new experiences which might serve as a trigger of past traumas, or a number of other factors which the mother experiences during her process of healing. The four phases are: (1) self mother, (2) Victim as mother, (3) Survivor Mother, and (4) Self Mother.

(1) The first phase, *self mother*, is intentionally in lower case to represent the mother's limited awareness and understanding of the process of parenting and/or the abuse experienced and how these have affected the self and the self as a mother (O'Dougherty Wright et al., 2012). During this phase, the mother has a limited understanding of her own and her child's needs, and very little emphasis is placed on her health and well-being, both as an individual and as a mother. It is common during this phase for the mother to be absent from herself and her child. (2) The next phase,

Victim as mother, is where mothers become aware of and start developing an understanding of their abuse or the effect of the abuse (O'Dougherty Wright et al., 2012). It is often during this phase that mothers start their recovery work or their journey towards healing, which is why the victim in this phase is capitalised. Mothers become aware of their pain related to the abuse and its effects. (3) The third phase, *Survivor Mother*, is when mothers start identifying as being survivors (O'Dougherty Wright et al., 2012). The identification of the self as a survivor is more pronounced, accompanied by a greater acceptance of who they are, as well as the ability to distinguish between the needs of their child and their own unmet needs. During this phase, there are fewer secondary effects based on the abuse and trauma, and there is a greater sense of 'being there' for their children and their children's needs. (4) The fourth and final phase, *Self Mother*, is where mothers have a greater understanding and acceptance of their limitations and a greater sense of self-worth (O'Dougherty Wright et al., 2012). It is in this phase that mothers are able to nurture, love, and protect both themselves and their children. It is here that both their needs and the needs of their children are important.

Given the existing knowledge gaps regarding the impact of complex trauma on parenting among biological mothers, this study aims to understand the lived experiences of parenting among biological mothers with childhood exposure to complex trauma in the Govan Mbeki Local Municipality, Mpumalanga Province, South Africa.

Methods

The study employed a qualitative research design, utilising a phenomenological approach within the interpretative paradigm to explore the lived experiences of biological mothers parenting with a history of complex trauma. The study is presented in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Participants

The study's participants were recruited from Tutela Family Care, a non-profit welfare organisation that provides social services to families and communities in Mpumalanga province, South Africa. Information posters about the study were advertised on the organisation's noticeboards, where participants made contact with the researcher independently. The study employed purposive sampling to ensure the selection of participants best suited for the research. The final sample comprised 10 biological mothers between the ages of 31 and 50 years. Of these, nine participants self-identified as Black African, while one identified as White (see Table 1). The majority were single parents.

All participants met the following inclusion criteria: (1) Were biological mothers who had experienced complex trauma during childhood, a criterion assessed using the Childhood Trauma Questionnaire (CTQ). The CTQ is a retrospective screening tool for childhood trauma, consisting of 28 items assessing five types of childhood maltreatment: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. Responses are rated on a five-point Likert-type scale, ranging from 1 (*never true*) to 5 (*very often true*). An example of the items includes 'People in my family said hurtful and insulting things to me'. The CTQ has been used in previous studies to assess retrospective childhood trauma and determine participant eligibility in South Africa (Hanslo, 2010; Sevenoaks et al., 2021). (2) Participants were required to reside within the Govan Mbeki Local Municipality. This municipality was selected due to the observed recurring patterns of trauma experienced by mothers in the area, as observed by the first author, who has worked in this area, and reported in the media. (3) They had to be between the ages of 30 and 50 years. This

Table 1. Participants' biographical information.

