What the Home Visitor Can Look for in the Parent-Child Relationship

Understanding trauma helps the home visitor to observe how a parent and child interact and better identify the red flags that indicate a need for services.

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PURPOSE

The purpose of this Brief is to provide information about how home visitors can better identify trauma and high levels of stress in the home of a family with a young child. This Brief provides an overview of trauma, adverse childhood experiences (ACEs), types of stress, and depression. Understanding trauma helps the home visitor to observe how a parent and child interact and better identify the red flags that indicate a need for services. Early identification of a struggling parent-child relationship due to trauma and toxic stress can help minimize the impact by initiating appropriate two-generational supports and intervention—which benefit both parent and child.

WHAT IS TRAUMA?

People of all ages—infants included[1]—may experience trauma, and the effects can be repeated through generations. Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster.[2] It "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."[3] Trauma can also be the result of a multitude of negative experiences, including domestic violence, medical conditions, physical or sexual abuse, neglect, poverty, loss of a loved one, or community and school violence.[4]

Without repair and supports, a person's traumatic experiences can affect their ability to provide secure, nurturing relationships with their children. Their children may then experience traumas through neglect or abuse, thus perpetuating the cycle from generation to generation, where traumatized children become the maltreating parents.[5]

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Early childhood trauma refers to traumatic events experienced by children from birth to age 6.[6] It is different from traumas experienced by adults because it impacts the developing architecture of the young child's brain, which is particularly vulnerable to stress. The prefrontal cortex, an essential part of the brain for self-regulation, is most affected by early stress. As a result, children in stressful environments find it hard to follow directions, stay on task, sit still, control impulses, concentrate, and learn. Disruption of brain development during the early critical and sensitive periods can become hardwired in a wide range of negative consequences, such as behavior challenges, mental health disorders, academic problems, delinquency,[7] and long-term negative health outcomes.

Complex trauma refers to an adult's or a child's experience of a multitude of traumatic events and the impact of those events. Complex trauma can contribute to a troubled parent-child relationship that requires specialized supports and should be addressed by qualified mental health therapists and other child-serving individuals and organizations.

ADVERSE CHILDHOOD EXPERIENCES (ACE)

Early childhood traumas or adversities are common. In 1998, researchers discovered an important linkage between what they termed "adverse childhood experiences" and lifelong physical and mental health conditions.[8] Early childhood trauma is associated with a multitude of long-term effects, such as alcoholism, depression, drug use, risk for intimate partner violence, sexually transmitted diseases, smoking, suicide attempts, and adolescent and unintended pregnancies.[9]

The original 1998 Adverse Childhood Experiences Study was conducted on over 9,500 predominately middle class patients. A second major ACE study was conducted in 2009 with a larger sample of over 17,000 participants. Table 1 depicts the ten adverse childhood experiences and their prevalence, in percentages.

Table 1: Ten Adverse Childhood Experiences

Category of childhood exposure	2009 Prevalence N=17,337
Psychological/emotional abuse	10.6%
Physical abuse	28.3%
Sexual abuse	20.7%
Substance abuse	26.9%
Mental illness	17.3%
Mother treated violently/domestic violence	12.7%
Household criminal member	4.7%
Parental separation or divorce	23.3%
Emotional neglect	14.8%
Physical neglect	9.9%

The number of ACEs experienced by this generally well-educated and middle-class cohort was surprising.

- 27% experienced one ACE
- 16% experienced two ACEs
- 10% experienced three ACEs
- 13% experienced four or more ACEs

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Cumulative Effect of Adverse Childhood Experiences

The more adverse childhood experiences, the higher the risk for future health and social problems. Table 2 shows the large differences in the prevalence of health risk factors and diseases between those individuals who had no adverse childhood experiences and those who had four or more.

