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CASE STUDY

Addressing Intergenerational Trauma in an Adolescent Reunification Program: Case Studies Illustrating Service Innovation

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Abstract

Adolescents in out-of-home care generally have poor prospects for reunification with their birth families. However, for some adolescents in care, with deliberate support and intervention, there may opportunities for successful reunification. The Adolescent Reunification Program (ARP) is an Australian program designed to assist young people aged 12–17 years return home to their families. The program focuses on supporting families, mentoring young people so as to meet their developmental and educational needs, and providing a safe home environment. It also included an innovative therapeutic component which focused on addressing the consequences of intergenerational trauma in order to help repair relationships between parents and children. The purpose of this paper is to describe the therapeutic component of the program and to examine the potential value of therapy in a family reunification context with a particular focus on client receptivity and preliminary evidence on outcomes. Using case illustrations, this paper describes the therapeutic component of the ARP and provides a preliminary evaluation of these components using a mixed methods approach, including standardised psychological assessments, qualitative interviews with parents and young people, and reflections from the program workers. The therapeutic component of the ARP may have helped to break the cycle of intergenerational trauma by bringing focus to the interrelationships between how people feel and how they act. This was done through the work of therapists attempting to combine non-judgmental exploration and positive therapeutic framing with practical support within the context of the environment where the family reunification occurred. Therapy in conjunction with practical supports within a multidisciplinary collaborative approach may help to facilitate better outcomes for reunification when working with complex families.

Keywords Reunification · Intergenerational trauma · Therapy · Child protection · Out-of-home care

A consistent finding in out-of-home care research is that reunification from long-term care is generally uncommon (Delfabbro et al., 2015). Most children who are restored to their families go home within the first two years of being in care. In support of this view, Australian longitudinal studies have shown that the prospect of children of returning home after being in long-term care (more than 5 years) is close to zero (Delfabbro et al., 2015). The consequence of this situation is that out-of-home care populations in Australia and other similar Western countries are growing (AIHW, 2019). In effect, the rate at which children are entering care is not being matched by the rate of children leaving care. As a result, identifying strategies to enhance the rate of reunification is considered to be a high priority policy directive in many jurisdictions, including Australia.

Adolescents, in particular, are a group with a poor prospect for reunification because many have been in care for some time. Having entered care as young children, they have often lost contact with their parents, or have built up relationships with long-term carers. Although adolescents are often in a phase of life of emerging independence, it is also a phase of identity formation. Connections with family remain developmentally important and, as Cashmore and Paxman (1996) have shown, adolescents who leave care often report a strong desire to reconnect with their families and can experience disruptions to their sense of identity if long periods in care have led them to lose contact with their birth families.

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The principal reason for this situation is that most statutory welfare systems are crisis-driven (Fernandez & Lee, 2013). Much of the focus is upon protecting children from unsafe environments and bringing them into care when they are in need of protection. Considerably less attention is directed towards finding ways to assist families when children first come into contact with the child protection system. The reason for this is that family situations are often highly complex when children enter care. Children usually enter care for multiple reasons and these problems frequently co-occur, so that the prospects of a short-term resolution of these issues is often unlikely. Problems frequently noted in the literature include: child abuse and neglect; homelessness; domestic violence; and substance abuse (Akin, 2011; Courtney, 1994; Delfabbro et al., 2013, 2015; Farmer et al., 2009; Fernandez & Hamill, 2010; Fernandez & Lee, 2013; Wells & Guo, 1999).

Internationally, some attempts have been made to develop services to reduce the number of children who enter care or remain in care. Usually termed 'family preservation services' (see Schuerman et al., 1994; Veerman, 2003; Walters, 2005), these programs usually focus on children and families who are either at risk of entering care or who have entered care for only short periods. Relatively few, if any services, have been developed to facilitate reunification for children and, in particular adolescents, who have been in care in long-term placements. It is recognized that in many instances, it will not be feasible for adolescents to return home. Many of the families from which they were removed may still be affected by the problems that led to the original entry into care. Parents may have serious mental health problems or disabilities; be homeless; or have died or be in jail. Others may have had little or no contact with the young person for many years and not have any desire or interest to re-establish a connection. However, as we show in this paper and in the evaluation of an adolescent reunification program piloted in an Australian state (authors Malvaso and Delfabbro (2020)), there is a significant minority of adolescent cases for which opportunities for reunification may exist, but where action has not been taken because of other practice priorities or limited resources.

In this paper, we present two case studies to summarise the insights obtained from applying an adolescent-focused reunification program directed towards families in which the principal problems leading to placement were related to intergenerational trauma. These problems were primarily psychological in nature. These are families where parents found it difficult to develop effective relationships with their children or display appropriate parenting because of harm or difficulties that they have suffered themselves, both as children and as adults. In some instances, the ongoing placement of the child in care may have presented further challenges to the young person's relationship with their parent. Here we examine the ways in which the inclusion of a dedicated and theoretically driven therapeutic component could facilitate reunification in families with previous histories of complex psychological and social circumstances. We argue that the therapeutic processes incorporated into the broader reunification program may be of considerable value to several audiences: policy makers who fund reunification services; social work practitioners; psychologists and psychiatrists who work in child welfare contexts. In the following sections, we provide a summary of a dedicated adolescent reunification program that formed the focal point for the therapeutic interventions. We also provide an overview of the theoretical work that informed the therapeutic approaches. This review focuses on the core principles relevant to audiences who may have an interest in applying these principles. More theoretically focused or specialist readers are referred to reviews that capture more specific developments and evaluations of therapeutic methods, which is usually not a principal focus of applied work in child protection. For example, narrative techniques described in this paper that ask parents to mentalize their parenting approach have affinities with research into Parental Reflective Function (Benbassat & Priel, 2012; Benbassat & Shulman, 2016). Readers are also referred to specific research on the Adult Attachment Interview (AAI) (e.g., Dykes & Cassidy, 2011; Warmuth & Cummings, 2015) and the cycle of child abuse (e.g., Badenes-Ribera, Fabris, Prino, Gastaldi, & Longobardi, 2020; Bartlett & Easterbrooks, 2015).

