Chapter 8
Forensic Evaluations of Parents in Child Protection Matters: The Significance of Contextual, Personal, and Racial Trauma

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Introduction

Forensic evaluations of parents in child protection matters are typically conducted at two points. Early in the life of the case, the focus is on risk and protective factors to recommend services to achieve parent–child reunification. At the permanency stage, the question is whether the parents have been sufficiently rehabilitated for their children to be safely returned. The impact of trauma is frequently underestimated at both stages. Multiple sources of trauma can be in operation, particularly for African–American parents: interaction with the child protective service agency; the psychological evaluation process; the parent's personal trauma history; and the family's multigenerational experience of racial trauma. Unless psychologists identify and understand these contextual, personal, and racial sources of trauma, the parent's symptoms and self-protective behaviors may be unwittingly escalated. The result is misdiagnosis, inadequate or inappropriate therapeutic interventions, and the ultimate loss of children permanently.

Contextual Trauma

Parental Reactions to Child Welfare System Involvement

For parents, involvement with the child welfare system is highly stressful, if not traumatic (Dumbrill, 2006; Morrison, 1996; Tuttle, Knudson-Martin, Levin, Taylor, & Andrews, 2007). Parents describe fear of the caseworker's power, and feelings of

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being out of control, and victimized. Many removals are made on an emergency basis. The process of the removal itself may be frightening to both parents and children, particularly if there has been no preparation. Some removals involve physical altercations and the presence of police officers. If the child is placed in a setting unknown to the birth parent, anxiety is generated about the welfare of the child in this anonymous home.

Parents are typically angry at the child protective agency but are simultaneously asked to cooperate with the agency. While the removal of a child can trigger motivation in parents to do everything possible to regain custody, many parents become immobilized and overwhelmed with the multiple demands that are made in the wake of their abject emotional pain. The absence of the child is likely to trigger intense sadness, while being viewed as an "unfit" parent is experienced as shameful. The presence of fear, anxiety, anger, sadness, shame, and being overwhelmed can easily interfere with the parent's ability to comply with expectations in an optimal manner. Rather than blaming parents for their predicament, acute distress, or difficult presentation, affording them the same sensitivity that is offered to other traumatized populations may de-escalate their situational, normal response to separation from their children.

The Psychological Evaluation Process

Parents are often required to undergo psychological evaluations involving interviews and testing. For the parent, the psychologist and the evaluation will be perceived as extensions of the child protective agency. As such, the response of the traumatized and overwhelmed parent will be one of self-protection, and/or an exacerbation of their trauma symptoms. Psychologists must consider the real possibility that the parent's behavior during an evaluation reflects a reaction to the trauma of the child's removal and not the parent's typical functioning. For example, a parent who reacts to an interview with minimal responses for fear of saying the wrong thing can be seen as not introspective and not likely to benefit from treatment. A parent who seems angry toward the psychologist or the evaluation process may be considered to have an impulse-control or mood problem, and, by extension, pose a potential danger to her children.

Impact of Personal Trauma

Maternal mental illness is present in a significant percentage of cases open for investigation of child maltreatment (Westad & McConnell, 2012). Research suggests a range of mental health problems (Gonzalez, 2014). Substance abuse is typically recognized, but many of these parents have co-occurring mental health conditions (Stromwall et al., 2008). Histories of trauma often play a significant but

unrecognized role in these conditions. Even in the absence of diagnosable mental health conditions, a history of personal trauma can play a major role in parenting and child maltreatment.

Trauma Sequelae and Serious Mental Illness

Child protective workers typically refer parents for evaluations if they have psychotic symptoms or serious problems with affect regulation. However, the role of trauma histories in these clients is often overlooked, and comorbid Posttraumatic Stress Disorder (PTSD) is often not diagnosed. Studies repeatedly indicate that the rates of both trauma exposure and PTSD in clients with severe mental illness are significantly higher than such rates in the general population (Alsawy, Wood, Taylor, & Morrison, 2015; Neria et al., 2008; O'Hare, Shen, & Sherrer, 2013). The trauma exposure in these studies does not seem to be the result of the psychotic symptoms but appears to predate psychotic symptoms. A history of interpersonal violence specifically was very common (Neria et al., 2008). These findings have been supported in multiple countries (Álvarez et al., 2012; Quarantini et al., 2010). When parents are diagnosed with severe mental illness, recommendations typically focus on ensuring compliance with medication and the trauma history is not addressed. This is an inadequate level of treatment.