Table 2. Comparison of Prevalence for Risk Factors and Diseases for Children with No ACEs and Those with Four or More ACEs[10,11]

Type of Health Risk Factor or Disease	Prevalence Among Those with No ACEs	Prevalence Among Those with Four or More ACEs
Current smoker	6.8%	16.5%
Considers self an alcoholic	2.9%	16.1%
Youth substance abuse	2%	9%
Suicide attempts	1.2%	18.3%
Youth mental health problems	11%	36%
Use of illicit drugs	6.4%	28.4%
Heart disease	3.7%	5.6%
Obesity	5.4%	12%
Sexually transmitted disease	5.6%	16.7%
Teen pregnancy	19.5%	41.1%

TYPES OF STRESS

Stress is a biological and physiological response experienced in the body when someone encounters a threat that cannot be easily tolerated. There are three distinct types of stress responses that can be experienced by children and adults.[12]

Positive Stress is a response that is mild to moderate in severity and does not persist for a long period of time (e.g., doctor's appointment, being pulled over for speeding). The stressor causes the heart to beat faster and stress hormone levels to increase a bit. Once the stressful event is over, the heart rate returns to normal and the stress response system returns to baseline. This type of stress is considered "positive" in that it offers an opportunity to practice healthy responses to mildly stressful experiences.

Tolerable Stress is an event or a threat that activates a more sharp response from the stress response system (e.g., death of a family member, a serious illness, or a bad divorce). This form of stress response is made tolerable by the extent of the individual's coping skills and/or their use of a support network to help cope and maintain a sense of control. These coping skills and supports reduce the physical stress response and promote a return to baseline.

Toxic stress can be experienced by infants and young children as well as older children and adults.[13] It is strong, frequent, prolonged stress that overloads the body systems. It differs from positive stress, which is mild and brief and helps a child along in development, and from tolerable stress, which is more severe than positive stress but is buffered by strong social and emotional supports from a parent or other caregiver.[14]

As described earlier, stress "turns on" the stress response system, which involves different parts of the brain and other bodily systems. Toxic stress produces a persistent activation of the stress response system, which changes the brain and body over time. It produces different effects from early childhood to adolescent to adult, but is particularly harmful to infants and young children, whose developing brain architecture can be damaged.[15] In children, toxic stress "is the body's biological response" to adverse childhood experiences[16] without the benefit of caring and nurturing emotional support from an adult.

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THE IMPORTANCE OF IDENTIFYING CONCERNS WITH PARENT-CHILD RELATIONSHIPS

Infants and young children learn their view of the world through relationships, which affect their intellectual, social, emotional, physical, behavioral, and moral development.[17] If the foundation of their world is unstable because of stressful circumstances or trauma in the parent or caregiver, they are at risk for an array of negative outcomes found in the ACE study. This is particularly true with an accumulation of four or more adversities. The longer the child's toxic stress is unidentified and addressed, the more wear and tear on the executive functions of the brain. The accumulation of maladaptive strategies is then hardwired into the child's biology, resulting in more pervasive and severe physical and mental health consequences.

Fortunately, the effects of trauma and toxic stress can be mitigated for both the child and parent, and home visiting can serve an important role. Research has demonstrated that positive parenting can prevent or ameliorate the harmful effects of adverse experiences.[18] With appropriate supports, children can become more resilient, bounce back from adversity, and be emotionally healthy.[19]

The Importance of Home Visiting

Quality home visiting programs help parents provide safe and supportive environments for their children, and over time, families and home visitors build strong relationships that lead to lasting benefits for the entire family. Research has shown that home visiting programs can have several beneficial outcomes:

- Women have fewer preterm births
- Moms and babies are healthier
- Children are better prepared for school
- Children are safer with reduced rates of maltreatment
- Families are more self-sufficient[20]

Home visitors can be some of the first and best observers of the parent-child relationship. Focusing on the parent's relationship with the child is important because children learn to understand their environments through their parents. A child who is not securely attached with the parent—that is, not connected deeply and emotionally in a relationship built on trust—is at high risk of social and emotional delays.[21]

Home visiting can address attachment problems. Home visits with expectant mothers provide clues to both the mom's physical and mental health. Anxiety, depression, and toxic stress are risk factors for adverse outcomes for the expectant mother and her baby.[22] Helping the mom address her issues prior to, and immediately after, the birth of her baby can improve her ability to interact in a healthier manner.

