The Effects of Parental Experiences of Trauma on Attachment and Early Childhood Mental Health:

Applying Trauma-Informed Practice and Providing Wraparound Services

Erika Ono, *MSW RSW*

Social Worker, BC Children's Hospital

Infant Psychiatry and Neuropsychiatry

PhD student, UBC Social Work

Learning Objectives

- To better understand the impacts of trauma on parenting and attachment
- To better understand the connections between trauma and parenting with early childhood mental health
- To increase skills in applying trauma-informed practice and providing wraparound services specific to early childhood mental health and families

Note

- I would like to acknowledge that although the experiences of trauma and its impacts on mental wellbeing can affect parenting and infant/early childhood mental health, this is not the case for all parents with these experiences.

- It is important to acknowledge and nurture resilience and protective factors.

Gender Analysis

- I have used the term parental trauma as to be inclusive of all parents; however, current literature focuses mainly on mothers, and my professional experiences have involved more mothers than fathers.

- While it is important to be inclusive of experiences of parents of all genders, currently, much of the expectations from service-providers are placed on mothers.

Relevance to Working with Children

- The topic of parental trauma and children's mental health is important to address in the field of infant/early childhood services as a high proportion of children who exhibit mental health concerns, behavioural challenges, and relationship difficulties have parents with trauma and mental health issues.

- This is why it is a crucial issue to address in order to provide services that can decrease the "intergenerational transmission" (Schwerdtfeger, & Goff, 2007) of mental ill health and trauma.

Avoiding Blame and Pathologizing

- Of the parent(s) / caregiver(s)
- Of the child

Trauma

"Experiences that overwhelm an individual's capacity to cope"

- Single incident trauma
- Complex or repetitive trauma
- Developmental trauma
- Relational trauma
- Historical trauma
- Intergenerational trauma
- "Multigenerational trauma"

Parental Trauma and Mental Wellbeing

For parents with experiences (past, current, or both) of trauma, parenting can be an especially challenging role.

Both anecdotally and from research, self-reports from parents indicate that they feel a sense of helplessness with their difficulties in protecting their children.

Parental Trauma and Mental Wellbeing

Trauma responses can present similarly to depression and anxiety, and research has shown that children with depressed parents show more depressed affect and behaviour problems, as well as challenges with interactions and relationship-building.

Parental Trauma and Mental Wellbeing

Review of the literature on the impact of domestic violence on children concluded that a toddler's need for adults to provide structure because of their developmental inability to understand and control their own emotions may be difficult to meet by parents who are overwhelmed and depressed.

Parental Trauma and Mental Wellbeing

- Domestic violence literature discusses how the mental health effects of trauma and violence can include loss of self-esteem and decision-making ability, depression, anxiety, phobias, self-harm, somatisation and dissociative disorders for the victim/survivor.

- In a study by Abrahams (1994), 76% of women experiencing intimate partner violence reported that depression affected their parenting.

Effects on Parenting

- Research shows that parental trauma can directly compromise infant mental health.

- The negative impact on an infant's development and behaviours can also contribute to challenges for the caregiver in caring for or feeling bonded with the infant, so that the infant then finds the caregiver's availability less predictable.

Effects on Parenting

There is a strong relationship between parenting and children's mental health, especially in regards to externalizing behaviour. Parenting behaviour is a big factor in influencing child attachment styles, which is connected to children's emotional regulation and mental wellbeing.

Attachment

Attachment is where the child uses the primary caregiver as a secure base from which to explore and, when necessary, as a haven of safety and a source of comfort.

Attachment

- Four types of infant-parent attachment: secure, (insecure) anxious/avoidant, (insecure) anxious/resistant, and disorganized. (Some variations in terms.)

- Children with disorganized attachment often have parents with unresolved trauma or loss. This is not to imply that the parent is responsible for the trauma or any resultant attachment difficulties that are experienced.

Effects on Infant / Early Childhood Mental Health and Development

The literature on relational trauma shows that the co-occurrence of trauma symptoms in a parent and young child can occur when the parent's responses are not regulated, and therefore, increases the child's responses.

Effects on Infant / Early Childhood Mental Health and Development

- The parent's emotional regulation can either promote or inhibit their infant's abilities to self-regulate his/her own emotions.

- Infants with parents with trauma experiences may show symptoms of PTSD and other infant mental health issues.

Effects on Infant / Early Childhood Mental Health and Development

"The field of infant mental health specifically focuses upon social emotional development, and so more detailed psycho-neuro-biological understandings of attachment can generate a more overarching model of normal development of the human mind/brain/body at the earliest stage of the lifespan and, therefore, more precise definitions of adaptive infant mental health" (Schore, 2001, p. 203).

Trauma-Informed Practice

“Those that are not specifically designed to treat symptoms or syndrome related to sexual or physical abuse or other trauma, but they are informed about and sensitive to, trauma-related issues present in survivors. A trauma-informed system examines and evaluates its services in light of the role that trauma plays in the lives of people seeking mental health and substance use services. This understanding is then used to accommodate the vulnerabilities of trauma survivors and to deliver services in a way that will avoid inadvertent re-traumatization”

(Regan, 2010, p. 217).

Trauma-Informed Practice

- Trauma-informed practice and care acknowledges the need to foster healing instead of intensification and maintenance of symptoms.

- It is essential that professionals recognize the persistent effects of abuse experiences and understand the particular treatment sensitivities survivors may have.

Trauma-Informed Practice

- This is important to consider when working with parents with trauma histories in areas of early childhood intervention and infant/child mental health services.