The Adolescent Reunification Program (ARP)

The ARP was designed to assist young people aged 12–17 years return home to their families. The program focuses on supporting families and mentoring young people so as to meet their developmental and educational needs. Practical and therapeutic supports are provided to ensure a safe home environment, and to encourage a better or at least workable relationship between parents and the children being returned home. The program provides assistance with parenting skills. Caseworkers help parents make contact with relevant services and engage in liaison activities with schools. The ARP operates in a non-judgmental, collaborative context in which parents are able to work with the same caseworker (in the majority of cases) over an extended period (usually 12 months).

The ARP includes two main interventional components: 1) solution-focused case management; and 2) therapeutic interventions to address intergenerational trauma. The purpose of this paper is to describe, utilising case illustrations, the innovative therapeutic component of the ARP. It provides a preliminary evaluation of these components using standardised psychological assessments, qualitative interviews with parents and young people, and reflections from the program workers. The program was developed and trialed in an Australian state

and further details of the full program and its evaluation can be found in [reference Malvaso and Delfabbro (2020)].

Theoretical Background to the Therapeutic Component of the ARP

An innovative feature of the reunification program was that it included a therapeutic component. A qualified psychiatrist was available to work with families (both the parents as well as the young people) to assist them to: deal with their experiences of trauma; build stronger attachments and relationships; and, enhance parenting skills. The psychiatric support was based on principles and approaches set out by Amos and colleagues (Amos, 2017; Amos & Segal, 2018; Amos, Segal & Cantor, 2015). Amos and colleagues synthesize contemporary research on attachment and trauma, focusing on what this research reveals about therapeutic interventions in families disrupted by statutory child protection interventions. Amos and colleagues drew heavily on Lyons-Ruths' research in which an Adult Attachment Interview coding system was developed for high-risk mothers with histories of attachment trauma that identifies the transmission of disorganised attachment styles from mothers to their children, both during infancy and later in middle childhood (Lyons-Ruth, Yellin, Melnick and Atwood, 2005; Bureau, Easlerbrooks and Lyons-Ruth, 2009). The work also drew on research exploring the characterisation of disrupted attachment as trauma (Schuder and Lyons-Ruth, 2004), evolutionary models of disrupted attachment (Cortina and Liotti, 2005) and trauma (Van der Hart, Nijenhuis and Steele, 2005), and influential work in the infant mental health area including parental reflective functioning (Fraiberg, Adelson and Shapiro, 1975; Cohen et al., 1999, Slade, 2007; Lieberman et al., 2015). Full details of the literature used in the synthesis and the therapeutic approaches are summarised in Amos et al. (2011, 2015, 2018) and Amos (2017). An overview is provided to assist insights into the principal ideas, methods and clinical stages recommended for working with families who are caught in intergenerational cycles of seriously disrupted attachment relationships and chronic interpersonal trauma.

The starting point for much of this work is the principle of attachment as developed through the early work of Harlow (1950) and Bowlby (1969). The term attachment refers to a basic bond that forms early in life between infants and their parents (usually the mother). Within the attachment literature, it is known that disruptions to early relationship building can lead to maladaptive behaviour and poorer psychological functioning in children. Those who have received little nurturance or inconsistent parenting grow up being more distrustful of others, less confident of their environment and less effective in forming social or intimate relationships. For some young people, symptoms can manifest in the form of poor emotional regulation; others experience difficulties in forming emotional connections out of fear of rejection. Some can also display patterns of avoidant or disorganised attachment in which the child does not consistently gravitate to the caregiver as a secure base or source of emotional support in times of distress.

A novel feature of Amos' (Amos, Segal and Cantor, 2015, 2017) work is that attempts are made to embed the principles of attachment within modern developments in primate evolutionary biology to capture how environmental pressures might bring about disruption to attachment relationships. Much of this work builds on the work of Chance (1992) who conducted detailed studies of social relationships in primate societies. According to Chance, interactions between primates can take two principal forms. The first or 'healthy' form is referred to as 'hedonic'. Hedonic social interactions are positive in nature and feature nurturance and support; reciprocal relationships where animals groom each other, protect their young and focus on the needs of the group. The alternative is termed 'agonic' and this state develops and endures when the group, or individuals, are placed under significant stress. Under these conditions, individuals shift their attention away from mutual support and nurturance towards competition between individuals and group survival. The result is an environment characterised by hierarchies based on strength, dominance and aggression. The strong survive by acting with hostility towards the weaker individuals and these weaker individuals, in turn, adopt appeasement strategies to avoid harm. For the weak and vulnerable there is no peace or security, but rather a mitigation of threat or abeyance of harm by being submissive and accommodating.

