

# Safe Mothers, Safe Children:

Preventing the Intergenerational  
Transmission of Trauma

The ACS/MSSM  
Children's Trauma Institute

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## ACS-MSSM Children's Trauma Institute



- The CTI is a collaboration between the New York City Administration for Children's Services and the Mount Sinai School of Medicine
  - Child welfare-focused NCTSN Category II site
- Our mission is to use trauma-related knowledge to improve child welfare practice and outcomes
- The CTI method involves partnering with stakeholders from within the child welfare system to develop projects to reduce the impact of trauma on children, families and staff

## NYC Preventive Services System



- 16,000 families with 30,000 children
  - Most clients are involved with CPS; about 33% of cases are self-referred
  - Identified child(ren) must be under 18 and at risk of foster care placement
- 80+ agencies running 200+ community-based programs
- Models range from “one-stop shopping” to case management/community referrals
- Goal is to prevent foster care placement, stabilize families within 12-18 months

## SMSC Project Rationale



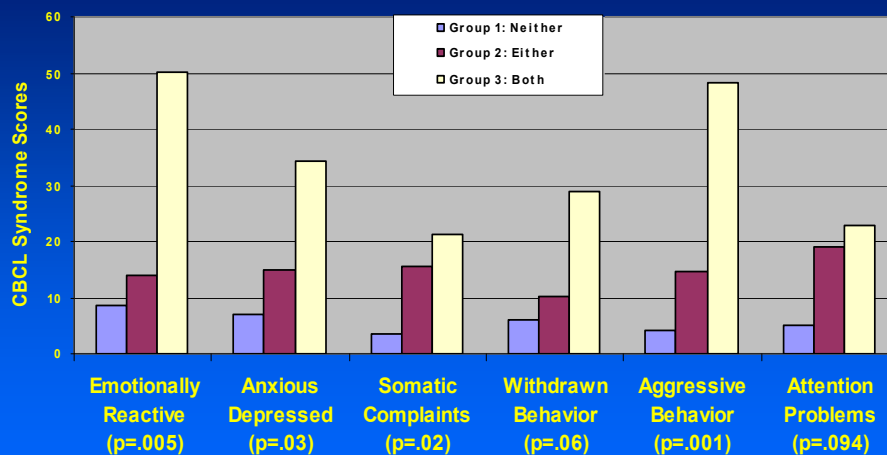
- Trauma-focused services are not routinely available to parents receiving preventive services, despite high rates of intergenerational violence and trauma
  - Existing evidence-based trauma treatments focus on needs of children, assume stability of parent
- Interviews with staff from 10 provider agencies confirmed our hypotheses about the need for trauma-focused intervention for mothers
- The project goal is to improve the efficacy of preventive services through on-site screening and intervention
  - Reduced rates of subsequent maltreatment, foster care placement; improved child and family well-being

## Research on Maternal PTSD



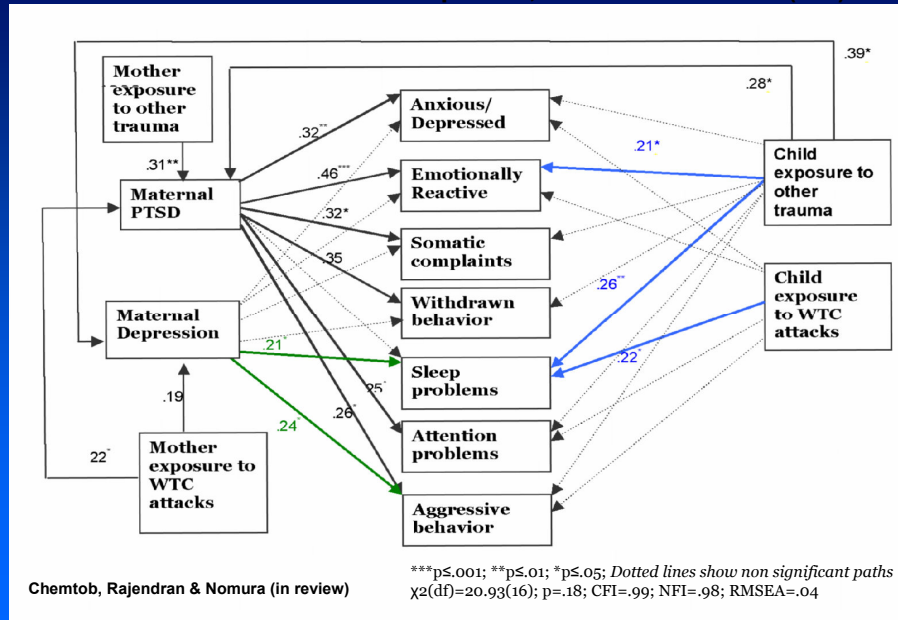
- Study focusing on young children who were exposed to World Trade Center (Chemtob et al, 2009)
- Findings show that maternal responses, particularly maternal PTSD and depression, strongly impact child symptomatology (more so than direct exposure to attacks)
- Similar findings in study among mothers and children in Israel affected by cross-border attacks