As is generally true for clients with psychosis, individuals with Bipolar Disorder also have higher rates of diagnosable PTSD than the general population (Assion et al., 2009; Hernandez et al., 2013). A review of several studies (Otto et al., 2004) found that the rate of PTSD among Bipolar patients is roughly double the rate in the general population. Goldberg and Garno (2005) found diagnosable PTSD in about one-quarter of the patients with Bipolar Disorder they studied. Again, within child protective service evaluations, a diagnosis of Bipolar Disorder often results in a focus on medication compliance and an absence of treatment for trauma.

Patients with Bipolar Disorder *and* PTSD have significantly worse social functioning (Neria et al., 2002) than those with Bipolar Disorder only. This comorbidity is associated with greater likelihood of the presence of a substance use disorder, lower likelihood of being in recovery, elevated rates of suicide attempts, lower role attainment, and more problematic quality of life (Otto et al., 2004). Certain problems associated with PTSD may be particularly responsible for these negative life outcomes. For example, triggers associated with traumatic histories can lead to distress and panic, making the patient generally more emotionally labile. In addition, the chronic overarousal and difficulty sleeping associated with PTSD can put patients with Bipolar Disorder at risk for new episodes. Avoidance of stimuli that elicit trauma reactions can also result in the avoidance of activities and situations that could result in an improved quality of life. While many individuals with Bipolar Disorder alone can be managed quite well with medication and can appropriately parent children, the additional presence of PTSD makes the parent more unstable and more likely to engage in behavior that could put a child at risk of harm.

Childhood trauma appears to be a significant factor for clients with Bipolar Disorder, as it is for clients with psychosis generally. Clients with Bipolar Disorder are particularly likely to have PTSD when there was a history of severe childhood abuse, especially sexual abuse (Goldberg & Garno, 2005). Maniglio (2013) studied the specific presence of a history of child sexual abuse among patients with Bipolar Disorder in a review of studies. The conclusion was that the trauma of child sexual abuse was associated with a more severe form of Bipolar Disorder that was strongly related to PTSD. In addition, the presence of a history of child sexual abuse was associated with more suicide attempts, substance use, and psychotic level symptoms. The presence of these additional difficulties puts the parent at greater risk of child protective service involvement and the permanent loss of children.

When only Bipolar Disorder or psychosis is identified in the psychological evaluation without recognition of a trauma history, the ensuing treatment will typically not address those aspects of the history that may trigger episodic dyscontrol or acute trauma sequelae. Thus, even if the parent is compliant with medication, the continued episodic dyscontrol is viewed as only the result of the psychosis or mood disorder and is not understood as connected to trauma. Without a focus on treating trauma as well as the comorbid condition, the likely outcome is an assessment that this parent will never be able to care for the child safely due to the comorbid condition, when the real issue is often an untreated trauma history.

Complex Trauma and Borderline Personality Disorder

Many parents in child protection cases have histories of chronic abuse and neglect as children. Complex Trauma is identified as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature and early-life onset" (van der Kolk, 2005, p. 401). The developing brain of the young child is impacted by these experiences in ways that scholars are now describing as "Developmental Trauma Disorder" (van der Kolk, 2005). These early experiences can have a lifelong impact in the areas of attachment, affect regulation, behavior control, biology, cognition, dissociation, and self-concept (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). A child who is not treated for these difficulties becomes an adult with impaired ways of coping that can negatively impact parenting. It is therefore important that a psychological assessment of a parent include an assessment of the parent's own early childhood history as a potential source of the parenting difficulty that has emerged.

"Betrayal trauma" refers to the experience of trauma caused by someone very close to a victim. In the case of children, it typically refers to abuse by parents and is thus related to the concept of Complex Trauma or Developmental Trauma Disorder. High levels of dissociation are associated with betrayal trauma as well as Complex Trauma and are further heightened in mothers who are then revictimized in adulthood (Hulette et al., 2011). Dissociation makes these women less aware of interpersonal threats to themselves and their children, and thus, they are more likely to be revictimized. The children of those women who were revictimized in adult-

hood were more likely to experience interpersonal victimization themselves as compared with the children of women who had not been revictimized as adults. In addition, betrayal trauma also appears to be related to the development of Borderline Personality Disorder. DeGregorio (2013) argues that the neuropsychological mechanisms impacted by serious and chronic childhood abuse create deficits in social, cognitive, emotional, and behavioral domains that are linked not only to the development of Borderline Personality Disorder but are also linked to problems in parenting. Parents with Borderline Personality Disorder experience problems with stress and reactivity, the ability to regulate affect, and effective attunement to their child's emotional states.

A recent review raises the question of whether Borderline Personality Disorder is really a disorder of Complex Trauma (MacIntosh, Godbout, & Dubash, 2015), as the core components of Borderline Personality Disorder contain features that have been described as consequences of chronic childhood trauma: affect dysregulation, problems with relational adjustment, and problems with identity integration (including dissociation). It is these features that may be core to an understanding of the psychological difficulties that can result in child maltreatment.

