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## UNRESOLVED LOSS AND TRAUMA IN PARENTS AND THE IMPLICATIONS IN TERMS OF CHILD PROTECTION

*This paper will explore the connection between unresolved loss and trauma in parents and the resulting issues in terms of child protection. A model for assessing unresolved trauma in parents and its implications for child abuse is outlined. Particular emphasis is placed on whether the individual has been able to 'come to terms' with his childhood experiences. It is argued that traumatic experiences in childhood are not in themselves problematic in terms of parenting ability; what becomes crucial is whether the individual has been able to resolve the issues. The implications of unresolved trauma are explored, including the risks in child protection terms. It is argued that this model is important for two reasons: firstly, it can act as a guide for important areas to explore in assessing risk in child protection work; secondly, it can inform treatment options and the possibility of, and timescales for, change. A case example in which a baby had sustained an unexplained injury is used to illustrate the model.*

**Keywords** trauma; lack of resolution; child protection; attachment theory; change

This paper will explore the connection between unresolved loss and trauma in parents and the resulting issues in terms of child protection. A model for assessing trauma in parents and its subsequent implications for child abuse is outlined. It needs to be emphasised that this represents only one aspect of an assessment and that a comprehensive assessment would include many other aspects not included here. For instance this model pays no attention to social, environmental or cultural factors.

The model is a trauma-based model. Trauma, in its various forms, is increasingly being recognised as forming the basis for a new paradigm for understanding psychopathology and hence the ability to parent safely. This paradigm rests on an integration of advances within neuroscience and the study of early attachment (Schoore, 1994, 2003a, 2003b). There is now a considerable body of literature on trauma, much of it from a psychodynamic perspective (e.g. Garland, 2002). This paper explores trauma largely from an attachment perspective. Attachment theory is becoming increasingly relevant to social work practice. As Howe comments, attachment theory's willingness to evolve and be informed by findings from the full

range of the biological, neurological, psychological and social sciences ensures its continued relevance to the understanding of children's psychological development and to the impact of trauma on child development (Howe, 2005).

An exploration of unresolved loss and trauma is important within social work for two reasons: firstly, it is an important component in assessing risk in child protection; and secondly, it can inform treatment options. Some 'newer' therapies are now beginning to integrate neuroscience findings about the impact of trauma on the brain. These therapies, which have a strong research base, offer the possibility of bringing about significant change for traumatised parents within timescales which are more realistic in child protection terms than the traditional talking therapies (Shapiro & Maxfield, 2003; Mollon, 2005).

The assessment would begin with an exploration of the trauma that the parent has experienced in her life. This would necessitate taking a detailed history of the individual. Sometimes much of this will 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 over time during the course of the assessment. The model would begin by asking the question: what traumas or losses has this person experienced in her life? Examples would include: the death of a parent; abandonment by a parent; severe neglect; sexual or physical abuse by a parent or a stranger. In adult life it could include miscarriage, terminations or the death of a child.

There are four important aspects 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 occurs the greater the potential damage;
- the longer the trauma lasts the greater the potential damage; and
- 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). Similarly, Putnam comments that the earlier the age and the longer the duration of the abuse the greater the risk of subsequent psychopathology.

Attachment theorists are now talking about 'big T' trauma and 'small t' trauma (Neborsky, 2003). Big T trauma would include deaths, sexual abuse, rape etc. 'Small t' trauma would include 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 increasingly recognised that neglect has a 'potentially devastating impact on all aspects of a child's development, including their physical growth and health, self-esteem, attention, impulse control and reactivity, socialisation, peer relationships, and learning capacity' (Duncan & Baker, 2003). Indeed, Schore comments that neglect can be more damaging for an infant or young child than abuse alone (Schore, 2003a). It therefore becomes important to recognise 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 early life experiences.

Once the traumas had been established, the question would be asked: is this trauma or loss resolved or unresolved? This would involve asking the question whether the person has come to terms with the traumatic experience. Attachment theory suggests that it is not trauma per se that is important in terms of parenting ability but whether there has been any resolution of the experience. 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). This 'earned autonomy', through a parents' 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 history, in itself, is not predictive of maltreatment of children; what is predictive is if the adult has not been able to resolve their feelings about these experiences.