Participant code	Race	Gender	Marital status	Age	Number of children
P001	African	Female	Single	50	3
P002	African	Female	Married	33	2
P003	African	Female	Divorcee	43	2
P004	African	Female	Married	34	2
P005	African	Female	Single	32	1
P006	African	Female	Married	37	2
P007	African	Female	Single	31	2
P008	African	Female	Divorcee	34	3
P009	African	Female	Single	34	2
P0010	White	Female	Single	40	4

age range was informed by previous research indicating that parents with children under the age of 5 generally report higher self-esteem, greater confidence in their parenting abilities, and a stronger bond with their children (Wang et al., 2016). They also tend to experience fewer symptoms of depression compared to parents of school-age children or adolescents (Wang et al., 2016). Consequently, younger mothers in their twenties may have less to share regarding parental challenges, as they are more likely to be parenting children under the age of 7. In contrast, older mothers, particularly those over 30, are more likely to have school-age or adolescent children, allowing them to provide a more comprehensive perspective on their parenting experiences (see Table 1).

Procedure and data collection

Before data collection commenced, the study received ethical clearance from the Faculty of Humanities Research Ethics Committee at the University of Pretoria, followed by gatekeeper permission from Tutela Family Care in Secunda, which facilitated participant recruitment and research at their facilities.

Before data collection commenced, participants were informed about the study. Information about the study was discussed with the participants, together with an information letter and consent form. The information letter and consent form were made available in plain language. Participants also had the opportunity to ask the researcher any questions they might have. In addition, participants were provided with the contact details of an independent clinical psychologist should they feel discomfort at any point in the study or if they needed to speak to someone. The services provided by the clinical psychologist were free of charge to all the participants. Data were collected through semi-structured individual interviews. In the initial phase, the CTQ was used solely as an eligibility screening tool, not as a data collection instrument. The CTQ is a self-report questionnaire designed to screen for a history of complex childhood trauma among mothers. The moderate-to-severe exposure cut-off scores for each type of childhood trauma were: $\geqslant$13 for emotional abuse; $\geqslant$10 for physical abuse; $\geqslant$8 for sexual abuse; $\geqslant$15 for emotional neglect; and $\geqslant$10 for physical neglect. The CTQ were administered by the researcher, and the independent clinical psychologist was available if any participant needed containment or experienced discomfort during the screening.

The data collection process included eight face-to-face and two telephonic semi-structured interviews, allowing participants to share their lived experiences in depth. The interviews, conducted at times convenient for participants, took place in a private and quiet setting to ensure

privacy. The eight face-to-face interviews took place at the Tutela Centre, in a private room, as participants viewed this as a safe space for them. Each interview lasted approximately 60 min. The initial sample included 15 participants; however, five withdrew from the study – three due to discomfort with signing the consent forms and two due to work commitments – resulting in a final sample of 10 participants. The three participants who withdrew from the study were concerned about who would have access to the data. It was explained to the participants that only the researchers on the project would have access to the data. Due to the nature of the study, participants were allowed to withdraw without any further questions. They were also provided with the contact details of the independent clinical psychologist if any discomfort was caused or if they needed to speak to someone.

The interview questions were carefully designed to align with the study's research question, ensuring their relevance in achieving the study's objectives. The semi-structured format also allowed the researcher to probe deeper and ask follow-up questions, facilitating a richer understanding of the mothers' lived parenting experiences. Some of the questions included 'What is your understanding of trauma?' and 'How would you describe yourself as a parent?'.

The interviews were conducted by the first author (S.A.S.), a female researcher with an educational background in psychology, holding an honours degree. At the time of the study, she was employed as a senior research technician and was a master's candidate with 3 years of research experience. No prior relationships had been established between the researcher and the participants.

Interviews were recorded using a password-protected device, ensuring that only the researcher had access to the audio files. These recordings were essential to the study, serving as cues to participants' emotional states and thought processes during the interviews, thereby enhancing the depth of understanding of the phenomenon under investigation (Willig, 2013).

During the interviews, the researcher maintained a journal and took notes, which were later used for debriefing with the second researcher to reflect on developing themes, interpretations, and the point at which data saturation was reached. No repeated interviews were conducted with participants.