Amos (2017) and Amos and Segal (2018) argue that similar principles may operate in families and particularly across generations. Those groups, families or parents that are subject to significant stress and disadvantage are more prone to developing more 'agonic' styles of interaction. When a parent is facing significant threats to his/her wellbeing, such as domestic abuse from a partner or mental illness, a child can become another threat or cause of depletion of the parent's resources. When faced with the significant challenges associated with raising a small child, such as becoming time poor, sleep deprived and mentally and physically exhausted, the stressed parent can become hostile, inconsistent, moody, and frequently anxious. In such situations, the child is faced with a parent who can be nurturing on occasions, but who is also often punitive, dismissive and domineering. As a result, the child may adopt appeasement strategies to placate the mother and, as a result of this relationship, may grow up with the sense that the rest of the world is threatening or hostile. A consequence is that some children may grow up and adapt to the world by becoming domineering and aggressive themselves, or others may continue to display a pattern of appeasement and submission towards others which makes them more vulnerable to mental illness, abuse, or unhealthy peer influences (Amos, Segal & Cantor, 2015).

Amos (2017) further argues that these 'agonic' styles of interactions are exacerbated by intergenerational trauma in situations where parents themselves were subject to maltreatment. Drawing upon psychotherapeutic principles, she argues that the arrival of an infant could, in fact, almost lead to a form of regression, in which the mother revisits her own sense of powerlessness and vulnerability through her immersion in the emotional relationship with her newborn. Instead of focusing on nurturance, she may instead relive some of her own early trauma and regard the infant as another external threat which draws attention to her own vulnerabilities. It is argued that what happens to these parents as children stays locked inside them and has ongoing effects that can be transferred across generations. The reactivation of previous trauma and its effects on parenting in the new generation leads to a 'cycle of trauma'. Amos (2017) hypothesises that 'unresolved shame' makes a significant contribution to this cycle because one of the effects of previous trauma is that the parent feels unworthy, unlovable and incapable of being a good parent. This sense of shame stays locked inside the person's unconscious, deep in memory, and can exert an influence on his/her actual thoughts and behaviour. There will always be a lurking doubt that will manifest itself in thoughts such as "I will never be a good parent", or "I don't deserve good things to happen to me". These feelings of unworthiness are reinforced by the difficulties in recalling positive experiences or good examples where the person had positive interactions with their own parents.

It is therefore proposed that agonic styles of interaction can re-emerge across generations. A new parent who is under pressure for what could be a variety of reasons goes into a defensive mode that is not conducive to nurturing behaviour. The infant is seen as competition or a potential threat to the parent's own depleted physical and psychological resources, leading to the adoption of parenting styles that are less responsive and emotionally involving and which can result in insecure styles of attachment. This then results in the re-emergence of the dominance-submission or appeasement patterns of interaction that were also a feature of the parent's own engagement with his or her parents. Thus, previous trauma has an influence on the type of parenting received by the next generation which can lead to poor parent-child attachment. Disrupted attachment has consequences for other areas of development and functioning, leading to emotional and behavioural problems in the child. It is therefore argued that addressing trauma can help to break this cycle. This is the fundamental assumption which underlies the therapeutic strategies described next.

Therapeutic Approaches: The Adult Exploration of Attachment Interview (AEAI) and the Parallel Parent Child Narrative (PPCN)

Drawing upon therapeutic principles, Amos (2016) refined an existing multi-stage therapeutic approach (Chambers et al., 2006) to address issues of intergenerational trauma and to improve the parent-child relationship. The first stage is the Adult Exploration of Attachment Interview (AEAI; Chambers 2012). The AEAI is a clinical interview designed to reveal similar information as the Adult Attachment Interview (AAI). The AAI was designed to facilitate rigorous research into the impact of a parent's own early attachment experiences on their attachment relationships with their children. It has also been suggested that the AAI has considerable clinical utility (Steele & Steele, 2015). The requirements for training and costs of becoming certified to administer the AAI, however, are prohibitive in many service settings. The AEAI was thus developed and, like the AAI, encourages parents to develop insight and understanding into the often hidden factors and processes that underlie repeating patterns of behaviour in intimate relationships. Training occurs in-house at [the non-government agency that delivers the ARP, Malvaso and Delfabbro (2020)] by the lead psychiatrist and developer of the AEAI. Not only do the caseworkers receive formal group training in the use of the AEAI, but are also afforded shadowing and debriefing opportunities with the psychiatrist. The practitioner begins the AEAI by constructing an attachment-focused genogram (DeMaria, Weeks & Twist, 2017) of the parent's childhood and adolescence. Once key caregivers have been identified, standardised questions are used to uncover detailed stories and memories from the parent's early childhood. The practitioner and parent together create a series of statements that reflect the implicitly encoded Internal Working Model about how parents and children feel, think and behave towards one another. The process is conducted in a way so as to encourage reflection and self-awareness, but not guilt or shame. It is recognised as a sensitive process because it can evoke strong emotional responses. For parents who are expected to have been subject to trauma themselves as children, the aim is to identify patterns or implicitly encoded memories that might influence how the parent relates to the child (e.g., Does a child bring back feelings of the parent's own vulnerability? Is the child another threat or a reminder of the parent's limitations? Are there some parenting practises that observers might assess as unhelpful, but can be understood in the context of the parent's childhood?)