WHAT CAN CAUSE STRESS FOR EXPECTANT FAMILIES?

Many situations can be stressful to expectant families and may become toxic if the stress is chronic and not buffered by supportive relationships. Home visitors may observe these highly stressful situations:

- Unwanted pregnancy due to rape
- Pregnant at young age
- Too many children
- Unplanned pregnancy due to birth control failure or other reasons
- Homelessness or unstable housing
- Communal or overcrowded household
- Instability related to electricity, food, or other basic necessities
- Chaotic home life/neighborhood
- Insecure income
- Family member with mental or physical illness, substance use disorder, incarceration
- Relationship conflicts and domestic violence
- Father of the baby absent
- Unsecured weapons in the home
- Lack of social support

However, it is not so much the type of traumatic events or chronic stress, but the way in which each individual responds to the stress. Different people can be subjected to the same experiences and have extremely different stress responses—from mild to debilitating reactions. The variation in the stress response system is attributed to the amount and severity of the trauma, the individual's level of resiliency and protective factors, and genetic makeup. A pregnant woman may be able to handle unstable housing, but may be overwhelmed when her housing

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problem is combined with substance abuse and domestic violence. The cumulative effect of four or more major stressors seems to be the tipping point for predicting numerous adverse outcomes.

Clues That a Home Visitor Might See in a Family Experiencing Stress

- Missed appointments
- Apparent parental stress
- Parent with mental health issues
- Parent with substance use issues
- Use of inappropriate and harsh discipline
- Parent is under the influence during visit
- How does the parent seem to be doing emotionally?
  - Is she looking forward to having the baby
  - Does she seem happy with her baby?
  - Does she appear to be overly stressed?
  - Does she seem angry?
  - Is she sad or depressed?

CHARACTERISTICS OF TRAUMA, TOXIC STRESS, AND DEPRESSION IN PREGNANCY

Pregnant women react differently to the physical changes and stresses in pregnancy, as well as to emotional changes. Similarly, signs of trauma and toxic stress differ. It's important to ask yourself, "I wonder if trauma has played a role in…." each of the following symptoms:

- Extreme weight loss or gain
- Insomnia or desire to sleep all the time
- Crying a lot
- Extreme mood swings from highly active to staying in bed for days
- Unprovoked anger and irritability
- Risky behaviors such as smoking, drinking, or substance abuse
- Missing appointments or prenatal visits
- Avoidant behavior or withdrawing from friends and family
- Having headaches, aches and pains, or stomach problems that don't go away
- Not following medical instructions[23,24,25]

Maternal depression may be caused by her exposure to adversity and can compromise the reciprocal relationship between mother and child that is essential for healthy development. Depression may occur due to environmental stressors, biological stress, and/or a family history of depression and can become toxic in the absence of a supportive relationship. Depression during pregnancy has been found to have a harmful affect on the unborn child due to its impact on multiple body systems—the way people think, the way they feel, the way they act and the regulation of the sleep/wake cycle which affects energy. In addition, depression is known to alter the stress response system in the body. When the body is exposed to chronic stress, anxiety, or depression, changes occur at the cellular level throughout the body. These changes can become permanent. When a woman is pregnant and depressed, all of these physical, system-wide changes occurring at the same time may alter the unborn baby's development through the placenta.

