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A Multiple Case Study Qualitative Design on How Childhood Trauma Relates to the Child-Caregiver Relationship

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Abstract

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MS, Mercyhurst College, 2010

BA, Mercyhurst College, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The number of children exposed to a traumatic event seems to be continuously growing. Currently there is no research that has examined specifically how a child's traumatic experience is understood in the context of the child-caregiver relationship. The purpose of this study was to understand the dynamics of the relationship between the child and caregiver after a child's traumatic event, from the caregiver's perspective. The research design for this study was a multiple case study qualitative design involving 9 participants, recruited through criteria sampling. These participants provided data obtained through semi-structured interviews. Based on the methodology and the research question, the theoretical foundation for this study was Salvador Minuchin's structural family therapy (SFT). Minuchin's theory provided the framework and pre-existing categories for the qualitative deductive analysis of participants' interviews. The study found that the most common triad among children with a trauma history is an odd man out triad. The odd man out triad is representative of at least one family member having a cut off relationship with another family member. Results also indicate the most common relational dynamic, or theme, between the child and/or caregiver(s) was a cut off relational dynamic. These dyads and triads aid in identifying how the family subsystems are operating and subsequently inform researchers and clinicians how families organize around a traumatic event. This study also can aid in getting professionals to use a systemic lens when working with children who have experienced trauma. In conclusion, the research in this study found that not only are children impacted by their traumatic events, but the caregivers are as well.

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Dedication

This dissertation is dedicated to my mother, Tina Wunch. She inspirers me to be a better person every day and without her I would not be where I am today.

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Above all, I thank my husband, Jason R. Von Hof, for being my best friend and number one fan as I complete this journey of obtaining my PhD. I am forever grateful for the love and support he has given me throughout my academic years.

I also would like to thank my committee members, Dr. Susan Rarick and Dr. Susana Verdinelli. My committee has supported me through the entire process of completing my PhD. I am grateful for their knowledge and support.

Most importantly I would like to thank the Barber National Institute. Without the support of BNI I would not have been able to complete my study. BNI allowed me to use their clients as the participants for my study. I will be forever thankful for the support that BNI has given me.

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Chapter 1: Introduction to the Study

Introduction

The many themes throughout the literature and research on childhood trauma illustrate the complexity of issues that can ensue when a child experiences something traumatic. Some of the themes include posttraumtic stress disorder (PTSD), caregiver trauma and trauma on parenting, trauma's relationship to parenting, and trauma and the family system. A systemic, otherwise known as family-focused, view on childhood trauma is an under-researched area. In this study I looked at the caregiver's perspective on relational dynamics between the child and caregiver after the child's traumatic event. This study provides an understanding of how a child's trauma relates to the dynamics between the child and caregiver(s). Additionally, this study aids in looking at a child's trauma in a systemic manner rather than individualistically.

The background of the research along with the purpose and intent of this study are discussed throughout this chapter. This includes a brief summary of the research, the identified gap, why the study is needed, and the research question. The initial background and the problem statement looked at how the gap in the literature is current and significant to the field of psychology. The theoretical framework for the study is discussed afterward along with how the framework relates to the study's approach. In addition the nature of the study, a summary of the methodology, definitions and terms for the study are described. The scope and delimitations follow, and the chapter concludes with a discussion of limitations of the study and the significance of the study.

Background

Various themes were found throughout the literature that included the definition of trauma, childhood trauma and PTSD, caregiver trauma and trauma on parenting, trauma's relationship to parenting, and trauma and the family system. Individuals may label trauma as physical or sexual abuse; however, trauma includes but is not limited to, physical abuse, sexual abuse, witnessing domestic violence, being in a motor vehicle accident, or feeling that are individual's life was in danger.

The literature also gave insight on how childhood trauma relates to PTSD and other physical and psychological problems. Researchers demonstrated that childhood trauma could increase emotional difficulties (Briere & Elliott, 1994) and could impact the child's attachment to the caregiver (Cook et al., 2005; Perry & Szalavitz, 2010). Within this theme there were risk factors that were identified such as poverty and children of families with a mental health history (Costello et al., 2002).

Looking at caregiver trauma and how trauma relates to parenting, researchers have stated the importance of the caregiver's role in the child's recovery. Researchers have also showed the significance of the caregiver's relationship with the child. A child's recovery and resiliency were found to significantly correlate with the child's caregiver (Howell, 2011).

Additional researchers have looked at how the caregiver's trauma history relates to parenting techniques, behaviors, and styles of the caregiver. These techniques, behaviors, and styles can have an impact on how the child responds or recovers should the child experience his or her own trauma. According to Douglas (2000), a parent's

trauma history is seen to correlate with the parent's anxiety and intimacy issues with the child. This was seen more so with parents who had a history of childhood sexual abuse specifically. Researchers also discussed how parental stress, satisfaction, efficacy, role reversal, and attachment and disconnection were related to a caregiver's trauma history.

Another theme I uncovered in the literature was trauma and the family system. This theme lacked the most research and had the most outdated information. Researchers discussed trauma within the context of the family. More significantly, this theme highlighted the importance of looking at the relationships within the family system and subsystems. Further, trauma created either an enmeshed or disconnected relational dynamic within the family systems (Figley, 1988).