The role of the therapist is to help the parent verbalise (or make explicit) what otherwise is a hidden or implicit process and to develop a conceptual framework or 'map' that explains the relationship between his/her own experiences and his/her interactions with the child. For example, a mother might understand that her exposure to event X gave rise to behavioural pattern Y, which then affects her child and their relationship in a certain way. Recognition of these patterns serve to provide predictability and meaning to her situation and experience,

creates a more coherent narrative of the mother's experience and helps to separate out what aspects of her identity and behaviour are a function of her circumstances and trauma. Once this is identified, it then becomes possible for the role of 'mother' to be separated out and to be the focus of the subsequent therapeutic processes.

An additional component of the therapeutic process is what is called the Parallel Parent and Child (Adolescent) Narrative (PPCN; Amos, 2017). In essence, this is a form of talking therapy in which parents and children / adolescents are encouraged to speak freely about their experiences of their relationship from birth to the present day. The focus is on the parent and child / adolescents' experiences of their parent relationship, not the parent's own experiences of childhood. When the parent's own childhood needs to be referenced, how this is done is informed by the age of the child or young person, and what they have already been told by the parent. This can be negotiated with the parent in the preparation for the process, but the links will often be made in a general way so as to protect the child / young person from exposure to potentially traumatising material. This process is conducted in narrative form with the child or young person present so as to gain insights and shared understanding of the contextual pressures on their relationship and how their desired connection of care and concern became one of disappointment and hurt. The interaction with the therapist flows freely and may move between topics, events, timelines, but the anticipated result is to create a sense of narrative chronology: what occurred, when, and in what order, and then to understand how the parent and the young person understand their story. Insights might be obtained into connections between previous trauma and current feeling or behaviour; how the parent or young person values or identifies himself/herself (e.g., as a 'bad parent or 'nurturing parent, difficult child, loving child). Similar to the AEAI process, the therapist tries to enable the parent and young person to reach a new understanding of their 'story'. These 'stories' are elicited in a non-judgmental, non-threatening way. Attempts are made to find ways to identify positive intent, features or strengths that are consistent with a more positive narrative. For example, the therapist might try to explore events or stories that highlight evidence that the parent and child do have a relationship and care for one another. Amos (2017) describes the process of PPCN in the following way:

> One focus of PPCN is to uncover the unexplored story of goodness, care and connection, at least at the level of intention, in the mother/child relationship. This introduces marked dissonance into a system of meanings and beliefs where the focus of their personal and relational narrative has been the 'badness' of both mother and child and the shame, anger and distress that this engenders. (p. 165)

Another principal focus of PPCN is to prevent the avoidance of aversive content, which occurs when either parent or child do not want to explore topics as a result of the strong emotional responses they engender. One way the therapist does this is to apply the principles of Narrative Therapy and introduce topics in a graded way: more sensitive and emotionally-laden topics are not explored until other issues have been discussed first. As with the AEAI, the aim is to remove trauma-related barriers to parent and child interacting in a 'hedonic environment' conducive to interactions that focus on the needs and feelings of each person.

Description and Preliminary Evaluation of the Therapeutic Components of the Adolescent Reunification Program (ARP)

In this paper, we examine the potential value of therapy in a family reunification context with a particular focus on client receptivity and preliminary evidence on outcomes. Using case illustrations, this paper describes the innovative therapeutic component of the ARP and provides an evaluation of these components using standardised psychological assessments, qualitative interview methods and reflections from the program workers. To the best of our knowledge, this is a world-first dedicated adolescent reunification program with an in-built therapeutic component to help families address intergenerational trauma, build stronger attachments, and develop parenting skills. The program is innovative because reunification is often not a consideration for adolescents who have been placed on long-term orders. Instead, the focus is on achieving stability and permanence in a long-term placement, and/or preparing adolescents to transition to independent living as they approach age 18 and "age out" of the care system. However, given the often poorer outcomes of care leavers compared to adolescents in the general population (e.g., Courtney & Dworsky, 2006), the ARP represents a concerted effort to ensure an alternative pathway for these young people by providing them with opportunities to achieve a functional, safe and stable relationship with their birth family in order to address their often emerging need for belonging and identity, whilst supporting birth parents to provide a home environment that can support the successful reunification (and possible exit from care) of their son or daughter.

Method

The ARP is a collaboration between the jurisdiction's child protection agency and a non-government organization [Centacare Catholic Family Services]. It commenced an intake of young people in May 2017. The target population was

adolescents aged 12–17 years on long-term care orders. The program also included an independent evaluation component conducted by [The University of Adelaide]. By the end of the evaluation period (December 2019), a total of 36 families participated in the ARP. Of these, 16 (44%) achieved successful reunification (i.e., remained home for six months or longer) and their cases were closed at after 12 months; 8 (22%) had returned home and were progressing well; 9 (25%) were not successfully reunified and their cases were closed; and three (8%) were still in the intake phase and little information was available concerning their reunification status at the end of the evaluation period. Further details about this program and its full evaluation can be found in Malvaso and Delfabbro (2020).

Study Design

The full evaluation involved a mixed (quantitative and qualitative) methods approach, including repeated standardised psychological measures, qualitative interviews with the families to identify factors that were facilitating or acting as a barrier to successful reunification, and interviews with program case managers and therapists to gain insight into clinical observations and learnings. Ethics approval for the study was provided by the University's Human Research Ethics Committee (approval number: H-2017-230). This paper presents case studies illustrating the therapeutic component of the program in practice with two families, and does so by triangulating information collected in standardised psychological measures, and by analysing qualitative interviews with parents, children and program staff.