The Adult Attachment Interview (AAI) (Main & 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 open-ended questions about childhood relationships and early 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 of loss or trauma is scored on the AAI when an individual displays disorganisation and disorientation in reasoning or discourse. An example of disorientation or disorganisation during an interview includes an individual referring to a deceased person as if she was still alive (loss) or becoming confused and disorientated when discussing fearful experiences with a parent (trauma). Distress whilst discussing a loss or trauma would not in itself be indicative of an unresolved state of mind (although preoccupation and repeated distress would be). Essentially resolution of loss or trauma is displayed when an individual is able to talk about the experience in a coherent, consistent and understandable manner.

However, it is also possible to assess for unresolved loss or trauma without the use of the AAI and it is invaluable for social workers to develop the skill to do this. Features of a lack of resolution would include the following: flashbacks, nightmares, intrusive thoughts, repetitive patterns of behaviour, talking about a dead person as though still alive and preoccupation about an experience. In carrying out an assessment it would be important to explore these areas in detail, for instance by asking whether the person experiences nightmares or repetitive dreams. What is essentially being assessed is the person's ability to talk about their life story, and particularly any traumas, in a coherent, understandable and consistent manner. Lack of coherence and inconsistencies point to a lack of resolution.

There is clearly a link between unresolved trauma and post traumatic stress disorder. However, unresolved trauma is a wider concept than post traumatic stress disorder. Whilst everyone suffering from PTSD would score as having unresolved trauma, the reverse is not also true.

In assessing for unresolved trauma it is important to recognise that there are two possible responses to trauma: either hyperarousal or dissociation. Traumatized individuals 'see and feel only their trauma, or they see and feel nothing at all; they're fixated on their traumas or they are somehow psychically absent' (Sykes Wylie,

2004). Thus, the fact that someone is not fixated on a past trauma is not, in itself, an indication that they have come to terms with the experience. It may be that they have dissociated from the experience, the implications of which will be discussed later in this paper.

There are a number of implications of unresolved loss and trauma, including the following. Firstly there is a strong correlation between unresolved loss and trauma and disorganised attachment in children (Main & Hesse, 1990). As Main and Hesse first discovered, unresolved parents tend to have infants whose Strange Situation behaviour is disorganised. There has since been a significant body of research to demonstrate that children with a disorganised attachment pattern often have a parent with an AAI classification of unresolved in relation to loss or trauma (van Ijzendoorn, 1995). A second implication is that lack of resolution of trauma is likely to lead to a narrative re-enactment of the unresolved trauma wherein the person unconsciously recreates the traumatic event over and over again (Neborsky, 2003). Where psychoanalysis talks of the repetition compulsion, attachment therapists refer to narrative re-enactment of the trauma. This is often most evident in the choice of a partner. Where a woman has experienced violence in her childhood and has not come to terms with the experience, she may unconsciously 'chose' partners who are violent to her and treat her in a similar manner, 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. Repetitive patterns of behaviour thus become a key theme to look out for in assessing for unresolved trauma.

Unresolved trauma leads to an increased likelihood that as a parent the person will treat their own child the same way they themselves were treated (Neborsky, 2003). If a person has been treated cruelly and sadistically in his own childhood and has not resolved his feelings about this, there is an increased likelihood that he will then repeat this pattern of parenting with his own children. This links with the defence of identification with the aggressor in which the traumatised individual unconsciously protects himself 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 of the continuing cycle of violence and is clearly of relevance to assessing the risk of child abuse.

However, in addition to identification, there is also an increased likelihood of '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 person who has abused them. A woman who has been sexually abused by her father in her childhood is likely to have considerable conscious or unconscious anger towards him. Neborsky and Solomon comment that 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 (Neborsky & Solomon, 2001). Finally, unresolved trauma is linked with the notion of the meaning of the child (Reder & Duncan, 1995). Reder and Duncan introduced this important concept to describe those children who may be at greater psychological 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 unmentioned child. The replacement child may then be placed in the impossible role of substitute for the

dead sibling. Alternatively, a mother who has been sexually abused by her father may come to treat her own child, particularly if a boy, as if he was the father. The meaning of the child in this case being that the child reminds the mother of all her unresolved feelings towards the abusive father. What is clear is that where a parent remains unresolved in relation to a loss or trauma there is an increased likelihood that their child will be caught up with having a particular psychological meaning for the parent, which could be damaging or destructive to the child.

