

UNRESOLVED TRAUMA IN PARENTS AND ITS IMPLICATIONS IN TERMS OF CHILD PROTECTION:

Introduction:

Many parents who come into contact with social workers may themselves have experienced significant trauma and loss during their own childhood. It is common for social workers to be assessing parents who themselves were sexually abused as children, treated violently or neglected. In addition, many such parents have themselves grown up within the care system with all the loss and disruption that this may imply.

This guide will explore unresolved loss and trauma in parents in relation to child protection issues. It will examine the implications, assessment and treatment of such issues.

Definitions of trauma:

Attachment theorists are now talking about 'big T' trauma and 'small t' trauma. 'Big T' trauma includes experiences of death, violence, sexual abuse, rape etc. 'Small t' trauma includes neglect or having a depressed or chronically misattuned primary carer. The effects of 'small t' trauma are often cumulative with repetitive, sustained emotional abuse over time. It is now being recognised that neglect has a potentially devastating effect on all aspects of a child's development. Both Score and van der Kolk argue that neglect may be more damaging for a child's emotional development than abuse alone (Schore, 2003, van der Kolk, 2003). It becomes important, therefore, to realise that just because someone has not experienced significant, 'big T' trauma in their childhood it does not mean that they have not been deeply traumatised by their early life experiences.

Unresolved loss and trauma:

Attachment theory argues that it is not trauma per se that is important in terms of parenting ability but whether there has been any resolution of the trauma. The research 'strongly suggests that the processing, working through and integration of childhood experiences is the relevant variable in a parent's ability to be a safe haven to his or her children' (Cozolino, 2002, p.206). This 'earned autonomy', through a parent's own healing of childhood wounds, appears to be able to interrupt the transmission of negative attachment patterns from one generation to the next. Thus, a traumatic childhood in itself is not predictive of maltreatment of children: what is predictive is if the adult has not been able to come to terms with their traumatic experiences.

Implications of unresolved loss and trauma:

There are a number of implications of unresolved trauma:

- Unresolved trauma is linked with the concept of the meaning of the child. Reder and Duncan introduced this important idea to describe those children who may be at greater risk because they carry a particular psychological meaning for the parents. As one example, they refer to 'replacement children', who are conceived after the

death of a previous, usually unmourned child. The replacement child may then be placed in the impossible role of substitute for the dead sibling. The child may in time come to be punished for failing to fulfil the impossible assigned task (Reder and Duncan, 1995). Where a parent remains unresolved in relation to a loss or trauma there is an increased likelihood that their child will have a particular psychological meaning for the parent, which could be damaging or destructive for the child.

- Lack of resolution of trauma is likely to lead to a narrative re-enactment of the trauma in which the person unconsciously recreates the traumatic event over and over again. Where psychoanalysis talks of the repetition compulsion, attachment therapists refer to the narrative re-enactment of the trauma. This is often most evident in the choice of the partner. If a woman has experienced violence in her childhood and has not come to terms with the experience, she may unconsciously 'choose' partners who are violent to her and treat her in a similar way, in this way re-enacting the trauma. Similarly, maltreated children placed with foster or adoptive parents may seek to re-enact the traumatic events in relation to the substitute carers.
- Addictions are closely linked with unresolved trauma. Substance misuse has been defined as self medication against emotional distress (Newcomb, 1995). There is a strong correlation between Post Traumatic Stress Disorder and substance abuse (van der Kolk, 2003). Where an individual has experienced significant trauma and has not resolved the feelings, there will always be the possibility that the person will use substances as a way of trying to block out the pain and distress. The significance of substance abuse as a risk factor within child protection is well recognised within the social work literature (Reder and Duncan, 2003).
- Unresolved trauma leads to an increased likelihood that the parent will treat their own child in the same way they themselves were treated. If a person has been treated cruelly and sadistically in their own childhood and has not resolved their feelings about this, there is an increased likelihood that they will then repeat this pattern of parenting with their own children. This links with the defence of identification with the aggressor in which the traumatised individual unconsciously protects themselves against feelings of fear and powerlessness by identifying with the abusive adult. This concept, which seems to be commoner in men than in women, provides some explanation for the continuing cycle of violence and is clearly of relevance in assessing risk of child abuse.
- In addition to identification, there is also likely to be 'retaliatory rage' against the traumatiser. If an individual has experienced significant trauma and has not come to terms with it, there will be an unconscious rage and wish to gain revenge over the perpetrator. A woman who has been sexually abused by her father in her childhood is likely to have considerable conscious or unconscious anger towards him. The younger the age at which the trauma occurred and the greater the severity of the trauma, the greater the likely degree of anger and rage. From a child protection perspective the danger is that the anger can then be displaced onto the child. For example, a mother who has experienced major trauma in relation to a man may be reminded of these experiences by her own son and then come to displace the anger onto the son.
- Dissociation is a common defence related to unresolved trauma. Parents who strongly dissociate are likely to neglect the emotional needs of their children and/or have difficulty in assessing risk in their partners.
- There is a strong correlation between unresolved loss and trauma and disorganised attachment in children. 'Unresolved' parents tend to have children whose behaviour