Data analysis

This study employed Interpretative Phenomenological Analysis (IPA) to explore and describe participants' lived experiences. Interviews were conducted in English, isiZulu, and Sesotho. For interviews conducted in isiZulu and Sesotho, translations into English were performed by the first author, who is fluent in all three languages. The translations were carefully reviewed for accuracy by both the first and second authors. In addition, the first author transcribed all interviews verbatim, ensuring an accurate conversion of spoken words into written text.

Data analysis followed the structured six-stage process commonly used in IPA, as outlined by Smith et al. (2008): (1) reading and re-reading the transcripts, (2) initial noting, (3) developing emergent themes, (4) searching for connections across emergent themes, (5) moving to the next stage, and (6) looking for patterns across cases.

The analysis was conducted independently by two researchers (S.A.S. and E.L.D.). The first author (S.A.S.), a research technician with a master's degree in psychology, analysed all transcripts, while the second author (E.L.D.), an associate professor with expertise in qualitative data analysis, psychology, and public health, assisted with analysing a portion of the transcripts. The comparison of their analyses resulted in a high level of agreement, indicating a strong intercoder reliability.

The researchers discussed and refined the identified codes and themes. However, transcripts were not returned to participants for comments, and participants did not provide feedback on the study's findings. Despite this, the findings remained consistent with the data collected.

Ethical considerations

Ethical approval was obtained from the University of Pretoria's Faculty of Humanities Ethics Committee (Reference: HUM016/0823), and gatekeeper permission was granted by Tutela Family Care. The study was conducted in accordance with the principles outlined in the Declaration of Helsinki. The following ethical principles were upheld throughout the study: anonymity, respect for dignity, informed consent, non-maleficence, beneficence, and justice. Before participating in the study, all participants were informed about the study in a language that they understood and were given the opportunity to ask the researcher any questions they might have throughout the study. All participants agreed to participate in the study, freely and voluntarily, and provided written informed consent. To further ensure anonymity, participant names were removed from all transcripts and replaced with participant codes. No adverse events were reported, and no participant required counselling services. Counselling services were available for all participants should they experience any distress due to participating in the study.

Scientific rigour

The scientific rigour of this study was ensured through several strategies: (1) *Credibility* was established by engaging with various literature sources to develop a comprehensive understanding of key concepts and their interconnections (Nowell et al., 2017). In addition, 40% of the interviews were analysed by a second coder to enhance inter-coder reliability. The codes and themes generated by both the first and second authors were compared and discussed to ensure consistency and accuracy. (2) *Transferability* was enhanced by providing thorough descriptions of the research context, outlining underlying assumptions, and approaching all aspects of the study with empathy and sensitivity to ensure applicability to similar settings (Korstjens & Moser, 2017). (3) *Dependability* was maintained by keeping a comprehensive audit trail documenting the entire research process. This record ensures transparency and is available to other researchers to support the replication or application of this study in future research endeavours. (4) *Reflexivity* was upheld through regular meetings where researchers reflected on the data collection process, discussed emerging insights, and maintained field notes and a research journal to document observations and reflections throughout the study.

Findings

In exploring the lived experiences of biological mothers parenting with a history of complex trauma in the Govan Mbeki Local Municipality, the data tell the story of how parents prioritise the well-being of their children, while neglecting their own needs, and that their experiences of complex trauma result in them wanting to protect their children from potential traumas, which results in overprotective parenting. This story is reflected in the following themes:

Theme 1: parents prioritising their children's well-being over their own

The mothers who had a history of complex trauma often made reference to prioritising the well-being of their children above their own, which often resulted in them neglecting themselves and

their basic needs. These sentiments shared by participants are illustrated by the following excerpts from two participants:

> It [referring to parenting] is very difficult. I never neglected them [referring to the participant's children] because I neglected myself as I never had time for myself, [or] self-care (Mother of 3, Age 50, Black, P001)