Studies that specifically examine a child protective service population appear to provide further support for the relationship between Complex Trauma and Borderline Personality Disorder. A comparison of birth mothers involved with child protective services with a community control group found that mothers involved with child protective services had a higher rate of reported maltreatment in their own childhoods, as well as more features of Borderline Personality Disorder (Perepletchikova, Ansell, & Axelrod, 2012). Those with the most Borderline Personality features also had the most severe histories of maltreatment. However, it was the presence of Borderline Personality features, rather than the maltreatment history or even the presence of substance abuse, which predicted involvement with child protective services. These parents appear to have more difficulty maintaining a risk-free environment for children, even if they do not abuse or neglect their children.

Trauma and Substance Use

Many people with traumatic histories, both children and adults, never receive the treatment they need in the aftermath of those experiences. Without adequate treatment and support, trauma often results in long-term subjective suffering from which people frequently seek to escape. A large and growing literature has found a positive relationship between histories of trauma and substance use problems (Keyser-Marcus et al., 2015). The presence of emotional dysregulation following child abuse seems to play a major role in the development of adult substance abuse (Mandavia, Robinson, Bradley, Ressler, & Powers, 2016). Parents who have used substances to self-medicate subjective distress produced by trauma often find themselves in further difficulty economically, socially, and legally, as well as in their capacity to parent in a reliable and consistent manner. As is true for serious mental illness, there

is a tendency in child protective service evaluations to focus on compliance with drug treatment and with a cessation of drug use, without identifying and addressing the underlying trauma that stimulated the substance abuse. Thus, when parents continue to relapse, they are blamed for not being ready to live in recovery, not having sufficient self-control, or not loving their children enough, when the real problem is often going back into a trauma-filled environment or not sufficiently quelling the symptoms associated with the original trauma.

Trauma and Parenting

Trauma from any source and its psychological consequences can impact parenting. Discussions of transgenerational trauma, intergenerational transmission of trauma, and historical trauma began in earnest in psychology with the examination of the impact of the European Holocaust on children of survivors. The idea that traumatic experiences of parents individually or communities of people collectively can impact subsequent generations continues to be the subject of considerable interest from psychological, historical, and biological perspectives.

Studies on the impact of parental PTSD specifically suggest an impairment in the parent–child relationship (van Ee, Kleber, & Jongmans, 2016). Several relational patterns are found in traumatized parents: less emotional availability; a more negative perception of their children; more easily dysregulated/distressed children. These relational patterns are like those of depressed and anxious parents. Caregivers substantiated for child abuse or neglect with a trauma history were found to have higher scores on the Child Abuse Potential Inventory than those without such a reported history (Craig & Sprang, 2007).

Trauma also appears to have an indirect effect upon parenting, in that there are elevated rates of postpartum depression in woman with a history of childhood trauma. Postpartum depression can affect the interaction and attachment between the child and mother and is associated with subsequent problems in the child (Choi et al., 2017). If a parent–child dyad with problematic interactions and attachment is the subject of a forensic evaluation, it is important to assess for both a history of parental trauma and of postpartum depression. This will provide the opportunity for an appropriate level of treatment that will assist each member of the dyad in the present and also serve a preventative function should the parent become pregnant again.

Intergenerational Transmission of Child Abuse

The literature is generally supportive of the concept of an "intergenerational transmission of abuse" (Bartlett, Kotake, Fauth, & Easterbrooks, 2017). However, the degree of this transmission and the factors that provide protection are subject to continuing research.

There have been findings that suggest "type-to-type" correspondence in transmission, that is, parents who were neglected tend to be neglectful and parents who were physically abused tend to become physically abusive (Kim, 2009). A recent study (Bartlett et al., 2017) found that mothers who had experienced some type of maltreatment as children were much more likely to have maltreated their children in some manner, as compared with mothers who had not had this experience. They concluded, "As expected, although type-to-type (homotypic) transmission of neglect was strongly predicted across generations, when mothers had childhood histories of abuse *and* neglect, the likelihood of their own children experiencing multiple types of maltreatment, even by preschool age, increased sharply" (Bartlett et al., 2017, p. 92).

The presence of multiple types of maltreatment seems critical in the production of mental health problems that could lead to transmission of child abuse. Edwards, Holden, Felitti, and Anda (2003) studied a large sample of adults in a health maintenance organization and found that the number of types of abusive experiences (physical, sexual, witnessing maternal battering) was associated with poorer mental health. Furthermore, emotional abuse (e.g., being called names by a parent, feeling hated by a parent) had a significant main effect on mental health as an adult, and its presence heightened the impact of other types of abuse.

