Working With Parents Who Experienced Complex Trauma: Challenges and Dilemmas in a Residential Inpatient Child and Family Unit (The Croft)

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The Croft Child and Family Unit

- provides assessment and treatment for children with complex developmental and/or psychiatric disorders and children presenting with severe emotional and behavioural problems

- the only unit in the UK offering specialist residential mental health treatment for children with their parents and siblings – a whole family approach

- has 12 residential places for children and their families, from Monday to Friday

- most admissions 8 weeks, some longer when needed

- offers outreach support before admission and after discharge

- is situated in Fulbourn, just outside of Cambridge
Family Therapy at the Croft

Family Therapy: substantial part of Croft treatment plan offered to every family from the beginning

Assumption that all parents are competent parents: what gets in the way?

Exploration of:
• Impact of child’s behaviour on the family and vice versa
• How child’s behaviour may be meaningful/helpful in the context of the family
• Generational patterns of relationships (genogram)
• Parent’s childhood: “What was your life like when you were your child’s age?”

Conversations: Non-blaming, reframing, highlighting resilience, strength-based
Parents’ experiences of trauma

High Rate of trauma disclosure by parents during their admission

• More than half of the parents who have been to the Croft have experienced significant trauma, and the majority have not disclosed this before

Different types of trauma:

• Physical/emotional abuse/neglect by parents/grandparents
• Sexual abuse by family member/friend/person with power
• Unresolved loss/death of parent/significant adult
• Sibling chronic illness

• An increasing number of parents present with symptoms of Complex PTSD

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Parents’ disclosure of trauma

Generally victims of complex trauma do not disclose/talk about their experiences:
“I am a bad person: I do not deserve help, I won’t seek out therapy for my sake”

At the Croft, often first opportunity to talk about past trauma:
“I am here for my child, I am in family therapy to support my child”

Residential admission allows parents to confront painful experiences/memories without having to resume daily responsibilities (work/child-care/daily routine) after therapy sessions

Staff are available to help parents manage their children after a distressing therapy session, and often provide invaluable support during the week in processing what has been discussed during a therapy meeting.

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Child’s Behaviour Resonates for Parents
Mechanisms: How does trauma experience impact on parenting?

• Fear of repetition: (e.g. lack of boundaries to avoid replicating abuse)

• PTSD symptoms impact directly on parenting and/or child (e.g. flashbacks, dissociation)

• child’s behaviour resonates with parent – child triggers/intensifies PTSD symptoms

• projective identification (e.g. child expresses anger/grief on behalf of parent)

• Double bind (e.g. I sacrifice my child to enable my mother to repair her own parenting experience/stay close to my mother)

• Attachment (parental unresolved trauma/loss linked to child attachment anxiety)

• indirectly via other family relationships (e.g. maternal trauma impacts on marital relationship which in turn affects child)

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Double Bind

Damned if you do, damned if you don’t...
Double Bind in Child Abuse

For child:
e.g. Caught between telling parent about abuse and risking harm to them/self OR
Not telling about abuse and suffering harm to self

For parent (victim in childhood):
e.g. Caught between addressing/processing past abuse and potentially failing as
Parent due to emotional instability/flashbacks OR
Not addressing/processing past abuse and potentially failing as parent due to
emotions being expressed by child/others in family/flashbacks, etc.

For health professional:
e.g. Caught between addressing parents’ past and potentially contributing to
parents’ failure due to emotional instability/flashbacks AND
to staff failure to promote positive change in family OR
Not addressing parents’ past and potentially not promoting any change in family
Child Double Bind in Child Abuse

If I tell someone about the abuse

If I don’t tell someone about the abuse

I’ll suffer

Others might get hurt

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Double binds inherent in abuse by a primary caretaker are likely to generate two contradictory working models of attachment (insecure avoidant and insecure anxious-ambivalent), reflecting disorganised attachment:

- **Self-protection:** Avoid pain and fear
- **Attachment drive:** Seek security

Freezing
Stilling
Dissociating

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Parents’ potential double bind in an inpatient child and family unit

If I address my past trauma

- I might not be able to look after my child(ren)
- My child may not get better

If I don’t address my past trauma

- I might become emotionally overwhelmed
- Staff and other professionals may think I’m failing as a parent

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Therapy team’s potential double bind

If I help/encourage this parent to address her past trauma:

- She may be able to look after her child(ren) better
- Her child may get better

Eg Therapist:

- She may not be able to look after her child(ren)
- Other staff may not be able to work with her on her parenting
- Her child may not get better (no 2nd order change)

If I don’t help/encourage this parent to address her past trauma:

- The nursing staff may have to look after the parent as well

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Dilemmas for Therapists in Inpatient Units

How do we establish second-order change in parents/children/families if we do not address what is preventing parents from being effective parents?

How do we respect/privilege the therapeutic attachment relationship, which is essential for people to disclosure trauma, and then refer people on to other services post-admission?

What do we do if a parent has disclosed trauma during the admission, wants to continue processing their experiences within the therapy team, and there are no community services available for further support (doesn’t meet threshold/long waiting list)?
Challenges for staff teams

Parents processing their past may become more distressed/have flashbacks and less able to implement behaviour management strategies with their child
  • Possible impact on staff/children/other parents

Child safety when parents experience flashbacks

Who does this work? (competitive dynamics among team members)

How do we support parents in processing their trauma in a time-limited admission?

Same post-admission treatment can not be offered to all parents (geographical constraints)

Complications of safeguarding – promote or close-down conversations?

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