Outcomes and Measures

The objective outcome for this program was successful reunification for 6 months or longer. Standardised psychological measures were administered at baseline (in the first few weeks of the young person returning home), at 3 months and at case closure. Parents completed the Family Assessment Device (National Family Preservation Network, 2009), Strength and Difficulties Questionnaire (SDQ; Goodman, 1997), and the K-10 measure of psychological distress (Kessler et al., 2002).

Qualitative interview protocols were developed for parents, the young people, and program staff (summarized in Appendix A). Questions related principally to four domains: 1) what aspects of the program were working well; 2) what might be improved; 3) the level and nature of supports available; and 4) how the family was coping from the perspective of the interviewee. Interviews were conducted by authors CM and PD and took place primarily in families' homes. Interviews were semi-structured in that the protocol was followed but questions were not always asked in order as they usually took the form of a conversation. This flexible approach was taken given the often complex home environments in which interviews were conducted. The aim was to conduct interviews with parents and young people every three months after the intervention had commenced, and with program staff at the end of the intervention. Interviews were recorded and transcribed by CM and NG and the content was organised into themes using thematic content analysis. Pseudonyms are used to protect anonymity of interview respondents.

Case Presentation

The two cases presented in this paper involve mother-child dyads. The first case involved the reunification of a 13-year-old female (Ellie) from residential care with her mother (Anna), who had a resident toddler and housemate. The second case involved the reunification of a 14-year-old male (Michael) from foster care with his mother (Hayley), stepfather and resident younger sibling. Both cases had previously involved domestic violence, substance use, and neglect, and in the first case the mother also had a history of depression. These cases have been selected for presentation because both families engaged in the therapeutic components of the program, complete data was obtained through the standardised assessments at each of the three time points, and both families participated in numerous interviews.

Results

At the end of the evaluation period, both cases had been closed and the families had achieved successful reunification for more than 12 months. Multiple measures were obtained from these two families and provided insights into how they were faring across the course of the program. A summary of the scores from these measures is presented in Table 1. The results indicate some similarities between the cases. K-10 scores indicated that both mothers were not experiencing any significant elevation in psychological distress, and according to the scores in the 'healthy' range from Family Assessment Device, the families were getting along well. In Case 1, the young person was still displaying some conduct and social problems throughout the time in the program, but had improved emotional functioning. The young person in Case 2, on the other hand, had fewer psychological and social problems.

Case 1: Ellie and Anna

Ellie was first removed from her mother Anna at the age of 18 months due to concerns of neglect and inadequate supervision relating to parental domestic violence, substance abuse, and mental illness. Anna's own development featured experiences of emotional and physical

Table 1 Summary of scores on standardized measures (mother reported scores)

	Time 1	Time 2	Time 3	Interpretation
Case 1				
K-10	17	17	14	Consistently in normal range
Family functioning*	34	31	33	Healthy score
SDQ-conduct	5	5	7	In clinical range
SDQ-Hyperactivity	7	4	6	Borderline
SDQ-Emotionality	9	7	5	Started clinical; ended normal
SDQ-Peer problems	6	1	5	Remained in clinical range
Case 2				
K-10	10	12	10	Normal range
Family functioning*	43	44	45	Very good
SDQ-conduct	5	3	0	Started clinical and ended normal
SDQ-Hyperactivity	4	3	2	Remained normal
SDQ-Emotionality	0	0	1	Remained normal
SDQ-Peer problems	2	1	1	Remained normal

Note. K-10 – the K-10 measure of psychological distress. SDQ – Strengths and Difficulties Questionnaire. *Measured using the Family Assessment Device

abuse perpetrated by her mother. As a result, she moved interstate to live with her father. At the age of 12, Anna was sexually abused by her father's stepson who was in his early 20s. Anna returned to the care of her mother but was then sexually abused by her mother's partner. Anna's mother denied that the abuse had occurred and Anna moved interstate yet again to live with family friends. By the age of 19 years, Anna had been introduced to illicit substances on which she became reliant when her partner committed suicide. Anna described this dependence on illicit substances as a way of "self-medicating" and managing her trauma and mental health problems. At the same time she was also homeless and agreed to a Voluntary Care Arrangement for Ellie with the local statutory child protection agency. Multiple attempts to return Ellie to Anna's care were made over the course of five years, but ultimately a long-term guardianship order was put into place after Anna failed to meet criteria to provide safe and appropriate care for Ellie. Five years later, Ellie returned to the care of Anna through the support of the ARP.

Insights from Program Staff

Ellie and Anna were offered therapeutic intervention during the 18 months that they engaged with the ARP. In the initial phase of the intervention, Anna declined to take part in the AEAI as she felt she had already engaged in these types of therapeutic approaches through her own psychologist and services accessed to address her previous substance abuse. However, she agreed to participate in PPCN with the specialist therapist with the support of her ARP social worker. Anna was initially uncomfortable revisiting aspects of her own childhood experiences and wanted to focus on resolving emerging relational difficulties between herself and Ellie. As a result, the initial sessions with the specialist therapist were "crisis-driven" and focused on responding to the immediate presenting difficult dynamics at home. The aim was to assist Anna and Ellie to implement behavioural based strategies to help address these issues. It was through this initial work that the therapist was able to introduce the possibility that there were some recurring themes within the mother-child dyad that were likely inherited from both Anna and Ellie's past experiences of relational trauma and, in particular, Anna's own trauma history.