A further implication of unresolved trauma is the development of primitive defences to protect the individual from the pain of the unresolved trauma. The whole gamut of defences is potentially available to anyone unconsciously warding off such pain. However, the following defences are particularly relevant to child protection work: addictions, dissociation, narrative re-enactment of the trauma and identification with the aggressor.

The significance of substance abuse as a risk factor within child protection is well recognised within the literature (Reder & Duncan, 2003). Substance misuse has been defined as 'self-medication against emotional distress' (Newcomb, 1995). It is important to note that there is a strong correlation between PTSD and substance abuse (van der Kolk, 2003). This correlation is likely to be equally strong between unresolved trauma and substance abuse. Where an individual has experienced significant trauma and has not resolved the feelings around this, there will always be the possibility that that person will use substances as a way of trying to block out the pain and distress.

Schore talks about the potential dangers of dissociation in mothers, arguing that maternal dissociation blocks infant attachment. He comments that episodes of persistent crying can act as a potent trigger for dissociation in the mother and that there is a strong link between dissociation and neglect. 'The caregiver's entrance into a dissociative state represents the real time manifestation of neglect' (Schore, 2001). It is also likely that a woman who has experienced major trauma in her childhood and who unconsciously uses dissociation as a defence will find it difficult to act as a safe haven or protective parent to her child, perhaps particularly in her choice of a partner. Consequently, it becomes very important that social workers become skilled at assessing individuals in terms of dissociation. The Manual for the Dissociative Experience Scale (Carlson & Putnam, 1993) is a self-report measure that can helpfully assess for dissociation. However, questions about childhood, and particularly about childhood memory or lack of it, are also ways of assessing for dissociation. A lack of memory about childhood should alert the worker to the possibility of a dissociative state. The way someone presents during interview can also indicate the presence of a dissociative state. The interviewer needs to be alert for individuals who appear to be 'cut off', have difficulty in engaging emotionally and have an inability to be 'present' during the interview. Schore argues that the earlier in a person's life the trauma happens and the longer it lasts, the more likely they are to use dissociation as a defence. Furthermore, dissociation is more likely if the abuse is from an attachment figure, 'so that the child has nowhere to run and no one to turn to' (Schore, 2003a).

Finally, it would be important to assess how these defences and unresolved issues impact in terms of child protection and risk to any children. Recent developments in neuroscience suggest that unresolved trauma remains unlocked in a 'hidden file', for

which there is little language, only image and feeling (Neborsky, 2003). Unresolved traumas are stored in more primitive circuits within the brain, with less left-hemisphere involvement. As a result, they are strongly somatic, sensory, emotional and inherently non-verbal. This is particularly the case when the individual has unconsciously used dissociation as a way of warding off unbearable pain. Two things can then access and activate the negative emotional consequences of this hidden file:

- experience of adult trauma; and
- intimate relationships, i.e. partner choice or a child.

It is well recognised that individuals who have a childhood history of unresolved trauma are vulnerable to adult experiences of trauma. Traumatic experiences in adult life can thus trigger unresolved issues from childhood.

Solomon describes how this dynamic can also happen in intimate relationships: 'The greater the intimacy with another person, the more likely that emotions, even archaic ones, will emerge, along with primitive defences' (Solomon, 2003). She goes on to comment that the choice of a loved one includes the probability of recreating earlier traumatic experiences, with the likelihood that unresolved issues will re-erupt within intimate relationships.

These primitive, unresolved issues can also be re-evoked by a child. The birth of a child, a baby crying, issues around toileting, etc. can all trigger unresolved trauma in the carer and the consequent negative affect. In particular, there is then the danger that retaliatory rage and fantasies of revenge can become displaced onto the child. When a child's attachment system becomes activated, the parents' reciprocal care giving system should also become activated. In this way the child becomes comforted and soothed when distressed. However, it seems that whenever the abusive or neglectful parent finds himself in a relationship in which the child appears vulnerable or in a state of need, old unresolved childhood feelings of fear, anger, distress or abandonment are unconsciously activated. 'Overwhelmed by his own attachment needs, the parent then fails to provide care and abdicates his position as protector precisely at the moment of the child's greatest need' (West & George, 1999). Crucially, the child's expression of attachment needs triggers the parent's unresolved feelings about their own childhood experiences.

