

Birth Parents with Trauma Histories and the Child Welfare System

A Guide for Mental Health Professionals

CARLOS' STORY

Carlos is a licensed psychologist who has provided individual therapy for a six-year-old girl named Crystal for the past two months. Crystal was referred for therapy by her child welfare worker, Linda, after being removed from her mother's care; in addition to being physically abused, the worker said Crystal witnessed domestic violence in the home. Crystal's foster parents continue to bring her to therapy and report that she is very aggressive and has trouble focusing on her school work.

Carlos reached Crystal's biological mother, Karen, by phone and invited her to his office to discuss Crystal. She missed the appointment, stating she had overslept. He set up a second appointment, which she attended but arrived late. Karen denied any concerns about Crystal's behavior and was vague when Carlos asked why her children were removed. Karen expressed wanting her children back, so they wouldn't have to go through what she went through as a child. When Carlos asked her to elaborate, she changed the subject. She said she has attended every scheduled visit with her children and looks forward to these visits, but added that it is difficult to say goodbye, and that she does not know what to do when Crystal asks her questions about coming home. Carlos explained that everyone would need to work together for the family to be reunified.

Crystal often cries in session because she misses her mommy. Carlos has left several messages asking for Karen to become more involved in Crystal's treatment, but does not always hear back in time for the next session. While Karen seems to care about her children, Carlos is frustrated that he has not been able to engage her in her daughter's treatment and is worried about how this could affect decision-making about Crystal returning to her mother's custody. Carlos recalls Karen's comments about her own history of trauma and wonders if that is affecting her communication with him.

Just as many children in the child welfare system have experienced different types of trauma¹, many birth parents involved with the child welfare system have their own histories of child and/or adult trauma. Traumatic stress in childhood can impact adult life, affecting a parent's ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability. Parents' past or present experiences of trauma can also affect their ability to keep their children safe, work effectively with child welfare staff, and engage in their own or their children's mental health treatment. Whether you are a mental health professional for the child, parent, or family, in order to provide effective services, you will need to understand the birth parents' trauma history²

¹ In this fact sheet, trauma refers to events outside the typical range of human experience—that is, events involving actual or threatened risk to the life or physical integrity of individuals or someone close to them.

² Although the focus of this fact sheet is birth parents, we acknowledge that other adults—including non-parent partners, grandparents, and step-parents—may also have histories of traumatic experiences and could benefit from trauma-informed mental health services.

How can trauma affect parents?

While trauma does not affect every parent in the same way, and not all parents will develop posttraumatic reactions after a traumatic event, a history of traumatic experiences may:

- Compromise parents' ability to appraise danger, resulting in:
 - Difficulty making appropriate judgments about their own and their child's safety,
 - Overprotection, and/or
 - Failing to notice situations that could be dangerous for the child.
- Result in trauma reminders (sights, sounds, situations, or feelings that remind them of the traumatic event) to which parents may have extreme reactions. Children's behavior can remind parents of their own past trauma experiences, sometimes triggering inappropriate or unhelpful behaviors toward their children. In order to avoid trauma reminders, parents may disengage, making relating to their children more difficult.
- Make it challenging for parents to form and maintain secure and trusting relationships, including those with their children. Parents may personalize their child's negative behavior or have negative feelings about parenting, leading to ineffective or inappropriate discipline.
- Negatively affect parents' feelings and behavior toward caseworkers, resource parents, and service providers—particularly when they experience or re-experience a loss of control. This can also interfere with their involvement in the children's therapy.
- Impair parents' capacity to regulate their emotions, leading to ineffective coping strategies, such as abusing substances.
- Lead to poor self-esteem and a negative view of themselves as parents, contributing to unhealthy interpersonal relationships.
- Impair parents' executive functioning, resulting in poor decision-making, problem-solving, or planning.
- Make the parent more vulnerable to other life stressors, including poverty, lack of education, and inadequate social support that can increase trauma reactions.

Mental health providers working with families involved in the child welfare system have an opportunity to help birth parents recover from their experiences of trauma. Viewing birth parents through a “trauma lens” helps mental health professionals see how traumatic experiences have influenced their perceptions, feelings and behaviors and assists the therapist and the parent in developing effective plans for changing course and moving forward.

How can mental health professionals use a trauma-informed approach when working with birth parents?

Whether your role is that of the parent provider, child provider, or family provider, there are certain things mental health professionals can do:

- Know that many parents involved in the child welfare system have their own trauma histories. You will be more successful in engaging them in treatment (their children's or their own) if you first establish a sense of safety, trust, personal choice, collaboration, and hope for reaching their goals.³

³ Harris, M. & Fallot, R. (Eds.) (2001). *Using Trauma Theory to Design Services Systems. New Directions for Mental Health Services* (89). San Francisco: Jossey-Bass.