The family progressed to in-home therapeutic sessions that, while still crisis-driven to some extent, included reflective exercises on the possible underlying origins of disagreements. Questions of trust and connection-seeking behaviours that were intrinsically linked to unresolved relational trauma needed to be addressed in order to resolve current tensions. With the disagreements at home decreasing in frequency and intensity, the therapist recommended out-of-home sessions to minimise distractions and alleviate competing pressures (Anna also had a toddler in her care at home) and to ultimately address the underlying issues of relational trauma.

This next phase of therapeutic intervention included opportunities to engage in PPCN in a more structured way. In this phase, the aim was to assist Anna in accepting that historical events needed to be revisited in order to challenge strongly held beliefs about what constitutes a "good parent". However, this process as well as the process of 'creating alternative narratives to good intentions' was initially extremely challenging for Anna and Ellie. Nevertheless, with time, the pair

worked together collaboratively and drew on their individual strengths and resilience to resolve disagreements. Some examples from key sessions are described next.

Turning Past Traumatic Experiences into New Narratives

Anna became comfortable with the idea of exploring her childhood and sharing these memories with Ellie and saw how they would be helpful for the therapeutic process. However, Ellie felt she already knew "mum's story", so Anna invited Ellie to share her own memories of the time before she was taken into care. Ellie recounted a story about her and her brother setting fire to their garage, and her memory of being locked in the burning building. Anna had arrived at the scene, but then left the children alone. Anna was able to allay Ellie's concerns about being left in danger by explaining that she had left the garage to call the fire brigade.

This story then led to another about a neighbour's child who Anna had supported because of severe neglect and drug and alcohol use in the child's family of origin. Eventually Anna could not continue to support this child because she became concerned by some of the behaviours the child was displaying that might be unsafe for Ellie. Ellie reacted intensely to this story and tried to leave the session, running to the locked door and calling to be let out. She was panicked and realised there was another door, this one unlocked, and was able to leave. Anna and the ARP worker followed to support Ellie, and the session continued in another room of the building. As the session continued, it became clear that Anna had some plausible concerns that Ellie had been sexually abused by the neighbour, who was approximately five years older than her at the time. Ellie became distressed again upon hearing this story, and after Anna had offered Ellie a cup of tea to diffuse the tension, the therapist was able to point out the link between the story of abuse, the misunderstanding about being locked in a burning garage and Ellie's extreme distress at finding one of the doors to the therapy room locked. This story was able to be reframed for Ellie – that her mother had had a "sixth sense" about her being in danger and how this reflected the depth of their connection. Anna identified that the connection had been broken when Ellie went into care and how it made her feel frightened to repair the connection in case they are separated again. Anna recognised that Ellie might have similar feelings.

Supporting each Other through Difficult Emotional Experiences

A few examples arose which reflected Anna's struggles using discipline as a way to manage Ellie's behaviour. One example was Ellie being desperate for contact with her father who was being inconsistent and unreliable in responding to Ellie's requests for contact. Anna had attempted to establish a regular routine around phone contact, with Ellie defying this routine by contacting her father more often than Anna felt to be productive. During the session, Anna came to realise that Ellie's need to contact her father might be arising from a need for greater security, and that Ellie might implicitly [unconsciously?] be inviting Anna to provide containment and boundaries.

During the session, Anna came to realise that Ellie's need to contact her father might be arising from a need for greater security, which afforded an opportunity for Anna to provide containment and boundaries for Ellie.

During the session, the pair was able to discuss how a parent cannot always protect their children from difficult emotional experiences, but can instead help them to work through these emotions safely and with support. Through further conversations with her ARP worker, Anna was able to strengthen her understanding that insecurity was driving Ellie's behaviours, and this again enabled parallels to be drawn with how she had done this herself in the past. Anna was then able to make a series of major decisions to help resolve these insecurities, including: ending a new relationship, allowing Ellie to sleep in the same room as her, and writing Ellie a letter that outlined the reasons for these decisions. This resulted in Ellie feeling more comfortable to seek out her mother for comfort and support, and the associated feelings of effective parenting lifted Anna's mood and energy levels.

Focusing on Positive Experiences

Anna offered to share some video footage of the time before Ellie went into care. The footage showed the pair singing together and playing hand clapping games. Ellie was immersed in this viewing, singing along with the video and playing one of the clapping games with Anna during the session. For a brief period it appeared as though the pair had completely forgotten that the workers were in the room. This led to a lengthy conversation about the strength of the bond between the pair prior to Ellie's removal. The therapist was able to explore with the pair this idea that a wall now exists between them ("the Great Wall of China") but that there are examples where the wall comes down. Ellie had recently admitted to Anna that she lied about something and, initially Ellie struggled with her mother providing her with positive feedback about being honest. Anna was able to reiterate these positive sentiments and comfort her daughter.

Identifying Underlying Emotions and Effective Communications

Anna and Ellie's relationship often shifted between cooperative and combative. When things turned combative, anger was usually the emotion expressed. This resulted in an opportunity for some psychoeducation about anger often being a secondary

emotion that replaces a more vulnerable emotion. Ellie was unable to connect with this idea, but Anna was able to offer ideas, identifying jealousy as a possible vulnerable emotion underlying Ellie's anger. Ellie responded defensively to this idea, but through psychoeducation principles, the workers were able to normalise this emotion by using common examples of when people feel jealous. Another example involved Ellie being angry at her mother for smoking and, with minimal intervention from the workers, Anna was able to identify that Ellie was becoming emotional and distressed over the fear of losing her again. At first Anna offered reassurance that she was healthy but then changed her approach to one of understanding rather than problem solving. This interaction was important for restoring their emotional connection in a vulnerable moment. Over the 12-month intervention period, the pair appeared to become more calm, able to share their emotions without becoming angry or dysregulated, and with minimal input from the therapist or ARP worker. It was pointed out that each was able to let their metaphorical wall down and strengthen their relationship.