is disorganised. There has been a significant body of research to demonstrate that children with a disorganised attachment pattern often have a parent with an Adult Attachment Interview classification of unresolved in relation to loss and trauma. Disorganised attachment patterns in childhood are a significant risk factor for the development of emotional and mental health problems in adulthood.

- Finally, children who experience severe trauma are likely to develop a deep sense of shame about themselves. From an attachment perspective it is dangerous for the child to think of their parents – on whom the child is totally dependent - as being ‘bad’ or threatening. It is much safer for the child to protect the image of the parent and instead think of himself as being ‘bad’. The child comes to internalise a sense of himself as being ‘bad’ and consequently feels full of shame about himself. Unless the child gains some resolution of this he will then grow up as an adult with a deep sense of shame. The risk in child protection terms is that a child may unwittingly trigger the rage that may lie behind a parent’s sense of shame.

Putting all these factors together, it is clear that unresolved trauma in parents constitutes a major risk factor for their children in terms of violence, abuse and neglect. Shapiro and Maxwell sum this up by stating that ‘people who are hurting are likely to hurt others, whether deliberately or unintentionally’ (Shapiro and Maxwell, 2003, p.216).

Children can, and often do, trigger unresolved issues in their carers. For instance, the birth of a child, a baby crying, issues around toileting etc. can all trigger unresolved trauma in the parent and the consequent negative affect. In particular, it seems as though whenever the ‘unresolved’ parent finds themselves in a relationship in which the child appears vulnerable or in a state of need, old unresolved feelings of fear, anger, distress or abandonment can be unconsciously activated. Crucially, the child’s expression of attachment needs triggers the parent’s unresolved feelings about their own childhood experiences. Similarly, a child may trigger a parent’s sense of shame and failure about themselves and consequently be punished for re-evoking such feelings.

The Role of the Social Worker:

Section 47 of the Children Act, 1989 requires local authorities to investigate if it is thought that a child is suffering, or is likely to suffer, significant harm. This is reinforced in ‘Every Child Matters’ in which ensuring safety for children is one of the key outcomes. I believe that an important part of any parenting assessment should be an exploration of any losses or traumas that the parent may have experienced. This should be addressed within the core assessments that social workers undertake.

The social worker should begin by identifying any losses or traumas that the parent has experienced in their life. This necessitates taking a detailed history of the individual. Examples of losses and traumas would include the death of a parent; abandonment by a parent; severe neglect; sexual or physical abuse by a parent or stranger. In adult life it could include miscarriage, terminations, domestic violence or the death of a child. In some cases much of the person’s childhood history may be already known (for instance, if the person has a history of being in care); other times it will not be known and will only become apparent during the course of the assessment.

Assessing whether a trauma is resolved:

Because unresolved trauma is such a significant risk factor within child protection it becomes important that social workers should be skilled in assessing whether an individual has come to terms with any traumatic experiences.

The Adult Attachment Interview (AAI) (Main and Goldwyn, 1998) has a sophisticated method for assessing whether an individual has come to terms with any traumatic experiences in his life. The AAI consists of a series of open ended questions about childhood relationships and early life experiences. It reflects how the person has come to make sense of their lives, put feelings into words, resolved traumatic experiences and integrated the various networks of information processing across emotion, sensation and behaviour in conscious awareness. Lack of resolution is scored on the AAI when an individual displays disorganisation and disorientation in reasoning or discourse. An example of disorientation or disorganisation may include an individual referring to a dead person as if they were still alive or becoming confused and disorientated when discussing fearful experiences with a parent. Distress when discussing a loss or trauma would not in itself be indicative of an unresolved state of mind (although preoccupation and repeated distress would be).

However, it is also possible to assess for unresolved loss and trauma without the use of the AAI. It is important that social workers ask explicitly if the parent has experienced any particularly painful or traumatic experiences in their lives. This would include a detailed exploration of the person's childhood experiences and relationships with their own parents.

Two key areas for social workers to consider concern addictions and repetitive patterns of behaviour. If an individual demonstrates either of these it is strongly suggestive that he or she has some unresolved issue that is being masked by the addiction or by the repetitive behaviour.

As part of the assessment social workers should consider all the implications of unresolved trauma, as listed above. For instance, social workers should attempt to gain some understanding of the meaning of each child for the parents.