> Parenting is being present more than anything; it is no longer about me but about them [referring to the participant's children]. Everything else is like put on pause, it's them first, then me afterwards (Mother of 2, Age 31, Black, P004)

These excerpts provide some insight into the stories shared by the mothers. Often, they viewed parenting as being present constantly and prioritising the well-being and needs of their children above their own. This led to mothers neglecting their own needs and not even finding time for 'self-care' as one participant described. One participant went on to further explain that their children have a much better experience of growing up because they have neglected themselves, this was evidenced when she said: 'Their [referring to the participant's children] childhood is a bit better than my childhood because when they were born, I decided to put them first and neglected myself' (Mother of 3, Age 50, Black, P001). Even though the mothers have prioritised the well-being of their children, it can often be seen in their parenting.

Theme 2: protective intentions give rise to overprotective parenting

The mothers have the best interests of their children at heart, which is seen both in their prioritising of their children and in how they parent. Often, the mothers' parenting is informed by their fear that their children might experience the abuse and traumas that they did when growing up. How this translates into their parenting is the displays of parenting that can be considered overprotective. The overprotective parenting is not only informed by their own experiences of complex traumas but also by being aware of the social environment that they are in, where, in a country like South Africa, with high rates of crime and violence, there is a need to be overprotective as a safety mechanism to protect their children from potential trauma. Throughout the conversations with the mothers, they shared how they made use of overprotective parenting approaches in an attempt to safeguard against potential traumas. Here are some snippets of the conversations illustrating this:

> I just think I'm a bit over the top [a colloquial expression for being overprotective] because I don't want them to go through it [it refers to childhood traumas experienced by the participant growing up]. (Mother of 2, Age 33, Black, P002)

> It is difficult [to be] parenting. It [referring to parenting] is discipline, it is more discipline. (Mother of 2, Age 43, Black, P003)

The stories shared by the participants also highlighted how being overprotective often meant that it restricted their children's experiences while growing up, that 'took away their joy' as discussed by one mother:

> What makes it [referring to parenting] difficult is because of the way that I grew up. It [referring to the experiences of abuse that resulted in the complex trauma] made me become overly protective towards the kids; they were no longer free around me. My overly protective nature ended up taking away their joy or happiness and their freedom . . . So I blocked them from doing a lot of things, always protective – even on things that I am not supposed to be protective on (Mother of 3, Age 50, Black, P001)

For many of the mothers, they weren't sure whether the way in which they parented was harsh or overprotective. Even though participants used harsh and strict labels to describe their parenting, it can be categorised as being overprotective. Overprotective, because these behaviours were often a mechanism of ensuring that they are protecting their children from experiencing potential traumas like they did while growing up. Here, one participant details this experience:

> He [referring to the participant's partner] knows that, naturally, I am harsh; he sees me when I discipline and shout at my younger brother because my mother is too soft. I am trying to prevent harmful things. (Mother of 2, Age 31, Black, P007)

Another participant reflects on how being overprotective or harsh in her parenting was a way of protecting against potential traumas, but specifically how she would still care about her daughter and go back to her afterwards:

> I think I'm too harsh towards her [referring to the participant's daughter] but on the other side, I would try to come back to her after being harsh to her . . . realising that I shouted at her because I was stressed by other things, I am too harsh, and I know it. (Mother of 2, Age 32, Black, P005)

The reflections and conversations with the mothers highlight how their past experiences of abuse and trauma inform their current parenting approaches, which can be viewed as being overprotective. The overprotective parenting is often an attempt to protect their children from potential trauma, which is not only informed by their own experiences but also the lived realities of high levels of violence and crime in South Africa, which has not been explicitly explored in the study but has been covertly alluded to in the conversations.