Insights from Qualitative Interviews with Family Members

Anna's opinion of the therapeutic processes included in the ARP changed from being somewhat sceptical in the first interview to asserting its importance and value in the final interview. The first session had focused on Ellie's desire to be in contact with her father, and Anna felt that this brought up a lot of emotions for Ellie that were not able to be resolved until they had another session. Anna explained her distress about this:

"*I'm finding it's actually hit a brick wall because we've brought up her dad and he's being irresponsible and it's put me in a place where I've had to become like the bad parent, because he's not calling her consistently and I've let my guard down so and said well you can call him instead for a couple of weeks, but welfare want to see him call on these days consistently. So, you know, I've had to try and stick by it which sort of caused a bit of rupture between me and Ellie because I'm looking like a bad parent. So, in a way, at the moment, it's probably caused more damage. But that's not really [the therapist's] fault because if I had the second meeting when my kids had gastro then it might have been different."*

As described above, this was resolved in the next session in which Anna was able to reframe the idea of being a "bad parent" as one who has to set boundaries. Anna was also able to see the importance of supporting Ellie's navigation through this distressing recollection of her experiences with her father.

At first, Anna was reluctant to engage in therapy that involved her past experiences but recognised the importance of participating in it for Ellie's benefit. She stated: *"I've done that much therapy in my life it's not funny. I'm sort of used to it, it comes second nature now. But I think she needs it"*. It appeared that for Anna, the turning point was when she was able to identify and understand links between behaviour and experiences. She was able to see how difficult behaviours could arise as a result of prior traumatic experiences. Although she felt that dealing with the trauma is painful, once faced, recognised and understood, it provides opportunities for parents to develop confidence in their abilities. This gave her a better understanding of how circumstances had changed since the time of Ellie's removal and how she was now able to provide her with a safe and stable home environment.

Anna also appreciated having the support of her ARP worker while engaging in sessions with the specialist therapist. She felt that the worker knew the family and their situation in more detail and was able to act effectively as an objective mediator between mother and daughter when emotions escalated. Both Anna and Ellie spoke about how the therapy had strengthened their relationship by bringing down the metaphorical walls between them and teaching them to walk away from arguments to give each some beneficial space apart rather than resorting to shouting and acting aggressively towards each other. Anna felt that it gave her the confidence to prioritise family time and being comfortable with their own unique family dynamics. In the final interview, Anna commented on the therapeutic sessions that *"they have been good and a lot work. I think through those sessions things had begun to settle into normality"* and that they had gone from *"fighting and struggling"* to being able to communicate their emotions in safer and more effective way with a lot less anger.

Case 2: Michael and Hayley

Michael was removed from the care of Hayley due to concerns of domestic violence, substance abuse and neglect in the form of inadequate supervision, failure to seek medical advice, and failure to meet the child's basic needs. Hayley's own history of neglect, exposure to her parent's substance abuse, criminal activity, and domestic violence resulted in her adopting a protective role with her two siblings. As the middle child with a two year difference between both her siblings, Hayley developed strategies from a very young age (approximately four years), to monitor dynamics within her family of origin and continually create adaptations to minimise the possibility of her and her siblings "being seen" and "blamed" when tensions developed within her parent's relationship. On top of the trauma relating to her early development, Hayley acknowledged that she had continued to utilise these strategies learned during her childhood as she entered into intimate relationships in adulthood and that a cycle of unhealthy dynamics, appeasement and associated substance use had ensued.

Insight from Program Staff

Initially Hayley and her partner (Matthew) were resistant to engaging in therapy as they were concerned that this might disrupt

the relative stability they were experiencing in the home at the time. However, Hayley acknowledged that her history of domestic violence and her early exposure to criminal behaviour, neglect, violence and substance use in her family of origin may be continuing to create difficulties in her relationships. She realised that failing to address her past was influencing Michael's continued progress in re-establishing connections with her and his siblings. This realization led to her being willing to engage in the AEAI. After a few sessions, Matthew also engaged in the therapeutic process and completed sessions using the AEAI. This was encouraged by program staff to support Hayley in reflecting on parenting approaches and strategies that had been established during the initial months of Michael's return home. This included supporting Hayley to acknowledge and challenge Michael's behaviour and inappropriate verbal communication with her, and equally to support Matthew to be less passive and discourage the use of destructive sarcasm as a way to address this behaviour.

Through the AEAI, Matthew identified the origins of his parenting approaches in the patterns of parenting he experienced from his own parents. His father was often rigid and inflexible in his parenting approach and had limited emotional availability. Matthew's inner working model of parenting from his father was that expressing emotions was a sign of weakness and was a feature of 'mothering' and not 'fathering'. Small but significant changes were subsequently observed in Matthew's parenting style. He became less rigid and more flexible, allowing the children treats after dinner if the majority of food had been consumed rather than all of it. Matthew also stopped making jokes about Michael seeking out Hayley's affection, and this in turn affected Michael's behaviour who became more comfortable with seeking out this affection in appropriate ways in public (e.g., holding Hayley's hand when walking to school). This process also helped Hayley identify and understand how Matthew's learning experiences during his childhood shaped his behaviour and to create alternative, positive understandings of his upbringing. Hayley was able to recognise that, although they had significantly different upbringings, Matthew also experienced hardships in his relationships and limitations in having his emotional needs met. This provided Hayley with insight into how he behaves as an adult and his approach to parenting.