Percentages (SE) of children with deviant CBCL syndrome scores according to whether the mother has neither, either, or both PTSD and depression, taking both teacher's and mother's reports



Nomura and Chemtob, Archives of Peds and Adolescent Medicine (in print)

## Simultaneous examination of maternal PTSD and depression symptoms, maternal and child trauma exposure, and child behavior (ITP)



## Focus on preschool children



- SMSC focuses on mothers of preschool children:
  - Compelling findings about the impact of maternal trauma-related symptoms on preschool age children
  - Positive outcomes observed from dyadic interventions with mothers and preschool age children exposed to domestic violence (Lieberman, 2005, 2006)

## Provider Interviews

### Interview foci



- Level of trauma experienced by parents
  - Decision to focus on mothers
- Impact of trauma on parenting
- Frequency of other mental health issues
  - Availability and efficacy of mental health services
  - Lack of coordination with adult mental health system

## Parental trauma exposure



- Some providers directly ask about trauma exposure, but none conduct standardized screenings
  - Most estimate that 40-50% of mothers have experienced prior abuse.
  - Most assume that trauma impacts parenting among fathers, but don't address it directly -- no provider felt able to accurately estimate rates of childhood trauma among fathers.

## Impact of trauma on parenting



- All recognized impact of trauma on parenting -- several noted that traumatized mothers have challenges with patience, empathy and showing affection toward their children

“If they haven't dealt with it, it comes out in their behavior. That's what they know. It's an obstacle in terms of being able to help or have empathy for their own children – they feel like if they went through it then the kids “will be fine” if they have to go through it.”

“They're much more focused on themselves – like they want to be good parents, but they're preoccupied.”

## Mental health needs and services



- Many providers screen clients for mental health issues
  - Depression widely recognized among mothers and fathers
  - Agencies that don't conduct standardized screenings appear to underreport anxiety
- Most agencies routinely refer clients for mental services
  - Barriers to engagement in treatment include stigma, lack of flexibility from the agency, lack of trauma-focused services

## Need for trauma-focused services



- All providers emphasized need for available resources, and several saw this project as filling a big void:

“What would be really useful for us if you could help to develop and identify a good screening tool that the social worker could use and administer as part of the assessment.”

“I think that providing free counseling for families affected by trauma, right here, is the best thing since sliced bread.”

## Systems work



- Stakeholder interviews represent the first step in building a Learning Community of providers
- Goals of Learning Community include:
  - Integration of trauma lens into preventive services
  - Improving linkages with mental health system
- Several agencies expressed interest in piloting the intervention
  - Established formal partnerships with two agencies
- Once partnerships were established, held regular meetings with pilot program staff
  - Ongoing discussion of mutual expectations, screening protocol, intervention model and approach

## Project Development

## Project structure



- Trauma Screening – all mothers receiving preventive services
- Assessment – clients with elevated PTSD symptoms and a child in the target age range
- Intervention – with eligible and interested clients
- Client and program-focused evaluation – data collected from clients and providers

## Screening protocol



- Agency case planners complete screening
  - Screening available in English and Spanish
- Project clinician provides ongoing technical assistance to case planners
- Post-screen protocol was developed to track clients with elevated symptoms
- Data collected from case planners about the feasibility and acceptability of the protocol

## Screening measures



- Demographics, child welfare involvement
- Posttraumatic Stress Diagnostic Scale (Foa et al., 1997)
- Center for Epidemiologic Studies-Depression Scale (Radloff, 1977)
- Woman Abuse Screening Tool (Brown et al., 2000)
- SCID Psychosis Screen
- Trauma Exposure Symptom Inventory (Ford et al., 2000)

## Post-screen evaluation



- Case worker evaluation of screen for each client:
  - How long did the screening measures take to administer?
  - How much effort did you put towards administration?
  - Did you learn something new?
  - Did the screen make your client feel uncomfortable?
  - Did the screen make you feel uncomfortable?