### **Use of the model**

This model has two potential uses for social workers. Firstly, this model can act as a guide to aspects to explore in interviewing for risk assessments. Once established that an individual has a history of trauma it would be important to explore all the areas within the model. As one example, it would be important to try to understand how the unresolved trauma might link with the meaning of the children within the family. Similarly, if assessing someone who has been sexually abused I would ask 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?'; 'Do you think that these issues ever spill over into how you treat your child?'. It is important that the questions and ideas are made explicit so that the individual can be given permission to

give voice to some of the shameful aspects of themselves. All the areas outlined above in the model should then be explored in detail.

Secondly the model has important implications in term of treatment and its timescales. 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 the child's needs. This requires the assessor to be able to make a judgement about how long it will take for the parent to make the necessary changes. This model can help to give guidelines. The four principles outlined earlier in the paper will also apply in terms of timescales: trauma at the hands of an attachment figure is likely to require therapy over a longer of period of time than abuse by a non-attachment figure. Similarly early, prolonged and extreme trauma will require longer treatment than later, shorter, less severe trauma. Essentially, single incident trauma later in life is likely to respond to therapy much more quickly than complex, early, prolonged trauma.

### **Case example**

Ms. R and her partner were referred to me for a risk assessment following a serious, unexplained injury to her three-month-old son. Ms. R had a five-year-old daughter from a previous relationship.

Ms. R had been in care as a teenager so much of her history was already known prior to the assessment at the clinic. She had been sexually abused as a young child by her father and had later witnessed considerable domestic violence between her mother and stepfather. She had come into care from the age of 13 and remained in care throughout her adolescence. She had begun using substances early in her adolescence and by the age of 16 was using heroin regularly.

She had met her daughter's father when 16 and became pregnant soon after. This man is described as being a heroin addict who was violent to her throughout their relationship. Their relationship ended when her daughter was about a year old when he went to prison for four years for drug related offences.

Her daughter was born at 35 weeks gestation and was initially methadone dependent. There were concerns about Ms. R's ability to care for her and she suffered from several injuries: on one occasion she sustained head injuries after falling off the bed, on another she was hospitalised at aged 18 months after ingesting her mother's methadone. However, after her partners' imprisonment, it seems as though Ms. R's drug use stopped and she became better able to care safely for her daughter.

She met her current partner when her daughter was three-and-a-half years old and quickly began living with him. She became pregnant soon after they began living together. This relationship also involved significant domestic violence. When their son was three months old he was taken to hospital by his paternal grandparents with significant bruising on his back. Medical opinion was clear that the injury was non-accidental. His parents were unable to provide any explanation for his injuries and he was subsequently removed from their care and placed with foster carers.

I met with Ms. R and her partner to begin my risk assessment. I arranged to see Ms. R on her own the following week and told her that I would need to talk to her

about her childhood and the traumatic things that had happened to her. She arrived 45 minutes late for her appointment. She was confused and disorientated and her speech was slurred. However, she immediately began talking in detail about her father's abuse of her. She also talked openly about the way in which the abuse continues to impact on her life. She told me that she had had a recurring dream since the age of about 14 in which she is hiding in terror from her father who is searching for her. She also said that when walking around the town she regularly thinks that she sees her father, only for it to turn out to be some other man. If she hears of a sexual offence being reported on the radio or tv she immediately thinks that her father has sexually abused someone.

When I saw Ms. R the following week she told me that she had used heroin prior to coming to see me the previous week. She said that her father had threatened her with violence if she ever told anyone about the abuse. She told me that she had only been able to talk about her father's abuse of her if she had been using heroin.

Ms. R also talked to me about her feelings about having a son. She told me that she felt frightened of the anger she sometimes feels towards him, commenting that her son reminds her of her father. She talked of her fear that her son could grow up to become like her father and her very real uncertainty and lack of confidence about how to be a mother to a son.

Gradually we pieced together the pattern of her PTSD and her drug use. It became clear that the nightmares and intrusive thoughts are particularly intense at certain times; specifically when pregnant or in a sexual relationship with a man. Thus, she told me that after her daughter's father was imprisoned she stopped using drugs and was drug free for several years. However, she began using again when she began living with her new partner and her drug use became significantly heavier when she became pregnant.