Insights from Qualitative Interviews Family Members

Engaging in the therapeutic processes as a family unit was reported as beneficial in this case. The stepfather and mother spoke positively about being able to sit in on their partner's session as they completed the AEAI and reported enjoying the exploratory processes of understanding how their partner's upbringing influences their current relationships and interactions with others. This was also beneficial for understanding factors that may be influencing the behaviour of other family members. The stepfather stated: *"it was good to hear and for me to understand the way you've processed things and all… it helped us understand each other that we would of never been able to as it allowed for that exploration".*

Discussion

Our exploration of the therapeutic component of the Adolescent Reunification Program (ARP) provides insights into the processes that help to facilitate positive outcomes when working with complex families. The case of Anna and Ellie illustrated several examples of how the therapy worked and its subsequent impact on the functioning of the family. Initially, Anna was reluctant to engage in therapy because she had already undertaken therapeutic interventions before and possibly without success. She was also reluctant to re-visit the complex events of the past because of her anticipated emotional reactions to these events. However, when it became evident that attempts to resolve the practical and behavioural issues arising in her relationship could not be resolved merely through advice and support, it became evident that the source of the problems ran deeper. Engaging with the therapy assisted Anna in being able to understand the links between her previous trauma and conflicts with Ellie and how these needed to be addressed and resolved to build a new relationship in the present. One example cited was Ellie's resentment and misunderstanding over her mother's departure when she was caught in the garage with a fire. Anna was able to explain that she was not neglecting her safety, but was trying to protect her by taking the necessary steps to call the fire brigade. In this way, the story of abandonment was able to be re-framed as one about parental protection. Anna was also able to gain insights into the links between Ellie's emotional needs and her desire to call her father more often, and how this was contributing to a cycle of discipline and resentment. Once the behaviour was understood as arising from Ellie's need for greater emotional support (which Anna could provide) then the behaviour engendering the need for discipline decreased. Anna, in effect, began to see Ellie's behaviour less of a threat to her authority, but as a request for greater emotional support. By combining these insights with evidence of positive experiences and a capacity for parental protection, it was possible to create a more 'hedonic' and less 'agonic' relationship between the two parties.

The second example further highlights the role that previous parenting experiences can have on current parenting. In the case of Matthew, the therapist saw an example of a person who had grown up in a household where emotional support and engagement and affection were discouraged. It was considered a sign of weakness and not part of Matthew's mental model of effective parenting. As a result, this style of parenting experienced during Matthew's own childhood carried over to his own parenting and was a barrier to providing Michael (the child) with an emotionally supportive environment. Once again, the therapeutic process, with its emphasis

on the role of past experiences was able to show how Matthew's own experiences and the potential harm it caused had affected his parenting and that this had implications for the current relationship with Michael.

The therapy component applied in the ARP also provide insights into the processes that appeared to facilitate better outcomes when working with complex families. The first element was that the therapy was being applied in the context of a positive process or in relation to a positive outcome; namely reunification. In other words, rather than parents being told that they needed to engage in therapy to avoid some consequence (e.g., children being removed) as can occur in family preservation contexts, the therapy was enabling them to achieve an outcome which was desired by all parties involved. A second effective feature was that the therapy was framed in a positive way to help support families through the transition and to build on strengths and resilience. In contrast to the often adversarial dynamics that can occur in child protection contexts, a non-judgmental therapeutic environment was provided and greater emphasis was placed on strengths rather than deficits. A third feature that was useful was the process of combining practical support with the therapeutic process (see also Malvaso and Delfabbro (2020)). This helped to create partnerships between the family and therapeutic workers and allowed the intervention to be less fragmented than might have been so if multiple agencies had been delivering different parts of the support. In effect, the practical needs or goals provided a motivation or reason for engaging in therapy and way of seeing the practical benefits of the therapy. Observation of the practical issues and everyday relationships between parents and children also provided a tangible vehicle to engage with parents, to create trust and context, and to introduce the therapeutic support in an incremental way.

Limitations

Evaluating programs of this nature is difficult for a number of reasons. First, when programs are individualised and tailored to the complex needs of different families, it can be difficult to isolate which elements or features of the program are linked with positive outcomes. The therapeutic component of the program was only one aspect and it is possible that other aspects (e.g., solution-focused casework) by themselves led to positive outcomes in these cases. Second, the interviews may be biased towards positive feedback from families who did achieve successful reunification, as interviews with families who did not achieve reunification are not presented in this paper. Despite these limitations, this paper highlights how therapeutic work, in conjunction with other strategies, can help to facilitate reunification of families with complex trauma histories.

Conclusion

In conclusion, the ARP therapeutic work confirmed Amos' (2017) insights that families affected by trauma often operate within a cycle. It shows that the past and the present are often linked and also that there is not necessarily a neat linear transition from a state of turmoil to one of harmony when working with complex family environments in child protection contexts. The work showed how trauma experiences can often resurface and how these affect behaviour and family dynamics and, in turn, reactivate trauma symptoms and distress. The therapeutic component of ARP appeared to help to break the cycle by bringing focus on relationships between how people feel and how they react. It did this by combining non-judgmental and positive therapeutic framing and exploration with practical support within the context of the environment where the family reunification occurred.

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Declarations

Conflict of Interest The authors declare they have no conflicts of interest.

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