## Preliminary Screening Results (N=42)

### Trauma exposure



- 90% of clients had experienced at least one traumatic event ( $\underline{M} = 2.8$ )
  - 30% reported 5 or more traumatic events
- Mother-report indicates that 97.1% of children had experienced at least one prior trauma ( $\underline{M}=5.94$ )
  - Substantially higher than observed in a sample of preschool children exposed to the World Trade Center attacks, in which 53.1% had been exposed to prior trauma (Chemtob et al., 2008).

## Child trauma exposure

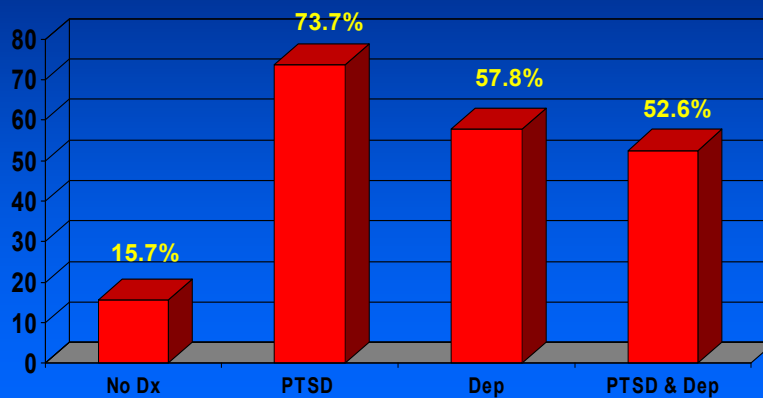


- 48% of mothers screened (n=20) have a child in the target age range (3-6)
- Mothers of preschool children acknowledged the impact of trauma on parenting:
  - 27.8% felt that trauma exposure affected their relationship with their child
  - 19.4% felt that trauma exposure affected their parenting abilities

## Trauma-related symptoms in mothers



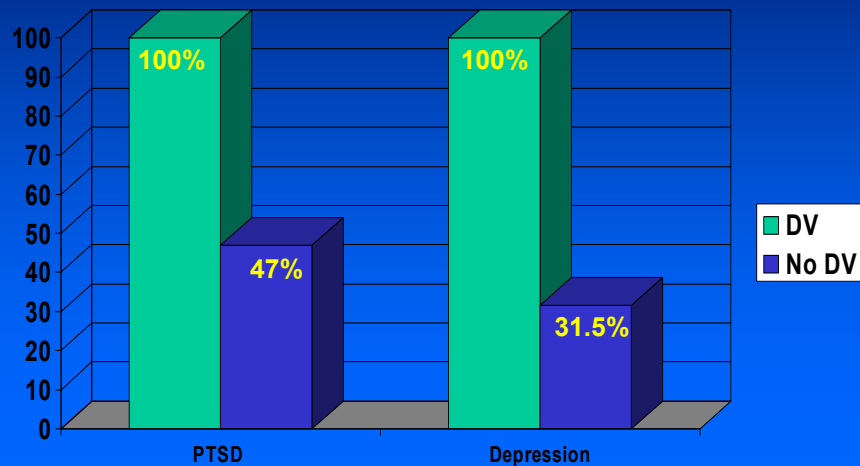
% meeting diagnostic criteria on screening (N=19)



## Domestic violence exposure



DV exposure and mental health status (N=26)



## Post-screen evaluation



- 82.9% of case planners stated that conducting the screening took “some” or “a lot” of effort
- BUT, 92.1% learned something new from doing so
- Case planners were more likely to report that the screening made them “uncomfortable” when the client had a higher level of trauma exposure ( $r=.39$ ,  $p<.05$ ), particularly interpersonal violence ( $r=.52$ ,  $p<.05$ )