Discussion

Complex trauma can be defined as when a person has experienced a traumatic event, in the form of abuse, which is chronic, interpersonal, and begins in childhood (Wamser-Nanney & Vandenberg, 2013). In South Africa, evidence suggests a 75% prevalence rate of past trauma and 43.8% of multiple traumatic events (van Zyl et al., 2017). Many who experience the impacts of complex trauma remain those who are most vulnerable in society, such as women and children. In an attempt to explore the lived experiences of women, specifically biological mothers, who have a history of complex trauma in the Govan Mbeki Local Municipality, and how it shapes their parenting. Our data tell the story of how biological mothers prioritise the well-being of their children, while neglecting their own needs, and that their experiences of complex trauma result in them wanting to protect their children from potential traumas, which results in overprotective parenting.

Literature suggests that the experiences of parents who have a history of trauma are likely to experience parenting differently than those without (Siverns & Morgan, 2019; Zvara et al., 2015), but it is important to note that parenting in itself is complex. Parents who have a history of trauma often find it challenging to set developmentally appropriate expectations, offer praise, and experience heightened anxiety in areas related to intimate aspects of caregiving (Douglas, 2000; Fujiwara et al., 2012; Kim et al., 2010; Siverns & Morgan, 2019). In the current study, the data tell the story of how mothers with a history of complex trauma often prioritise the well-being of their children while neglecting their own needs. The experiences of biological mothers parenting in the current study can be explained using the 'developing a mothering self' framework outlined by O'Dougherty Wright et al. (2012).

Using the framework of O'Dougherty Wright et al. (2012), it could be suggested that the mothers in the current study find themselves in the *Survivor Mother* phase. The *Survivor Mother* phase

sees mothers' personal identification of themselves as survivors of complex trauma as being very salient; however, there is a greater awareness and attention being placed on the well-being and needs of their children and not their own (O'Dougherty Wright et al., 2012). It is clear that the mothers in the current study find themselves in the *Survivor Mother* phase, as there is greater prioritising of the well-being and needs of their children while neglecting themselves. The next phase of the framework, called *Self Mother*, is when mothers are able to demonstrate a greater understanding and acceptance of who they are and their limitations (O'Dougherty Wright et al., 2012). This acceptance is coupled with protecting and nurturing both herself and her children. Using the story woven together in the data, it can be seen that mothers who have experienced complex trauma need to work through all the phases of the framework to be able to both prioritise her own needs and those of her children. This becomes important when reflecting on interventions for mothers who have experienced complex trauma.

Being able to acknowledge that mothers within the current study find themselves within the *Survivor Mother* phase, where a greater emphasis is placed on being there for their children, provides insights into the story that the data tell us about how protecting children against possible cycles of abuse or trauma informs reasons why parents tend to employ overprotective parenting, as seen in the data. The fear that their children might experience trauma results in their overprotective parenting approach, which is synonymous with this phase. Although O'Dougherty Wright et al. (2012) alluded to parenting, which could be on a continuum of under- to overprotectiveness, the stories from the current study suggest how mothers being there for their children could also be seen through an overprotective parenting approach employed.

A study exploring the parenting practices among women affected by intimate partner violence, HIV, and poor mental health in South Africa found that women who had a history of childhood trauma, or even complex trauma as in the current study, often employed overprotective parenting (Silima et al., 2024). Even though the current study did not explicitly explore the influence of co-occurring experiences, such as socioeconomic factors, HIV, and mental health, it might shape experiences of parenting. Similarly to the stories shared in the current study, where mothers' fear that their children might experience harm or trauma resulted in overprotective parenting. This finding was also reported by Silima and colleagues (2024), who noted that parents employed restrictive measures to protect their children. Other studies have shared similar findings, where mothers who experienced childhood sexual abuse were likely to make use of overprotective parenting as a mechanism to protect their children from experiencing what they did (Douglas, 2000; O'Dougherty Wright et al., 2012). A review of mothers who have experienced childhood sexual abuse found that mothers in 29 studies reported overprotective parenting (Lange et al., 2020). It is important to note that even though these studies have examined singular forms of abuse or trauma, the impacts of complex trauma could be even further exacerbated due to the chronic and interpersonal experiences of the trauma from childhood, which mothers in the current study have shared. Douglas (2000) provides some insight into the experiences of complex trauma and parenting by alluding to mothers being hypervigilant to potential traumas, which resulted in the overprotective parenting that could be seen as excessively cautious and protective of their children.