The presence of trauma symptoms in parents plays a mediational role in the intergenerational transmission of risk for physical abuse. Milner (2010) found that individuals with problems with self-reference (identity confusion) and with tension reduction behavior demonstrated heightened risk. Both problems are particularly associated with histories of Complex Trauma. High levels of defensive avoidance, a symptom typically associated with PTSD, was also predictive of heightened risk of intergenerational transmission of physical abuse.

Similarly, dissociation, a common consequence of repeated trauma, has also been implicated in the intergenerational transmission of child abuse. Focusing again on physical abuse, Narang and Contreras (2005) found that elevated dissociation was associated with higher physical abuse potential. Furthermore, parents who were physically abused and were also raised in a family environment characterized as uncohesive, unexpressive, and conflictual had higher levels of dissociation. Dissociation is often not identified during forensic evaluations unless the examiner inquires about it directly or it is manifested during the interview. When manifested, it can easily be misunderstood as a lack of interest in the content of the discussion, resulting in a parent being seen as uninvested in the process. Neglecting to identify dissociation can easily result in a client's lack of improvement when services are offered.

Another study confirmed emotional dysregulation and negative affect in mothers who experienced physical abuse as children to be mediators of the intergenerational transmission of child physical abuse (Smith, Cross, Winkler, Jovanovic, & Bradley, 2014). Emotional dysregulation and negative affect are likely to be identified in a forensic evaluation. However, if they are not understood as related to trauma, they can be easily misunderstood as general hostility and resistance.

Racial Trauma

Although multiple authors cite the importance of identifying trauma, few recognize the existence and importance of racial trauma, especially for African–American parents within the context of child protective services and related forensic psychological evaluations.

A disproportionate number of African–American children across the country are placed in foster care and eventually freed for adoption through child protective service involvement (Dettlaff & Rycraft, 2010; Miller & Ward, 2008; Roberts, 2002). Factors that contribute to the disproportionality are: poverty; living in an urban poor neighborhood; institutional racism in the form of policy and procedures; a lack of staff cultural awareness and competence; staff fear of liability; high caseloads; and ineffective service delivery.

Bias in legal and mental health services was also reported to contribute to the disproportionality for African–Americans in the child welfare system. Several sources (Dettlaff & Rycraft, 2010; Miller & Ward, 2008) report disproportionality stemming from legal services to include the following issues: the quality of legal representation; inequity in child protective agency and court decisions; and the tendency to use middle-class standards for family reunification. Roberts (2002) reported that court decisions where parenting capacity is considered irrelevant to the issue of the child's "best interests" and the court's tendency to rely on forensic evaluations produced by the child welfare agency rather than attorneys for parents and children contribute to disproportionality. Dettlaff & Rycraft (2010) reported mental health services to be insensitive to the needs and worldview of African–American parents. In addition, Roberts (2002) reported mental health services contribute to disproportionality for African–Americans by: legitimizing the ongoing separation of parents and children; interpreting parental poverty and cultural issues as indicative of psychological deficiency; giving mental health providers monetary incentives to render opinions that side with the child welfare agency; giving the child welfare agency incentives to choose mental health providers that agree with them; and penalizing parents when they disagree with or question child protective service actions or child removal. Thus, for African–American parents, involvement with child protective services mirrors the race-based discrimination and oppression they experience in the larger society. This increases the likelihood that they will have a negative response to the child protective service system. This negative response reflects their lived experience of racism.

"Racial trauma," the repeated exposure to the chronic stressor of racism, has a cumulative effect on the individual and across multiple generations in a manner that is similar to the symptoms and sequelae noted in PTSD and Complex Trauma (Carlson, 1997; Carter, 2007; Comas-Diaz, Hall, & Neville, 2019; DeGruy, 2017; Ford, 2008; Franklin, Boyd-Franklin, & Kelly, 2006; Helms, Nicolas, & Green, 2012; Holmes, Facemire, & DaFonseca, 2016; Watson, Deblaere, Langrehr, Zelaya,

& Flores, 2016). Symptoms resulting from racial trauma include: reexperiencing; hyperarousal; hypervigilance; avoidance; dissociation; memory impairment; denial; limited emotional range; emotional reactivity; helplessness; anxiety; depression; anger/rage; self-blame; shame/guilt; poor self-concept; identity confusion; adoption of the belief system of the oppressor; self-defeating or overcompensating behaviors; poor/unstable relationships; inability to protect the self and others from situations that signal racism; exhaustion; and a high incidence of immune system and other medical problems (Carlson, 1997; Carter, 2007; DeGruy, 2017). As is true for more traditional forms of trauma, when racial trauma is also not identified and treated, parents will be at a higher risk for continuing to experience symptoms that will negatively impact their treatment success, functioning, and child protective service case.