Hyperarousal and Dissociation:

There are two possible responses to trauma: either hyperarousal or dissociation. Traumatised individuals see and feel only their trauma, or they see and feel nothing at all; they are fixated on their trauma or they are psychically absent (Sykes Wylie, 2004). One is an emotional flooding, the other an emotional cutting off. Whilst hyperarousal is linked with an ambivalent attachment pattern, dissociation is linked with an avoidant attachment pattern.

Hyperarousal is suggested when an individual experiences flashbacks; repetitive dreams, including nightmares; intrusive thoughts and a preoccupation about an experience. The person becomes preoccupied with the traumatic event and relives it in a variety of different

ways. Individuals who are hyperaroused are vulnerable to using substances and developing addictions in an attempt to block out the unbearable feelings.

Dissociation is a common defence against trauma in which thoughts, feelings and memories that cause anxiety are either cut off from consciousness or from the associated affect. It is an internal flight when external escape is not possible. For instance, adults who were abused as children often talk about the way in which they emotionally removed themselves from the event and looked down from the ceiling as though the experience was happening to someone else.

Dissociation includes individuals who have no conscious memories about an event (dissociative amnesia) and individuals who retain the memory but without the associated affect. Parents who strongly dissociate can become so absorbed in their own internal state that they are unable to 'tune in' to the needs of their child, in this way becoming neglectful. In addition, people who dissociate often have problems in assessing risk in others, particularly in their choice of partners.

It is also important to note that hyperarousal and dissociation are not mutually exclusive. Some individuals can alternate between being emotionally flooded and emotionally cut off in relation to past traumatic events.

Questions:

A basic principle is that if you do not ask the question you will not get the answer. It is important that questions are asked explicitly. However, it is also important to acknowledge the pain and distress that traumatic events can evoke. I usually say something like: 'I know that this is a painful thing to talk about but I need to try to understand you and your life experiences as fully as possible'. The pace of the interview will then need to be guided by the person's emotional response. At the end of such a session I would usually ask how the person is feeling now and, if appropriate, ask how they will take care of themselves after the session.

It is important that social workers ask questions in their own words and in ways which feel right for them. The following questions are offered as guides and are not necessarily to be repeated literally.

As a note of caution, it should be noted that some people can become retraumatised by talking about a traumatic experience. If the parent displays considerable distress while discussing a traumatic event the social worker should consider stopping talking about the event and instead refer the person to a specialist from another discipline with expertise in complex trauma. People should not be pushed to talk about an event if it may retraumatise them.

General Questions:

'What effect do you think that your childhood experiences have had on you as an adult?'

'What effect do you think that the (traumatic event) has had on you?'

'How have all these experiences affected your ability to parent your children?'

Individuals who are prone to hyperarousal tend to exaggerate and dramatise the impact of their experiences. In contrast, people who dissociate tend to minimise and deny any problematic experiences.

Questions about hyperarousal:

‘How do you think that the (traumatic event) continues to impact on your life?’

‘If so, in what ways?’

‘Do you find yourself dreaming about the experience?’

‘Do you have nightmares?’

‘Do you find yourself having flashbacks about the experience?’

‘Do you find yourself having intrusive thoughts and remembering the experience?’

‘Do you ever find yourself avoiding certain places or experiences because of the traumatic event?’

If the individual answers yes to any of these questions it would then be important to explore the issue in much more detail; e.g. asking for more details about dreams or nightmares in terms of frequency, content and the impact on the person’s life.

Questions about dissociation:

‘What are your earliest memories?’

‘Can you give me three happy and three unhappy memories from your childhood?’

‘Do you have gaps in your memory of any periods of your life?’

‘Do you find yourself daydreaming or in a world of your own?’

‘Do you ever feel disconnected from your body, for instance, that it felt unusually large or small?’

Individuals who dissociate tend to have little memory of their childhood and find it hard to think about unhappy experiences. Another important factor is to listen out to the way in which the person tells their story: people who dissociate often talk about painful, traumatic events in a ‘flat’, emotionally cut off manner.

Resolution of Trauma:

Resolution of trauma is shown when a person can talk about a traumatic experience in a logical, coherent and understandable manner with an appropriate level of affect. Modern neuroscience is showing the way in which unresolved trauma can affect Broca’s area, the part of the brain related to speech (Cozolino, 2002). The expression ‘speechless terror’ reflects the way in which becoming mute is a common response to trauma. It is common in child protection work to come across parents who simply do not have the words to describe a traumatic experience. Incoherence, confusion and an inability to find words to describe the experience may all be indications of a lack of resolution of a traumatic event.