- Keep in mind that parents may be reminded of their trauma histories by their children’s traumatic experiences or behavior, or by a traumatic event they went through with their children. Watch for signs of a parent appearing numb, disengaged, or angry, and consider whether interactions with the child welfare and/or mental health system could be serving as reminders for that parent.

- Identify opportunities for the child and parent to use their strengths and develop skills to make sense of—and achieve mastery over—their traumatic experiences. Help channel parents’ desires to be effective and supportive of their children.

- Empower parents to participate in meetings and to play a role in choosing services and goals. With appropriate help, parents will feel more supported by the child welfare system and, in turn, will be more able to support their children.

- Provide psychoeducation about the impact of trauma on both parents and children. By talking about how trauma can affect parents and their children generally, clinicians can start a conversation and begin to promote safety, trust, and collaboration. For many parents, hearing a professional say that there is a connection between their traumatic events and their present reactions can empower and motivate them to make positive changes.

When working directly with parents, assess for co-morbid conditions, such as depression, substance abuse, anxiety, and dissociation. Substance use—which may be a way the parent copes with posttraumatic symptoms—can heighten trauma-related symptoms. When treating parents with trauma reactions and substance abuse problems, clinicians should treat the two problems in an integrated manner, rather than sequentially.⁴

What treatment resources are best for treating children and parents affected by trauma?

To optimize their ability to support their children’s recovery, some parents may need to work on their own trauma issues in individual therapy. Generic interventions that are not trauma-informed—such as anger management or parenting classes—will often be ineffective in addressing these needs. Fortunately, there are many evidenced-supported trauma interventions for both adults and children.⁵ Mental health professionals should choose interventions that address the needs of the family while taking into account clinical focus, level of intervention, phase of treatment, and co-occurring disorders. Many effective trauma treatments include the following components:

- Building a strong therapeutic relationship acknowledging family and individual strengths
- Psychoeducation about responses to trauma, including neurobiological (impact on the brain)
- Relational engagement and attachment
- Enhancing family and social supports
- Emotional expression and self-regulation skills
- Cognitive processing or reframing

⁴ Najavitz, Lisa M., *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. Guilford Press, 2002.

⁵ For information on adult trauma treatments and interventions, go to: National Center for PTSD at <http://www.ptsd.va.gov>; Sidran Institute at <http://www.sidran.org>; California Evidence-based Clearinghouse for Child Welfare at <http://www.cebc4cw.org>; National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov>; and National Traumatic Stress Network at <http://www.nctsn.org> For help locating local adult trauma services, contact area rape crisis centers, domestic violence shelters, or Red Cross chapters.

- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that the parent can master and integrate them into his or her experience
- Personal safety training and other important empowerment activities
- Resilience-building and closure⁶

When both the parent and child are in individual treatment, coordination among clinicians and child welfare staff is critical. Clinicians can also provide helpful guidance to child welfare staff about how trauma can affect safe parenting and the benefits of trauma-informed mental health treatment. Good, evidence-based trauma interventions for children and adults are becoming increasingly available, as is training for clinicians working on a daily basis with people affected by trauma.

How can clinicians protect themselves from secondary traumatic stress?

Working with families involved in the child welfare system can be both challenging and rewarding. It can be difficult to empathize with parents who have maltreated or failed to protect their children and who also struggle with trauma symptoms that manifest as anger, avoidance, or resistance. Clinicians should be prepared for the personal and professional stress associated with working with trauma survivors, and mental health agencies should provide the support necessary to help clinicians manage and mitigate their own traumatic stress reactions.

When clinicians encounter challenging or frustrating situations, it helps to maintain an awareness of family resilience, as well as trauma. Just as vicarious exposure to trauma can lead to secondary stress in service providers,⁷ a strengths-based approach that recognizes resilience and support within families may have positive, secondary outcomes for providers, enhancing how they understand, manage, and find meaning in their work.

This fact sheet is one in a series of factsheets discussing parent trauma in the child welfare system. To view others, go to <http://www.nctsn.org/resources/topics/child-welfare-system>

⁶ Child Welfare Collaborative Group, National Child Traumatic Stress Network & California Social Work Education Center. (2008). *Child Welfare trauma training toolkit. Trainer's guide (1st ed.)*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

⁷ *Secondary or vicarious traumatic stress (also called compassion fatigue) describes trauma reactions in helping professionals following extensive exposure to clients' retelling of their trauma experiences.*