Several studies have found a relationship between race-based stressors, trauma symptoms, mental health, and well-being. A direct relationship has been found between the level of racial discrimination and the level of dissociation (Polanco-Roman, Danies, & Anglin, 2016). Experiencing microaggressions has been found to be associated with depression and somatic symptoms (Holmes et al., 2016). Lastly, experiences with racial discrimination, and/or the frequency of racial discrimination, was found to predict PTSD diagnostic status, and was also found to be related to poorer general functioning in African–Americans (Sibrava et al., 2019). These studies demonstrate that, in order to be "culturally competent," attempts to address mental health and well-being among African–Americans must include a component that identifies and addresses racial trauma.

Racial trauma also impacts patterns of parent–child interaction and discipline. In comparison to white middle-class populations, African–American parenting styles often appear harsh and are more likely to include physical discipline (Dodge, McLoyd, & Lansford, 2005). African–American parents are often judged negatively during observations with their children and are frequently referred to parenting classes and family therapy. These negative characterizations often reflect a lack of recognition that the parenting styles, attitudes, and discipline patterns of African–American parents are adaptive and serve as a protective factor for many African–American children. Dodge et al. (2005) reported the parenting styles of African–Americans demonstrate the following strengths: these styles protect children from encounters with racism and from the dangers of the street; African–American children typically view strict discipline as a sign of family love and caring; greater African–American parental control and supervision were related to increased child well-being and higher grades in low-income neighborhoods. Within the African–American community, physical discipline is not necessarily seen as a sign of aggression. When African–American parents use culturally appropriate levels of physical discipline, it is done within the context of unqualified love and acceptance for the child, at levels that are far below the threshold for physical abuse (Dodge et al., 2005).

Assessment Process

Parent Interview

The goal of the parent interview is more than just collecting data. It is the psychologist's opportunity to demonstrate sensitivity toward the traumatized, anxious, upset parent, and demonstrate sensitivity to the power inequity and sociopolitical context of the evaluation. Psychologists can start the clinical evaluation by asking the parent several questions:

- How the parent feels about the interview
- Whether the parent has concerns about the evaluation
- What the parent's perceptions are regarding experiences with child protective services and the court

In addition to the above questions, the psychologist should also:

- Communicate awareness of the possibility of cultural, racial, and disproportionality issues in the evaluation and child protective service process;
- Establish the parent as the expert regarding these issues;
- Verbalize an openness to learn about and discuss these issues with the parent.

This approach provides the opportunity for the parent to feel empowered, decrease some of their self-protective behaviors, and to be more open and cooperative during the interview. It also allows the psychologist to demonstrate empathy, join with the client, and potentially be viewed as an ally.

During the evaluation, many parents will not identify their experiences as "traumas" or "maltreatment." Therefore, traumatic experiences can be elicited through questions that would produce a more general narrative about the parent's history. Parental narratives are likely to clarify themes of significance to the parent. It is important for the psychologist to be alert to the kinds of persistent interactions and misuse of power that characterize homes with chronic emotional abuse and domestic violence. Trauma narratives should include information about:

- Recollections of losses and separations
- Reasons for changes of residence
- Parenting practices in the parents' childhoods and with their own children
- Histories of conflicts in the home and in the community
- Sexual activity
- Experiences of coercion in adolescence and adulthood

The literature indicates that it is imperative to ask African–American parents specifically about their racial trauma histories. As recommended above for general traumas, the psychologist should also elicit narratives from the parent about their lifespan experiences with racism and discrimination. Examples of areas of inquiry include:

- The parents' experiences with racism and discrimination over their lifetime
- Specific instances of racism and discrimination that have had the most impact on them
- How these experiences shape who they are today
- What these experiences taught them
- What strategies they use to combat or counter their experience of racism and discrimination
- Whether these discrimination experiences and coping strategies manifested themselves during the current child protective service case

The nuance and richness of the parent narratives during the clinical interview far surpasses the type of information gleaned from merely having parents fill out impersonal personality and parenting inventories. This approach is especially critical for African–American parents, as it will produce a more accurate assessment and better prepare parents to engage in treatment.

Formal Testing

For the child protection agency and the court, psychological testing is viewed as a benign and objective way to determine the presence of problems. Unfortunately, the history of testing shows it to be far from impartial. Rather, psychological tests, psychological theories, and the use of standardized norms have a history of being employed to legitimize bias and the social control of oppressed groups (Franklin, 1991; Kamin, 1974; Sue & Sue, 2016). The standards of functioning are based upon the attitudes, behavior, and performance of a white middle-class population. This does not recognize that the culture of oppressed parents imbues them with a different set of attitudes, behaviors, strengths, and worldviews that are adaptive for them (Boyd-Franklin, 2003; Kamin, 1974; McLoyd et al., 2005; Ramseur, 1991; Sue & Sue, 2016).