In addition, resolution is displayed when an individual is able to talk about an experience with an appropriate level of affect; this could be thought about as being a midway point between hyperarousal and dissociation. In other words, can a person talk about an event

without being either emotionally cut off from the experience or overwhelmed with emotion?

Finally, in terms of risk it is important to explore retaliatory rage. Questions such as 'Do you ever find yourself imagining getting revenge over the abuser?'; 'Do you ever find yourself behaving in the same way that he treated you?'; 'Does your child ever remind you of your abuser in any way?'. Making these ideas explicit can give permission to the parent to give voice to some of the shameful aspects of themselves.

Assessing the impact of unresolved loss or trauma:

There are four important points to consider in assessing the potential impact of loss and trauma:

- Trauma in relation to an attachment figure is likely to be more damaging than trauma in relation to a stranger;
- The earlier in a person's life the trauma occurred the greater the potential damage;
- The longer the trauma lasts the greater the potential damage;
- The more severe the trauma the greater the potential damage (Cozolino, 2002, Brewin, 2003).

Thus, recent research into incest victims has found that the closer the relationship between the child and the perpetrator the greater the subsequent behavioural and psychiatric problems (Putnam, 2005). Putnam comments that the earlier the age and the longer the duration of the abuse the greater the risk of subsequent psychopathology.

In contrast, security of attachment and stability in childhood act as protective factors in relation to adult trauma. The well nurtured individual is likely to be resilient in dealing with any adult traumas. 'Those who are nurtured best, survive best' (Cozolino, 2006, p.14).

Treatment issues:

Counselling or psychotherapy may well be appropriate for many parents who have unresolved traumatic issues. If a parent can gain some resolution of their childhood traumas, they are much more likely to be able to parent their children in a safe, protective manner, thereby becoming a safe haven for them. However, given the need to plan children's futures as soon as possible, there is an urgency about any therapeutic work: children cannot wait indefinitely for their parents to come to terms with their issues. For this reason psychoanalytic therapy, which has traditionally argued that change is a slow process which requires engagement over several years, may not always be the treatment of choice.

It is common for letters of instruction within care proceedings to ask whether the parent can make the necessary changes within timescales that are consistent with their child's needs. This requires the assessor to make a judgement about how long it will take for the parent to make the necessary changes. The four principles outlined above give some guidelines in terms of timescales: trauma at the hands of an attachment figure is likely to require therapy

over a longer period of time than abuse by a stranger. Similarly, early, prolonged, severe trauma will require longer treatment than later, shorter, less severe trauma. Single incident trauma in later life is likely to respond to therapy more quickly than complex, early, prolonged trauma.

The National Institute for Clinical Guidance recommends either trauma based cognitive behaviour therapy or Eye Movement Desensitization and Reprocessing (EMDR) as being the treatments of choice for PTSD and trauma in general (www.nice.org.uk/CG26/guidance). EMDR is now gaining increasing acceptance as being highly effective in working with traumatised people. EMDR is a therapeutic method that involves bilateral stimulation, often involving eye movements. It seems to be able to integrate left and right hemisphere functioning with the result that traumatic memories can be talked and thought about, rather than being endlessly relived. Emotional Freedom Technique (EFT) is also gaining a reputation for being able to work quickly and effectively with people experiencing unresolved trauma, addictions and phobias. EFT was devised by Gary Craig during the 1990's. It is based on acupuncture principles and involves tapping on certain acupressure points on the body whilst a particular thought is held in mind. EFT practitioners argue that stimulating specific points on the skin sends electrochemical signals directly to the brain. If at the same time the person thinks about a situation that triggers an unwanted emotional response tapping can alter the brain's response to the situation (Feinstein et al, 2005). Both EMDR and EFT can at times rapidly accelerate the pace of change and are challenging the idea that change is necessarily a long, slow process. EMDR and EFT also have the advantage that they are not purely verbally based so can work effectively with clients who are not articulate or who struggle to find words to describe their experiences. EFT also seems to be particularly helpful for people who become retraumatised whilst retelling their story because it does not require the person to verbalise the traumatic incident.

Further Reading:

www.traumacenter.org has many articles on trauma in relation to both children and adults.

Healing Trauma, Attachment, Mind, Body, and Brain, (2003) eds M. Solomon and D. Siegel, W.W. Norton and Co is a very helpful, if rather dense, account of current thinking about trauma.

L. Cozolino has written two books about the integration of neuroscience with psychotherapy, relationships and, by inference, social work: *The Neuroscience of Psychotherapy*, (2003) and *The Neuroscience of Human Relationships*, (2006) W.W. Norton and Co.

Francine Shapiro's book *Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols, and Procedures* (2001) The Guilford Press is the classic introduction to EMDR.

www.emofree.com has numerous articles about EFT and is a helpful place to start for anyone interested in EFT.

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