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Post-Traumatic Stress Disorder in birth parents in child protection services

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Birth parents of children in the child protection system have high rates of mental health problems and trauma exposure. To date, however, very little systematic evidence exists about the extent of Post-Traumatic Stress Disorder (PTSD) in this population. In this issue, we summarise a review we conducted of all international published empirical research about rates of PTSD in birth parents involved with child protection services and recommend ways that child protection services can improve responses based on this evidence.

Key findings

We found disproportionately high rates of current PTSD in parents involved in the protective system: 26% for mothers; 13% for fathers, compared to 5% for women and 2% for men in the general population.

The evidence synthesis also found common factors related to PTSD symptoms in parents in the child protection system that could be targeted with appropriate supports:

- co-morbid mental health problems, including behavioural addictions
- history of childhood experiences of sexual and physical abuse
- exposure to intimate partner violence
- higher risk for perpetration of child abuse.

Recommendations to improve responses to PTSD

Our research has the following implications for practice to improve responses to PTSD in parents as an integral part of child protection interventions:

- identification of PTSD in parents should be a routine practice in the protective services
- where identified, PTSD should be addressed early and with appropriate evidence-based supports
- development of trauma-focused interventions that are specifically tailored for parents in child protection services
- a wider focus on operationalising trauma-informed care principles in protective services.

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Background

The aim of our recent review paper was to provide a systematic account of the prevalence of PTSD, and factors associated with it, among parents in the child protection system. This evidence can be used to design better research-informed supports for parents with PTSD.

Mental health of birth parents in the child protection system

Many birth parents of children in the statutory child protection system have their own significant trauma history, (including sexual/physical abuse and neglect), as well as disproportionally high rates of mental health problems (estimated between 22-80%). While there were no national or international prevalence estimates of PTSD among parents in child protection populations prior to the review by the research team, it had been suggested that many parents in the child protection system are affected by PTSD and particularly complex PTSD (CPTSD).

CPTSD is often a result of ongoing and repeated trauma that starts in childhood with wide-ranging and long-term effects arising from a disruption of a person's sense of self, attachments, and their childhood development. CPTSD commonly follows from severe, pervasive, frequent, or multiple forms of emotional, sexual or physical abuse, exposure to violence, and/or neglect.

Not all individuals exposed to trauma develop clinically significant PTSD symptoms or serious parenting difficulties. These difficulties are more likely to develop when trauma begins in childhood and is of an interpersonal nature, such as childhood maltreatment or exposure to intimate partner violence.

Impacts of PTSD on parenting

PTSD symptoms may impact on a person's relationships with others, including their own children, and manifest in:

- persistent negative evaluations about self and others
- detachment
- impulsive and aggressive behaviours
- irritability
- use of harsh physical punishment
- lack of sensitivity to emotional cues
- negative expectations about parenting
- less emotional availability or higher avoidance
- negative perceptions of others, including own children.

When parents are adequately supported, PTSD symptoms are less likely to result in parenting and family challenges.

Impacts of PTSD on child outcomes

Parents' symptoms of PTSD can be associated with child wellbeing outcomes such as:

- anxiety
- depression
- PTSD
- behavioural problems
- low birth weight and feeding problems
- higher rates of sleep and eating problems

Given these impacts, it is vital that PTSD in the parenting context is addressed early and with adequate resources.

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Trauma from child removal

One specific source of PTSD for parents in the child protection system is the removal of their child, which has been described as “one of the most traumatic experiences that a human being can endure”. Similar to those who experience the death of a child, the involuntary loss of a child can result in profound feelings of grief and loss, anger, guilt and shame.

Although child removal was first linked to PTSD over 30 years ago, there are still no consistently delivered supports for parents following a child’s removal. Anecdotal evidence suggests that parents fall outside of existing service provisions after child removal, leaving them to manage significant health, lifestyle, and relationship difficulties on their own.

This lack of support significantly increases the risk of successive subsequent child removals as these parents are at increased risk of engaging in unhelpful coping strategies such as repeat pregnancies, suppression of feelings and substance abuse, all of which complicate recovery and parenting behaviours.