In addition to standard techniques, psychologists should consider using tests designed specifically to assess traumatic experiences and sequelae. Some of these tests include the Trauma Symptom Inventory -2 (Briere, 2011) and the Inventory of Altered Self-Capacities (Briere, 1998). Atkins (2014) provides a critique of 16 instruments used to measure perceived racial discrimination. Of the 16 instruments that were studied, only the adult Index of Race-Related Stress (IRRS) (Utsey & Ponterotto, 1996) was found to have all its racism subscales confirmed via factor analysis (Cultural, Institutional, Individual, and Collective Racism). The IRRS is a 46-item test that measures the frequency with which African–Americans encounter discrimination on a 5-point Likert scale. The IRRS also comes in a brief 22-item version (Utsey, 1999). In addition, a study by Sibrava et al. (2019) utilized the Everyday Discrimination Scale (Williams & Mohammed, 2009; Williams, Yu, Jackson, & Anderson, 1997), which was reported to be a 9-item scale with good psychometric properties that has been used in the United States and internationally.

Written Report

Being treated with dignity and respect is very important for all parents, particularly for those of African descent (Boyd-Franklin, 2003; DeGruy, 2017; Sue & Sue, 2016). However, a lack of respect is often evident in the written psychological report. Parents may see the document and feel misunderstood, demeaned, over-pathologized, or even re-traumatized. This emotional harm contributes to difficulties completing services, including cooperation with future evaluations. The written report should offer a balanced view of the parent, where strengths, survival skills, and cultural issues, as well as problem areas are noted. Parents' statements should not be transcribed in broken English, which contributes to the parent appearing intellectually limited and incompetent. Surnames and not first names should be used to refer to adult clients.

Testing Section

The testing section of the written report should discuss the ways in which the parent differs, if at all, from the predominant normative group of any psychological tests administered, including cognitive, personality, or parenting instruments. This section should outline what the literature says about performance differences between respective groups, and the cautions indicated by these differences. Any suggestion that IQ or other test scores are absolute or immutable or are more than a sample of behavior, with a related margin of error, should be avoided. If an adaptive behavior measure was not given, a diagnosis of Intellectual Disability cannot be used (American Psychiatric Association, 2013).

Diagnostic Issues

The presence of diagnoses in a forensic psychological report often suggests to child protective services staff and the court that the client cannot parent. These professionals typically do not understand that having a mental health diagnosis does not necessarily indicate that parents are low functioning in comparison to the general population. The inappropriate portrayal of parents as pathological increases the likelihood that their children will not be returned to their care. When using diagnoses in child welfare cases, it is particularly important that the evaluator identify not only whether treatment is indicated, but also what the specific child safety risks are, if any, from such a diagnosis.

There are symptoms associated with trauma, particularly flashbacks, that may be misunderstood as symptoms of psychotic-level conditions. This kind of misdiagnosis has disastrous consequences for providing appropriate treatment as well as for child welfare outcomes. In addition, if there are comorbid diagnoses like Posttraumatic Stress Disorder, Complex Trauma, or other trauma sequelae, these

are associated with a more complicated clinical picture. As stated earlier, without the recognition of trauma in the diagnostic assessment, progress in treatment of comorbid conditions may be significantly impaired. It is critical that trauma symptoms and issues be identified.

Despite the similarities between the symptoms of racial trauma and PTSD, the *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5)* (American Psychiatric Association, 2013) does not specifically recognize race-based trauma in its diagnostic nomenclature (Carter, 2007; DeGruy, 2017; Ford, 2008; Franklin et al., 2006; Helms et al., 2012; Holmes et al., 2016; Watson et al., 2016). A PTSD diagnosis requires an index event described as "actual or threatened death, serious injury or sexual violence" (American Psychiatric Association, 2013, p. 271). Most race-based events will not meet this criterion, despite the high level of victim suffering (Carter, 2007; Helms et al., 2012; Franklin et al., 2006; Watson et al., 2016), unless there is the threat of serious physical injury.