- This is important in working with all children and families, as we do not know if experiences of trauma are present in their lives.

Trauma-Informed Practice

- It is important to draw attention to how caregiver-blaming (especially mother-blaming) – whether explicit or implicit, and even when unintentional.

- The protection of children from trauma and mental health issues more often than not falls on the shoulders of mothers.
- I.E. “Failure to protect”.

Trauma-Informed Practice

Trauma-informed practice is not only a way of providing services, but also a way of being.

Wraparound Services

Why are wraparound services important?

Delivery of services in BC to children and parents with experiences of trauma and/or mental health issues

- MCFD (Child protection/family services)
- CYMH
- CYSN
- Family preservation
- Parenting programs
- Hospitals / psychiatry (inpatient, outpatient)
- Children who witness abuse programs
- Early childhood intervention: IDP, SCD, etc.
- Schools

Services for adults (parents)

- Adult mental health services
- Private counselling
- Trauma therapy (i.e. Family Services of Greater Vancouver, anti-violence agencies such as BWSS)

Wraparound Approach to Services Delivery

- The wraparound process is an approach to service delivery that “is a collaborative, team-based approach to service and support planning”.
- (VanDenBerg, Bruns, & Burchard, 1996, p. 1)

- Dr. Lenore Behar of North Carolina first used the term wraparound in the early 1980’s to describe the application of an array of comprehensive community-based services to individual families.

Wraparound Services

A wraparound process can be described as one in which the team:

- Creates, implements, and monitors an individualized plan using a collaborative process driven by the perspective of the family
- Develops a plan that includes a mix of professional supports, natural supports, and community members
- Bases the plan on the strengths and culture of the child and their family
- Ensures that the process is driven by the needs of the family

Wraparound Services

The wraparound approach is especially beneficial for family with multi-system needs.

This involves elements also present in the systems of care approach, which places a special emphasis on linkages between agencies.

The wraparound approach requires system collaboration and integrated services.

Wraparound Services

- This approach conducts a process of strengths-based assessment, incudes a treatment team consisting of multi-agency and interagency staff, family members, any other support persons, and the family receives some form of case management.
- Research shows that most problems that arise in the wraparound process are clearly related to professionals, administrators, and parents not agreeing on a consistent approach, rather than to the level of complexity of the need of the child and family.

Wraparound services and trauma-informed practice

- The wraparound approach to service delivery, intertwined with a trauma-informed approach, is beneficial in meeting the service needs of families where parental trauma and early childhood mental health issues are present.

- Research on the recovery or reversal of the negative effects of early trauma indicates that the outcomes may not be permanent.

Wraparound services and trauma-informed practice

- Professionals working with children are in the position of providing support and guidance for both the parent(s) and the children, which is a large factor in buffering the effects of multigenerational trauma.

- By “listening to the parent and validating strengths and positive steps, their children will also begin to feel a stronger sense of control and hope in their lives” (Carpenter & Stacks, 2009, p. 837).

Wraparound Approach

- Strengths
- Challenges in implementing

Questions / Discussion

Case Example

- 6 months old infant, apprehended at birth by MCFD. Troubles with feeding, sleep, difficult to console.
- Now in a Voluntary Care Agreement, plan to transition back to mother's care with a supervision order.
- Mother is 21 years old, previous child in care (lived in multiple foster homes and group homes), history of sexual abuse and neglect. Diagnosis of Bipolar Disorder. Trying to recover from crystal meth use. Recently completed probation, had a psychiatrist, PO, case manager through DCC. No longer involved.
- Father is not present at this time, in treatment for substance use.
- People/services involved: MCFD social worker, supportive housing family program coordinator, supportive housing support workers, Sheway, friend/boyfriend, father's mother, IDP.
- Other services used by mother: Daytox (drop-in day programs)

Case Example

- 3 year old referred to infant psychiatry by her pediatrician, due to troubles with emotional regulation, extreme tantrums, episodes of “rage” (ranging 1-2 hours). Lives on Vancouver Island, parents took child to ER, but were told to go home as “behavioural”, not medical. Has an older half-sister (10 years old, lives with her father).
- Lives with mother and stepfather. Stepfather’s grandparents live close by and provide some childcare and support. Stepfather reports he grew up with a “very strict” father and depressed mother. Mother’s mother kicked her out of the house when she got pregnant at 16. MCFD involved with first child in first year of life, then went to father’s care. No current contact with her daughter.
- People/services involved: pediatrician, psychiatrist, hospital social worker.
- Referred to neurology for possible seizures and OT for possible developmental coordinator disorder and sensory sensitivities.
- Referrals in progress: CYMH, in-home family support worker.

Case Example

- 3 children: ages 18 months, 3 years old, 5 years old. The 5 year old was diagnosed with ADHD and “behavioural challenges”. The two younger children are behind in their developmental milestones.
- The two younger children are in foster home, mother has 3 overnights visits a week, transitioning back to her care.
- Mother diagnosed with PTSD, depression, anxiety. Previous child in care, grew up in multiple foster homes. Experienced abuse in foster homes. Her parents and grandparents grew up in residential schools.
- People/services involved: VACFSS, family preservation counsellor, elder at VACFSS, supportive housing family program coordinator, several friends, IDP.

Case Example

- 4 year child. Kicked out of preschool, changed foster home 2 months ago.
- Mother died of heroin overdose when child was 6 months old. Father was in jail, history of involvement with legal system, recently (1 year ago) became involved and wants to resume care of his child.
- People/services involved: parenting intervention and assessment program, MCFD social worker, foster parents, AA sponsor.