Systematic literature review

Our research team conducted a world-first synthesis of all published empirical evidence regarding PTSD rates in parents in a statutory child protection system. Fifteen studies met the inclusion criteria:

1. evidence of PTSD symptoms measured with a validated screening tool
2. sample involved parents in child protection services/programs (e.g., early intervention, home visitation, mother-baby programs), family support services, and protective intervening; targeted parenting programs, protective/mandatory reporting, child removal and OOHC services, and foster/kinship care services

Eleven studies reported 12-month PTSD rates for mothers, with a combined prevalence estimate of 26%. Three studies reported rates for fathers, with a combined prevalence estimate of 13%. Three studies did not report prevalence rates, but reported sample means for PTSD measures that were generally above the PTSD clinical cut-off.

Overall, the review pointed to elevated rates of PTSD symptoms in parents of children in the child protection system, compared to the general population.

Factors related to PTSD

Co-morbid mental health conditions

Some of the studies indicated that parents with PTSD had disproportionately high rates of co-morbid mental health disorders. Parents with co-morbid PTSD and depression had been exposed to a significantly greater number of different trauma types (e.g. physical assault by family member, sexual assault, accident, torture) compared to those who only suffered from PTSD. PTSD also demonstrated strong co-relationships with other mood disorders and suicide attempts.

Violence victimisation and perpetration

A third of the included studies reported parent’s own childhood victimisation of physical or sexual abuse. Mothers’ history of abuse was associated with current PTSD symptoms as well as using force with their own children. Furthermore, another third of the studies reported on the relationship between parents’ PTSD and their perpetration of child abuse or abuse potential. Compared to non-abusive parents, mothers and fathers who were abusive towards their children displayed more severe PTSD symptoms and were more likely to have been abused themselves as a child. In addition, this association was stronger in families where parents reported current interparental conflict.

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The complex association between PTSD and abuse victimisation/perpetration suggests that intervening with parent's own PTSD symptoms may help to prevent potentially abusive behaviours, particularly in regards to child abuse. This is a common pattern of intergenerational transmission of abuse and trauma reported in other systematic reviews.

Misuse of alcohol and other drugs

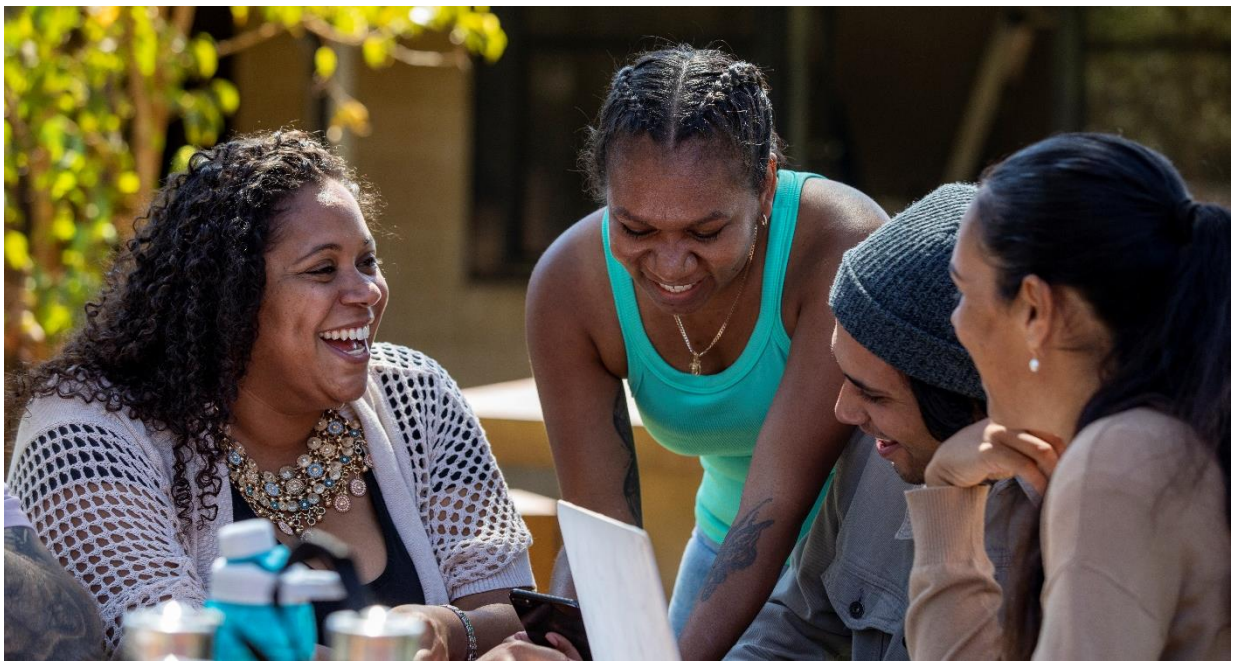
Substance abuse is often used as a form of 'self-medication' to psychologically escape or 'numb' the symptoms of PTSD. The current review provides some indication that drug use – particularly intravenous drug use – is more likely in parents with PTSD, compared to parents with no PTSD. In addition, the abuse of alcohol and other drugs can complicate the management of PTSD as they are known to relate to higher levels of:

- PTSD symptoms
- antisocial behaviours
- anger/hostility.

Aboriginal and Torres Strait Islander context

While none of the included studies in our review had specific data relating to Aboriginal and Torres strait Islander parents, the cultural context of trauma is a critical consideration in Australian child protection practice. First Nation children make up over one third of the child protection population. Due to the colonisation of Australia and unjust assimilation policies, Aboriginal and Torres Strait Islander peoples have suffered separation from land, Country, family, and cultural identity for generations. This has resulted in multiple, repeated, intergenerational experiences of trauma, grief, and loss that are felt by individuals, families, and communities.

One specific trauma related to the child protection system is the forced removal of Aboriginal and Torres Strait Islander children from their families and communities from mid-1800s to 1970s that still continues in the statutory system. The experience of the 'Stolen Generation' resulted in unimaginable suffering and mistrust in welfare systems by the Aboriginal and Torres Strait Islander communities. More data is needed before specific recommendations on how to best support Aboriginal and Torres Strait Islander parents with PTSD can be made, but it is important to acknowledge this specific source of trauma in the Australian Aboriginal and Torres Strait islander population.



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Evidence-informed recommendations

1. Identification of PTSD in parents as a routine practice in the protective services

Parents with PTSD will not necessarily express concern about a traumatic experience to professionals early on. They may present with a range of problems including low mood, anger, relationship problems, or physical health complaints. Their traumatic experience may not even be mentioned. This is partly due to avoidant behaviours that are characteristic of PTSD, which may prevent seeking support or talking about their difficulties.

Screening for PTSD

One systematic way to identify current PTSD in parents is to screen for current PTSD symptoms using validated tools soon after the parents first enter protective services. The following is an example of a widely used, brief and empirically validated screening measure, the Primary Care PTSD Screen for DSM-5.

Please use a YES/NO response

In the past month, have you...

- Had nightmares about the event(s) or thought about the event(s) when you did not want to?
- Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
- Been constantly on guard, watchful, or easily startled?
- Felt numb or detached from people, activities, or your surroundings?
- Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Other PTSD screening tools used

Name of tool	Details
PTSD Checklist (PCL) Weathers et al., 1993	18 item measure ranging from 1 (not at all) to 5 (extremely).
Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1995)	17 item measure ranging from 0 (never) to 3 (five times per week or more).
Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979)	15 item measure ranging from 0 (not at all) to 3 (often).
Primary Care PTSD Screen (PC-PTSD; Cameron & Gusman, 2003; Prins et al., 2016)	5 items, yes/no responses, see box above.
Short Post-Traumatic Stress Disorder Rating Interview (SPRINT; Connor and Davidson, 2001).	8 item self-report measure that assesses the core symptoms of PTSD ranging from 0 (not at all) to 4 (very much).