In cases where a race-based traumatic event does reach the threshold for a diagnosis of PTSD, there is a question as to whether giving a diagnosis is appropriate. Diagnoses presuppose pathology in the individual, rather than recognizing racial trauma symptoms to be a normal response to a malevolent environment (Carter, 2007; Franklin et al., 2006; Holmes et al., 2016). This becomes important in child welfare cases because a treatment plan for an individual with PTSD would be one of the trauma-informed therapies, whereas a treatment plan for racial trauma could simply involve some type of system intervention or client education. Within this context, a PTSD diagnosis may serve to further stigmatize the parent and cause child protective services to view the parent as more impaired than warranted. This could result in a longer mandate for services than is warranted, and result in a delay in family reunification.

African–Americans are typically inappropriately overdiagnosed, overmedicated, and undertreated in comparison to white middle-class populations (US Public Health Service, Office of the Surgeon General, Center for Mental Health, National Institute of Mental Health, 1999). This finding supports the authors' observation for African–American parents in child welfare cases to be more likely to be erroneously diagnosed with psychosis, Bipolar Disorder, or a Personality Disorder. Diagnostic differences may be due in part to the cultural insensitivity inherent in psychological tests and among many evaluators. However, it may also be due to the misinterpretation of sequelae of racial trauma as symptoms of clinical pathology rather than normal cultural variants. For example, African–American parents may be diagnosed as "paranoid" when they verbalize that "the system is against" them or be considered "religiously preoccupied" or "psychotic" because they admit "God frequently talks" to them. They may also be diagnosed with Bipolar Disorder because they present as "angry" during the interview. After being inappropriately diagnosed, it is not unusual for African–American parents to refuse to participate in the prescribed treatment. This refusal is typically labeled as "noncompliance" by the child protective service agency and the subsequent forensic psychologist, which in turn limits the likelihood that the child will be returned to the parent's care.

Service Recommendations

There is a timetable within which parents must successfully complete services before their children can be returned to their care. There are often problems with the timeliness, the availability, the quality, the cultural appropriateness, and the breadth of services available through child protection agencies, particularly those provided to African–American parents (Dettlaff & Rycraft, 2010; Miller & Ward, 2008; Roberts, 2002). If parents do not complete services and improve, they may be deemed either unwilling or unable to correct the factors that are thought to be responsible for harm to their children.

When parents are not considered sufficiently rehabilitated, they are typically blamed for their lack of progress when many other factors may have played a role. The multiple external variables that pose problems are rarely recognized. For example, if a serious mental illness is diagnosed, the primary recommendation is typically medication. However, if Posttraumatic Stress Disorder and other trauma sequelae are present and not diagnosed, psychopharmacology may be inappropriate or insufficient. Other barriers to treatment include: no money for transportation to services; services that are far away from the parent's community; no childcare; scheduling services during the parent's work hours; not sufficiently explaining the rationale for services; poor communications with parents about appointment dates, times, and addresses; frequent turnover in service staff; the excessive use of group rather than individually oriented services; generic services that do not address the specific facts of the parent's child protective case; overscheduling parents with an excessive amount of services at one time; a lack of specialized mental health services; and not adequately addressing rapport, client resistance, and cultural preferences. Under these circumstances, parents are not likely to demonstrate significant improvements even when they attempt compliance with the recommended interventions. In contrast, clients who receive effective psychosocial interventions that target their trauma sequelae are much more likely to be able to manage their affective reactivity, create stability for their children, and achieve a positive child protective service outcome. Finally, it is important for psychologists to differentiate between suggestions for continued services that might be generally helpful and those that are required for a child to be safe, because suggestions for further treatment are often interpreted as necessary for reunification.

The literature suggests treating Posttraumatic Stress Disorder directly, once it is diagnosed, even when clients have comorbid diagnoses (Grubaugh et al., 2016). Similarly, it is recommended that those with histories of both psychological trauma and substance abuse problems be treated in an integrated manner (Dass-Brailsford & Myrick, 2010), as these clients tend to relapse quickly when treatment for either trauma or substance abuse is delayed.

When the symptom picture suggests borderline pathology or Complex Trauma, typically associated with histories of chronic trauma dating to childhood, Dialectical Behavior Therapy (DBT) should be considered. It should be noted, however, that evidence-based treatments are likely to require modification or time extensions, due to the number of multiple current stressors impacting these parents. Many parents

involved in the child welfare system are also struggling with the chronic difficulties associated with concentrated poverty, like adequate housing, income, problematic schools, safety, and health issues. In addition, current approaches to the treatment of Complex Trauma suggest a three-stage model (safety, stabilization, and engagement; trauma memory and emotion processing; application to present and future), particularly for those with impaired relationships. This model involves considerably more time than treatments designated for simple trauma and classic PTSD (Courtois & Ford, 2013). Therefore, psychological evaluations should also include clear recommendations about what will be required to offer reasonable, adequate, and appropriate interventions. Furthermore, the psychologist should describe the kinds of positive changes that are likely to result from appropriate treatment.