## Assessment measures



- Parenting Stress Index-Short Form (Abidin, 1995)
- The Conflict Tactics Scale-Parent-Child (Straus, 1979)\*
- The Adult-Adolescent Parenting Inventory-2 (Bavolek et al., 2001)
- Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004)\*
- State-Trait Anger Expression Inventory-2 (Spielberger, 1999)
- Novaco Anger Inventory (Novaco, 1994)\*
- Clinician Administered PTSD Scale (Blake, et al., 1995)
- Structured Clinical Interview - Axis I Disorders (First et al., 1996)
- Connor-Davidson Resilience Scale (Connor & Davidson, 2003)\*
- Interpersonal Support Evaluation List (Cohen & Hoberman, 1983)
- Life Orientation Test-Revised (Scheier et al., 1994)
- The Strengths and Difficulties Questionnaire (Goodman, 2001)

## Intervention Model: Parenting STAIR

## Treatment adaptation: Parenting STAIR



- An adaptation of STAIR (Skills Training in Affective & Interpersonal Regulation) with a parenting focus
- 20-session, three phase intervention:
  - Psychoeducation and skill building
  - Processing of trauma/trauma narrative
  - Dyadic therapy with mother and pre-school age child
- Expected outcomes:
  - Reduced rates of child maltreatment
  - Improved mother and child well-being
  - Improved client engagement in preventive services

## Phase I: Skill building



- Psychoeducation about PTSD
- Increasing emotional awareness
  - Recognition of triggers
  - Provide skills to modulate negative feelings
  - Reduce risk of client becoming overwhelmed
- Explore the impact of PTSD symptoms on relationships
- Address the effects of trauma on parenting
  - Intergenerational transmission of trauma
  - Trauma can impact mother's view of her child
  - PTSD is associated with more punitive parenting, aggressive behavior

## Phase II: Trauma Narrative



- Client and therapist work together to create a narrative story of the traumatic experience
  - Story acknowledges impact of the trauma while encouraging awareness of personal and relational strengths
  - Allows the client to process the traumatic event at her own pace, without being overwhelmed by the experience
  - “Narrative of Hope” – interrupting the intergenerational transmission of abuse

## Phase III: Parenting Dyad



- Sessions are structured in two parts:
  - 30 minutes - mother and child play together with coaching from the therapist; session is videotaped
    - Therapist models warm, engaging and positive interactions with the child
    - Focus on re-introducing concept of play
    - No discussion of traumatic material
  - 30 minutes – child leaves the session
    - Sections of the videotape are reviewed with mother
    - Process the mother's emotional experience with her child

## Phase III: Parenting Dyad



- **Topics of Dyadic Sessions:**
  - Reflection, attunement and attachment
  - Parental awareness – play and praise
  - Teaching feelings – what are they?
  - Teaching coping – what do I do with my feelings?
  - Caring, communication and saying goodbye

## Intervention Update



- **5 assessments have been completed to date**
  - 4 women met eligibility criteria
    - 3 are engaged in treatment
    - 1 seems ambivalent but scheduled an initial appointment
  - 1 woman did not meet eligibility criteria but requested a referral for therapy
  - Of these 5 women, only 1 had ever participated in therapy

## Case example: L – 37 years old



- Referred to preventive services one year ago, following a CPS investigation
- 4 children (ages 16, 14, 13, 4)
- Experienced CSA by father from ages 9 – 12
- Meets full criteria for PTSD
- Began treatment 5 years ago, but became overwhelmed and ended abruptly
- Identified strong impact of PTSD symptoms on parenting
  - Feels triggered if older sons try to hug her
  - Feels unable to tell her children that she loves them; forces herself to do so when “playing around”
  - Extremely protective with youngest son; asks him every day if anyone has touched him inappropriately

## Case example: T – 40 years old



- Self-referred to preventive services several years ago
- 10 children (ranging in age from 20 to 3)
- Experienced CSA by a teacher in childhood
- Mother abandoned her at age 12
- Married 3x - first husband severely abusive, second husband committed suicide, third husband abusive
- Meets partial criteria for PTSD and has many affective symptoms
- Has never been engaged in treatment
- Does not directly identify impact of trauma on parenting, but describes herself as “overwhelmed and traumatized”
- Agency staff identify significant impact of trauma on parenting, which prevents them from closing her preventive service case:
  - Loving toward younger children, but struggles to parent older children and sends them to live with relatives

## Lessons Learned



- Rates of maternal PTSD and child exposure to traumatic events higher than expected
- Implementation challenges:
  - Organizational affiliations between different systems - lack of understanding of goals and focus
  - Research approval process
  - Sustaining the screening process
- Consistent with the CTI method, the process of stakeholder involvement proved to be extremely important