After their son was born they both continued to use heroin and their lives became increasingly chaotic. It seems as though the need to obtain money to fund their drug habit came to dominate their lives and Ms. R began working as a receptionist in a brothel and her partner became involved again in crime. In the three days prior to their son being taken to hospital he was cared for by seven different people in a chaotic manner.

## Analysis

If we look at Ms. R in terms of the discussion in this paper, it can be thought about in the following way.

Ms. R had clearly experienced significant trauma in her life, including being sexually abused by her father and witnessing domestic violence between her mother and stepfather. Further, it was clear that she had not been able to come to terms with these experiences and that she was still unresolved in relation to them. Evidence for this would include her recurring dreams about her father and the intrusive thoughts and flashbacks. Indeed it was my view that she had been suffering from PTSD for a number of years which had not previously been diagnosed. This view was later confirmed by an assessment by a clinical psychologist.

This unresolved trauma then became further evidenced through her narrative re-enactment of the trauma. Both of her relationships with men had included significant violence and both had treated her sadistically. She also told me that her experience of sex, particularly with her first partner, had been violent. She had thus unconsciously recreated the traumatic events of her childhood over and over again.

Furthermore, there were clearly some important issues in terms of the 'meaning' of her son for her and the way in which he reminded her of her father. Although she continued to maintain that she had not caused the injury to her son, she did acknowledge how angry she had felt towards him. She was open about the way in which she feared displacing some of her rage towards her father onto her son.

In terms of defences, it seemed clear that she had defended against the pain of the unresolved trauma through drug use. The link between her unresolved childhood experiences and her addictions was made clear by the fact that she used heroin immediately prior to an appointment here in which she was due to talk about her childhood. She told me that she was aware that she used drugs in order to 'numb the pain'. Finally, she said that she could only ever bear to have sex when she was either drunk or on drugs.

The way in which this defence of substance addiction increased the risk to her children was evident throughout her history as a mother, firstly through her daughter being born methadone-dependent and then later ingesting methadone, and secondly through the injury to her son. It was also clear that her preoccupation with funding her drug habit after her son's birth meant that she was unable to care for him safely or appropriately. Thus, although it was never established who caused the injury to her son, the very least that could be said of her was that she had not been able to protect him from danger and harm.

Following through the model, it became apparent to me that Ms. R's lack of resolution of her trauma made her particularly vulnerable at certain times; specifically when in a sexual relationship with a man, whilst pregnant and following the birth of a child. These two aspects — being in a relationship with a man and having a child — seemed to activate the negative emotional consequences of her hidden file of trauma. In other words, these are particularly high-risk times for her and any children in her care.

## Conclusion

I believe that this model has important implications for child protection work, both in terms of assessing risk and in informing treatment interventions.

In terms of assessing risk, it is clear that where there has been a major trauma and the person has not been able to come to terms with this, it will have major implications for that person's ability to parent safely and protectively. Specifically, the model can help to identify particular high risk areas for an individual. Any work done to help an individual to resolve these particular areas could significantly reduce any risks to children within the family. In my assessment of Ms. R I believed that her lack of resolution of the traumatic events of her childhood and her continuing rage with her father meant that she remained a risk to any child in her care. I

recommended that she was assessed for PTSD and that she had psychotherapy to help her to resolve the issues from her childhood. I identified that being in a sexual relationship with a man, becoming pregnant and following the birth of a child were likely to be high-risk times. I also thought that having a male child was particularly provocative for her. Because she had been abused by her father over a significant period of time and had witnessed domestic violence involving her mother, I believed that therapy would need to be long term and intensive. Consequently, I was doubtful about whether she could make the necessary changes within timescales that were suitable for her children.

In terms of treatment, it is clear that if a parent can be helped to begin to 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 able to be a safe haven for them. This is a positive aspect that is coming out of attachment research, which makes the provision of skilled therapeutic work to traumatised people, and particularly parents, of extreme importance.

What becomes crucially important within this model is for social workers, and indeed any professionals involved in risk assessments, to become more skilled at identifying lack of resolution of trauma. It also becomes particularly important for workers to be aware of the link between unresolved trauma and the potential for violence. In this way, the worker will not just identify with the pain of the individual but will also recognise that someone who is in severe pain and distress is capable of inflicting similar pain on others.

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