Special consideration regarding interventions is also necessary as it pertains to domestic violence. A parent living in a situation characterized by intimate partner violence may well be traumatized by those experiences. The general tendency in child protection cases is to focus on eliminating the violence from the child's life. It is important to remember, however, that even when the violence stops, a parent who has been traumatized by these and other experiences may be struggling with trauma sequelae that can negatively affect parenting. Such parents may remain highly anxious, depressed, dissociative, and/or affectively labile. They can misperceive benign situations with children as very threatening or, conversely, be nonresponsive. Often, the perpetrator is underserved once removed from the home, and there are minimal services geared toward clinically appropriate and safe family reunification. Generic parenting or anger-control classes that do not address the trauma triggers inherent in the parent's interactions with the child or partner, or that do not address the specific characteristics of the parent's interactions with the specific child or partner, will be minimally effective.

As is true for personal trauma, African–American parents will only make partial improvements if racial trauma is not identified and incorporated into treatment. African–American parents need providers who possess an understanding of cultural issues and who will help them respond to racism in a manner that will facilitate rather than sabotage the return of their children. Trauma treatments like Eye Movement Desensitization and Reprocessing (EMDR), focused directly on memories of racial events and symptoms, have been useful in processing trauma across a variety of cultural issues (Nickerson, 2017). Numerous authors (Anderson & Stevenson, 2019; Coard & Sellers, 2005; DeGruy, 2017; Helms et al., 2012; Polanco-Roman et al., 2016; Sue & Sue, 2016; Sue et al., 2019) offer other techniques that forensic psychologists can also recommend for therapists to use to help African–American parents decrease racial trauma:

- Preemptive and anticipatory conversations with clients about race and racism
- Helping the client develop the ability to accurately read racist encounters
- Helping the client develop a repertoire of active strategies to implement during racist encounters
- Helping the client develop the ability to process or rewrite racist encounters in a positive manner

- Helping the client develop cultural pride and a positive racial identity
- Moving beyond client survival and coping toward concrete strategies that clients, bystanders, and allies can perform in response to perpetrators

The literature reports the above strategies have the potential to decrease dissociation and mitigate the effects of racial distress in African–American populations (Anderson & Stevenson, 2019; Coard & Sellers, 2005; DeGruy, 2005; Helms et al., 2012; Polanco-Roman et al., 2016; Sue & Sue, 2016; Sue et al., 2019). Therefore, it is incumbent upon mental health professionals to incorporate issues regarding positive racial coping, racial identity, and racial socialization into their work with African–Americans, as well as refer clients to African-centered community-based organizations.

Finally, given the socioeconomic conditions of many of these parents, it is sometimes necessary for child protective services to help with housing, vocational development, and employment opportunities. However, poverty is not a legitimate reason for removing children or terminating parental rights, and problems in economic and housing stability, endemic in poor communities, should not be the reason a psychologist finds a parent unfit for reunification.

Conclusion

Trauma is central to the lives of many parents involved in the child welfare system. This chapter has reviewed ways in which trauma can affect a parent's psychological status, although its significance and impact are often under-recognized and misconstrued. Inquiries into the client's current perspective about the child welfare system and the psychological evaluation process, the client's personal trauma exposure, and the client's experiences of racial trauma are all necessary. Without a full understanding of the existence of trauma and its impact, it is likely that the findings of the evaluation will be limited at best and potentially harmful to the parent and child. Therefore, it is incumbent upon the evaluator to take steps to develop rapport with the parent, to take a thorough history with particular attention to traumatic experiences (including racially traumatic experiences), to assess whether trauma sequelae are present in the current symptom picture, and to offer treatment suggestions and plans that take traumatic histories, culture, and the context into account.

Questions/Activities for Further Exploration

1. Why is it important to understand the context in which a forensic evaluation occurs? What is the impact on parents of being evaluated in the context of a child protection case?
2. What measures can psychologists take to minimize the impact of contextual trauma?

3. What is the role of trauma in the intergenerational transmission of child abuse?
4. What is meant by "racial trauma"? How does racial trauma affect African–American parents and child welfare forensic psychological evaluations?
5. Consider the relationship between the experience of separation from children for African–American parents today with the legacy of forced removal of children from enslaved Africans historically. How might that legacy impact parents involved in the child welfare system? Are there other groups who have experienced or are experiencing similar family disruptions by governmental agencies?
6. What are some techniques psychologists can employ to assess histories of trauma in parents?
7. How is the accurate identification of trauma and its sequelae important in recommending services for parents involved in child protection cases? What are the likely outcomes when trauma is not identified?
8. What are some specific strategies that psychological evaluations can recommend to help African–American parents decrease racial trauma?

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