Symptoms of maternal depression and other signs of toxic stress during pregnancy, and in the couple of weeks following delivery, may include:

- Prior history of depression
- Not planning for the baby's arrival
- Depressed mood, feeling sad, empty or tearful (in teens, depressed mood can appear as constant irritability)
- Significantly reduced interest or feeling no pleasure in all or in most activities
- Decreased energy
- Feelings of worthlessness
- Feelings of excessive or inappropriate guilt
- Reduced ability to concentrate or make decisions nearly every day
- Recurrent thoughts of death or suicide, with or without a specific plan

Unfortunately, 40% to 60% of low-income mothers of young children and pregnant and parenting teens report being depressed—much higher than 5% to 25% of pregnant and parenting women in general.[26]

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IDENTIFYING AREAS OF CONCERN WITHIN THE PARENT-CHILD RELATIONSHIP

Despite variations in parental styles and cultures, home visitors can look for "consistent, sensitive responses" to a child, which are enough to create a trusting relationship that fosters social and emotional development.[27]

Even the best parents will sometimes misread a baby's cues, or be unable to respond appropriately.

> Positive parent-child interactions may look quite distinct in different families. A wide range of care giving styles, playful interactions, and emotional responses support healthy child development. Parents' responses to children's cues and behaviors differ. This may depend on their own temperament, personal history, current life situation, and their cultural goals and beliefs.[28]

Some signs and symptoms of trauma or toxic stress may apply to all mothers, infants, and young children, regardless of age. Others may be specific to an age.

Potential Concerns for the Parent-Child Relationship for a Mom and Her Newborn in the First Three Months

Home visitors observe "the story" of parent-child interactions and can determine if toxic stress is impairing the relationship. "[I]t is the infant who allows a story to be told. The ways in which a parent handles the baby, provides care, and plays (or does not interact playfully)"[29] can help the home visitor determine what the mother may need—help with basic needs, emotional support, developmental guidance, relationship assessment and support, or mental health therapy.

Mom's behaviors that may suggest problems with developing a healthy parent-child relationship include:

- Inability to care for the baby
- Unwilling/unable to respond to the baby's needs
- Unable to soothe and calm the baby
- Inconsistent care giving
- Harsh tone and touch
- Flat affect, no range of emotions, withdrawn, unsmiling or no shared smile response

Behaviors the infant may have if needs are not met or if the infant is not attaching to the mother:

- Flat affect, no range of emotions, withdrawn, unsmiling or no shared smile response
- No cooing or interaction
- Difficult to soothe or console
- No eye contact or tracking
- Poor sucking response
- No interest in sights, sounds, or touch[30]

Potential Concerns for the Parent-Child Relationship for a Mom and her Child Age 3 to 36 Months Old

In addition to the list above for the mom, you may notice:

- The absence of "serve and return" interactions—the process in which a baby babbles or gestures and the caregiver responds
- Use of inappropriate physical discipline
- Neglect and/or constant under-stimulation of the child[31]

Behaviors a child under 18 months of age may display if needs are not met or the child has an unhealthy relationship with mom:

- Shows regression in language (e.g., stops cooing and babbling) or delay in communication development (e.g., doesn't wave or point; doesn't say at least six words)
- Has delayed physical motor skill development milestones (e.g., creeping, crawling, sitting, etc.)
- Flat affect, no range of emotions, withdrawn, unsmiling or no shared smile response
- Rejects/avoids being touched, held, or cuddled
- Difficult to soothe or console or unable to comfort or calm self
- Extremely fearful or on-guard
- Does not turn to familiar adults for comfort or help
- Unprovoked aggression
- Does not interact appropriately with parent (e.g., hits, bites, kicks)
- Hypervigilant (e.g., stays near mother or caregiver)
- Hypersensitive to sounds, light, touch
- Hyperactive
- Trouble sleeping
- Lacks curiosity and does not explore
- Little or no eye contact
- Frequent and long-lasting fussiness or irritability
- Trouble with eating/feeding—too much or too little

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In addition to the list above, toddlers and preschoolers may show these symptoms and behaviors:

- Unable to use toys in imaginary ways
- Often seems sad or worried
- Fails to listen or respond
- Rarely uses words to express feelings
- Seems unable to control feelings most of the time[32]
- Body complaints that have no medical explanation
- Feeling helpless/passive
- Repetitive/post-traumatic play; talking about a traumatic event and reacting to reminders/trauma triggers
- General fearfulness/new fears
- Easily startled
- Aggressive behavior
- Sexualized behavior
- Avoidant, anxious, clingy
- Restless, impulsive, hyperactive
- Difficulty identifying what is bothering them
- Inattentive, difficulty problem solving
- Irritable
- Sad/depressed
- Poor peer relationships and social problems (controlling/over permissive)[33,34,35,36,37]

OBSERVING THE PARENT-CHILD INTERACTION

Nurturing, responsive interactions that children have with their parents and caregivers are the basis for attachment, as well as for social and emotional development. The quality of parent-child interaction during the first year of life plays a crucial role in social-emotional development outcomes, not only in infancy, but throughout the life span. Infants and children whose parents accurately identify and interpret their signals and respond in a sensitive manner tend to display more self-calming behaviors, less irritability, more positive attachment patterns, and more positive social engagement. In general, they show more favorable social-emotional developmental trajectories over time. Children who receive consistent and nurturing interactions in the first three years develop better social-emotional and communication outcomes by the time they enter kindergarten, as compared to children who don't experience such consistent care giving.

When observing a parent interact with her young child:

- Pay attention to your own feelings as you observe
- Objectively describe what you see and hear; quote the family's own words
- Avoid interpretive judgments and generalizations
- Notice the overall tone of the interaction

During the observation, ask yourself:

- What is the interactive style (actively observant, sensitive, forced, facilitative, controlling, intrusive, uninvolved, or misinterpreted)?
- How does the parent help the child adjust to new people and/or activities?
- How does the parent respond if the child is acting out?
- How do the parent and child communicate with each other?
- How do they touch each other?
- How does the parent engage the child?
- Does what the parents say about their child match with what you see?
- Who takes the lead in the interaction? How do others respond?
- Is the parent-child interaction positive and encouraging?
- How do the parent and child recover from distressing situations?
- During the home visit, does the child look to the parent for comfort and reassurance?
- Does the parent respond to the distress of the child compassionately?
- How is the parent able to support the child's emotional needs?
- Is the parent able to read child's cues and respond appropriately? For example, does the child respond to the mother's voice or maintain a mutual gaze with his mother?[38]
- Does the mother respond to continuous crying by an infant or toddler?

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Using a Protective Factors Approach to Helping Families

Strengthening Families is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building six protective factors:

1. Nurturing and attachment
2. Knowledge of parenting and child development
3. Parental resistance
4. Social connections
5. Concrete support in times of need
6. Social and emotional competence of children

For more information on working with families using the protective factors approach, please read the *2015 Prevention Resource Guide: Making Meaningful Connections.*[39]

SUMMARY

Research shows that babies who receive affection and nurturing from their parents have the best chance of developing into children, teens, and adults who are happy, healthy, and possess individual-level protective factors such as relational, self-regulation, and problem-solving skills. Research also shows that a consistent relationship with caring adults in the early years of life is associated with better grades, healthier behaviors, more positive peer interactions, and an increased ability to cope with stress later in life.

By being inside the home of a child and mother or other caregiver on a regular basis, home visitors have a unique opportunity to look for signs of trauma,toxic stress, and depression that may impair healthy parent-child interactions. Knowing the signs of toxic stress and trauma in a child and in a mother, from pregnancy through the first years of the child's, life can set the stage for encouraging and modeling positive parental relationships and providing other supports. There will be times when the family's stress, depression, or traumatic history may affect their ability to bond with their child appropriately and more intensive intervention than the home visitor can provide will need to be provided. If this occurs the home visitor should refer the family to appropriate therapeutic or community services and ensure the family follows through with the referral.

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