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Many PTSD screens can be administered by case workers or social workers (as opposed to specialised clinical staff) and that can be implemented as part of a holistic functional assessment. It is crucial that screening tools are accompanied by clear guidance about appropriate referral pathways or response protocols for when parents screen positive for probable PTSD. Case workers will benefit from formal education and on-the-job training for the use of these tools, some tips and resources below:

- Mental Health Screening and Assessment Tools for Everyday Practice Training
- Mental Health Assessment in Adults course
- CPT for PTSD Training: Trauma Counselling Training & Workshops for Practitioners.
- Roleplays of interviews and assessment training which focus on the following can help birth parents with PTSD symptoms (Bland et al. 2021):
    - analysing the biological, psychological and social effects of PTSD in their daily life
    - applying a strengths-based perspective to identify their strengths, stressors and coping mechanisms
    - understanding parent's previous and current level of day-to-day functioning
    - identifying parent's future needs and goals
    - deciding the intervention approach based on effects, strengths, level of functioning and needs of parents
    - integrating clinical (therapeutic) and critical approach for assisting daily functioning and obtain parent's goals.

2. Where identified, PTSD should be addressed early with appropriate supports - service needs

Evidence-based treatments for PTSD include trauma-focused Cognitive Behavioural Therapy and Eye Movement Desensitization and Reprocessing (EMDR) and/or medication (Teti, 2017). Prior to specific treatment for PTSD or another trauma-related disorder being approved, parents require a comprehensive health assessment from a health professional. Where trauma symptoms are identified, birth parents should be provided with practical supports to make and attend a GP appointment for a health assessment.

While evidence about family-focused interventions for PTSD is limited (Suomi et al., 2019), other evidence-informed family interventions that have been used to specifically target PTSD in both parents include: Combined parent child cognitive Behavioural therapy, Trauma recovery and empowerment model, Child parent psychotherapy, and Cognitive processing therapy (Thompson, 2018).

A key approach to better supporting parents who exhibit PTSD symptoms through the child protection system is to offer services earlier and continue to offer services and support repeatedly at each point there is a risk of re-trauma. For example:

- at pre-natal reporting
- child removal
- subsequent pregnancy
- any life circumstances that may put pressures on mental health.

When parents are supported early to provide the best possible care for their children, the need for intensive protection services diminishes. It should be kept in mind that PTSD symptoms can make it difficult for the parent to engage and sustain their therapeutic relationships, thus extra efforts should be made with parents to sustain their engagement with services.

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3. Specific trauma-focused interventions should be tailored for child protection services

Currently there a few trauma/PTSD-focused approaches that are specifically tailored for birth parents in the child protection context. Programs which include elements to address parents' history of trauma may improve parent wellbeing. Improved parent wellbeing may then translate into improved parenting and better child wellbeing.

Black Box Parenting -program (Torres et al., 2015) has been adapted to child protection context and is the preferred parenting program for NSW Department of Communities and Justice. The program aims to repair the relationship between parents and children by addressing the relational damage caused by past trauma (both parent and child).

In some cases, simply being heard and having trauma acknowledged can encourage parents to engage with support services. In the absence of PTSD-focused parenting programs in the child protection context, some non-trauma specific evidence-based interventions have been trialled with high-trauma populations to support parenting skills of parents with PTSD such as:

- Mom Power (Rosenblum et al., 2017),
- Promoting First Relationships® (Pasalich et al., 2019)
- Group Attachment-Based Intervention (GABI©; Steele et al., 2019).

Our current review provides strong evidence about parents' exposure to intergenerational trauma as well as multiple forms of abuse as the main source of their PTSD. Many parents in the child protection system likely suffer from 'complex' or developmental trauma given their experience of early-onset childhood trauma. On this basis, clinical literature on complicated and/or traumatic grief responses can inform better therapeutic responses to parents in child protective services.

For example, evidence-based parenting skills curricula can be utilised to address individual PTSD symptoms. These feature strategies for parents to learn to:

- address specific trauma-related difficulties
- regulate negative emotion
- manage interpersonal conflict
- understand power dynamics.