Implications for society, practice, and research

The findings of the current study have important implications for society, practice, and research.

Society. The most vulnerable in society, namely women and children, face multiple forms of abuse, which result in complex trauma when considering that societies are marked by systemic violence, historical oppression, and socioeconomic precarity in South Africa. The abuse and trauma

experienced can be addressed through community-based approaches to address gender norms, where abuse which perpetuates complex trauma stems from. In addition, involving communities in social learning interventions, which outline observation, modelling, and interaction to acquire ways of addressing intergenerational transmission of violence and trauma.

Practice. Understanding and addressing singular forms of abuse and trauma through interventions have been widely discussed within the literature; however, a lack of understanding of intervention design for mothers who experience complex trauma exists. It is recommended to use the *developing a mothering self* framework as a starting point for intervention design, which could consider:

- Addressing the poor mental health outcomes of mothers who experience complex trauma.
- Provide psychoeducation on the psychological impacts of complex trauma on mothers and their children.
- Educate mothers about the complexities and intricacies of navigating parenting within the context of complex trauma.
- Allow for roleplaying and skill development of mothers who have experienced complex trauma to improve their parenting that is more developmentally appropriate, considers limit settings and discipline that is not overprotective in nature, and fosters appropriate parenting practices and behaviours that drive adaptive outcomes for both mothers and their children.
- Consider addressing the importance, for both mothers who have experienced complex trauma and their children, of prioritising their needs and self-care to develop healthy relationships and a sense of self.
- Awareness of appropriate forms of attachment, behaviours, and communication in parent–child relationships where a history of complex trauma exists.

In addition to the recommendations, it is important to realise the unique social and structural factors within settings to ensure that interventions are contextually relevant and address the needs of those for whom the interventions are targeted.

Research. The current study provides a small attempt to understand the complexities of parenting among mothers who have experienced complex trauma. Further research is needed to advance the field of complex trauma, which could be addressed through a larger, mixed-methods design. In addition, a gap still remains in research that should also consider the potential influence of co-occurring experiences, such as crime, mental health, and other social determinants, on the dynamic between complex trauma and parenting, as well as the impact of complex trauma on the parenting of fathers.

Limitations

While this study provides unique and valuable insights, the current study has some limitations worth noting. First, the study only included a single municipality, excluding insights from a broader sample. Second, the participant sample included only Black and White mothers, restricting cultural representation. Third, the study focused on mothers aged 30–50 years, excluding younger mothers who might have had different experiences. Fourth, while the study employed qualitative methods, it did not include mothers who did not experience complex trauma to be able to examine similarities and differences across the two groups. Fifth, the study didn't explore the role of co-occurring experiences, such as community violence, substance use and other determinants on parenting. Finally, the study did not consider biological fathers with trauma histories.

Conclusion

Examining the parenting experiences of biological mothers with a history of complex trauma tells the story of how mothers prioritise the well-being of their children while neglecting their own needs. In addition, mothers also feared that their children would experience harm or trauma, which resulted in overprotective parenting. The *developing a mothering self* framework provided a lens through which to understand the experiences of parenting by mothers with a history of complex trauma. The findings provide important implications for society, practice, and research.

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ORCID iDs

Sekelo Atalia Shube https://orcid.org/0000-0002-2279-8362
Eugene Lee Davids https://orcid.org/0000-0002-3805-3904

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Data availability statement

The data supporting this study are not publicly available but may be made accessible upon reasonable request to the authors, in accordance with the University of Pretoria's data sharing policy.

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