Development and incorporation of trauma-specific interventions are needed to help parents understand how their traumatic experiences can negatively affect their caregiving and relational attitudes and behaviours. These programs help parents build a repertoire of alternative parenting strategies. Parents where traumatic childhood experiences have led to PTSD should be offered improved access to psychological therapies and parenting programs to prevent intergenerational transmission of child maltreatment.

4. Wider focus on operationalising trauma-informed care principles in protective services

In addition to PTSD, many more parents in the child protection system have experienced trauma. While there is a growing interest in trauma-informed care for children in child protection, few efforts currently exist to address and manage parents' own trauma when they come into contact with child protection. The core tenets of a trauma-informed care are based on four 'R's: realising the widespread impact of trauma and pathways to recovery; recognising the signs of trauma among consumers and staff; responding by integrating knowledge about trauma into practice and policy; and proactively resisting re-traumatisation. Trauma-informed care should be implemented both organisationally (i.e., the ways in which service systems are governed), and operationally (i.e., the ways in which services are delivered).

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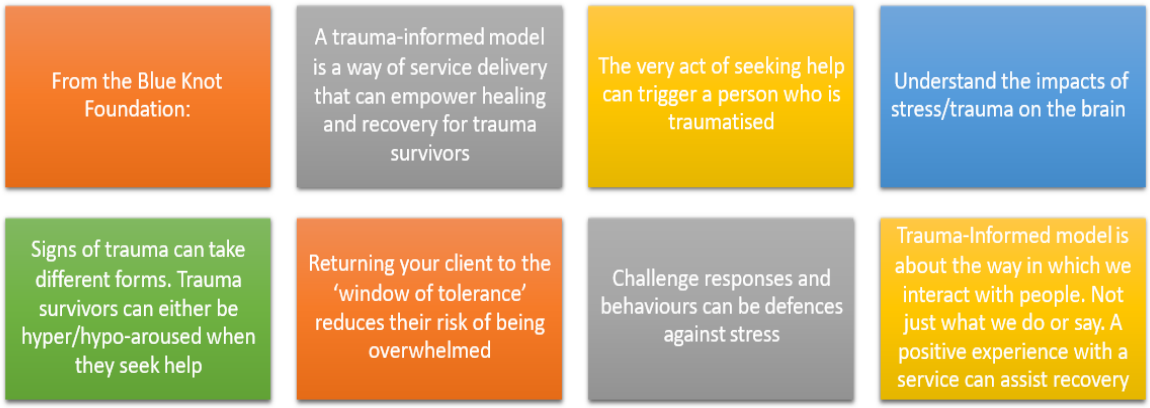
A trauma informed model by Blue Knot Foundation



The organisational aspect of trauma-informed care has been developed within social and welfare service sectors, with high-level guidance around principles of safety/trustworthiness, choice/collaboration /empowerment, and a strengths-based approach. The image above from the Blue Knot Foundation is an example of this approach. However, there is very little guidance on how to operationalise these principles in child protection practice and in interactions with birth parents. There is a critical need to fill this policy-implementation gap in child protection services where trauma histories are common among both children and parents.

Tips on PTSD & trauma-informed care in child protection practice

- In your role as service manager or team leader, you can help workers shift their perceptions about trauma to a strength-based concept of 'a complex human experience'. Approach it from the perspective that human behaviour is influenced by previous experience that can be both positive and negative.
- Help the client focus on questions such as 'what has happened to you' to explore past experiences (domestic violence, sexual abuse, child removal, previous involvement with child protection system) which might have resulted in traumatic experience on parents.
- Tune into parents' experiences of societal stigma around mental health challenges that might discourage them from sharing information about trauma symptoms and their impacts.
- Base your engagement with birth parents on relationship-based practice: building trust, working collaboratively and giving hope to birth parents in the context of their specific challenges.
- Implement culturally safe and trauma-informed care practice in interactions with all clients to prevent re-traumatising parents through the child protection system

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