Even though the majority of the studies showed how the caregiver's childhood trauma impacted the caregiver's ability to parent, how a child's trauma related specifically to the dynamics between the child and caregiver was not addressed. This is a significant gap within the literature, because the relational dyads and triads between the child and caregiver have not been explored. A dyad is a subsystem such as mother-father or brother-sister (Minuchin, 1974). Minuchin (1974) stated a triad includes three subsystems, such as the child, mother, and father. Further, researchers have not looked at how the caregiver views the relational dynamics between the caregiver and the child after the child's traumatic event. Additionally, only Figley (1988) discussed family dynamics and trauma but was significantly outdated. This study filled the gap in the literature by interviewing the caregivers of children who had a trauma history and discovering how the child's traumatic experience related to the child-caregiver relational dynamics. The

present study extends knowledge in the discipline by looking at childhood trauma in a systemic fashion rather than individualistically. This was done by interviewing the caregivers and asking systemic questions relating to the relational dynamics between the child and caregiver since the child's traumatic event. These interview questions avoided an individualistic viewpoint by not asking questions only relating to the child. After the interview I created a structural map, which showed a picture of the relational dynamics between the child and caregiver. Structural maps, or family maps, are diagrams of the family organization (Minuchin, 1974).

Problem Statement

The number of children exposed to a traumatic event is continuously growing. Costello, Erkanli, Fairbank, and Angold (2002) reported that 72% of children had experienced a stressor in their childhood, and more importantly 25% of these children had an extreme stressor in their childhood. Traumatic events or stressors can be anything that resulted in the child feeling that the child's life or another person's life is in danger. Stressors can include, but are not limited to being physically or sexually assaulted or abused, witnessing domestic violence, being in an accident, being kidnapped or held hostage, being a war civilian, and/or being part of a terrorist attack, as stated by the DSM-5 (American Psychological Association [APA], 2013). Children who had experienced a medical procedure or had a medical illness, witnessed traumatic events, or had indirect exposure (hearing of the traumatic event of someone) should also be considered as experiencing a stressor or a traumatic event (APA, 2013).

Cohen, Berliner, and Mannarino (2010) reported that more than half of United

States children and adolescents had been exposed to an event that could be perceived as traumatic, and that some of these children have even developed symptoms of posttraumatic stress disorder. Potential symptoms related to a traumatic event, or PTSD, can include: nightmares or intrusive thoughts, avoidance of items related to the stressor, numbing or disconnection from others, increased arousal or jumpiness, poor sleep, and poor ability to concentrate (Briere & Elliott, 1994).

Researchers discussed how families adapt to traumatic events through routines and roles in the family system, and how families organize around the traumatic event (Kiser, Nurse, Lucksted, & Collins, 2008). Researchers also discussed the significance of the mother's role in the child's life after a traumatic experience (Dinshtein, Dekel, & Polliack, 2011). Moreover, researchers discussed how caregivers' own trauma history impacts them as caregivers to a child who has experienced a traumatic event (Timmons-Mitchell, Chandler-Holtz, & Semple, 2008). In addition, researchers discussed how the mother's coping strategies after the child's traumatic experience were impacted, and what the common coping strategies look like for these mothers (Hiebert-Murphy, 1998; Hiebert-Murphy, 2000).

To date, no researchers have examined specifically how a child's traumatic experience is understood in the context of the child-caregiver relationship. A traumatic event is something that not only affects the individual that was traumatized; it is something that affects the caregivers who are close to the child.

Purpose of the Study

The purpose of the present study was to provide an analysis of a caregiver's perspective on the relational dynamics between the child and caregiver after a child's traumatic event. Thus, in this study I looked at how a child's trauma relates to the dynamics between the child and caregiver after the traumatic event experienced by the child. Looking at trauma through the child, rather than the family system, leaves an individualistic impression of the child's traumatic event. A traumatic event is something that not only affects the individual that was traumatized; it is something that affects the caregivers who are close to the child, because they may feel guilt for not protecting their child (Banyard, Englunch, & Rozelle, 2001; Hiebert-Murphy, 1998). This points to the significance of looking at the child's trauma through a systemic lens. This demonstrates the purpose and phenomenon of the study, which was to understand the dynamics of the relationship between the child and caregiver after a child's traumatic event, from the caregiver's perspective.

Research Questions

The following is the research question utilized for the study.

RQ1: What are the relational dynamics between the child and caregiver after the child's traumatic event based on Minuchin's theoretical framework?

Theoretical Framework for the Study

The theoretical framework for this study was Salvador Minuchin's structural family therapy (SFT) model. This model was developed in the 1960s, and one of the core components of this model is the functioning and dynamics within a relationship.

"Structural family therapy is underpinned by a clearly articulated model of family functioning, and had been developed and used most consistently in services for children and families" (Vetere, 2001, p. 133). Minuchin's SFT model focuses on a system view of the family and problems associated with the family system. Vetere (2001) stated that overt and covert actions influence the choices and behaviors of the individuals within the family. In a family with overt interactions the alliances between the family members are open and known. For example, if the mother and child were in an alliance together the other family members would be aware of this. However, in a family with covert interactions the other family members would not know of the coalitions between the family members. Therefore, if the mother and child are in a coalition with each other this is something the mother and child keep secret from the other family members.

While this model is one often used to drive clinical treatment, it is also one that explored relationships in families and among family members. This model has specific ways of looking at how relationships affect the functioning of a dyad or triad. The model has the clinician, or in this case myself, draw specific structural maps that show how the relationships are functioning. Dynamics that can occur between the caregiver and child are either close, close but conflictual, enmeshed, disengaged, functional or conflictual (Minuchin & Fishman, 1981; WPIC, 2005). These relational dynamics form the dyad or triad between the child and caregiver(s) (Gilbert, 2004; Minuchin & Fishman, 1981). This framework provides a way to look at how the parents are responding to their child and what the dyads or triads look like after the traumatic event.

The dyads or triads show that the trauma has created either a detouring triad, an

odd person out triad, a double bind triad, or a disengaged triad (Gilbert, 2004; Minuchin & Fishman, 1981; Minuchin, Reiter, & Borda, 2014; Shazer, 1975). A detouring triad occurs when a conflict between individuals is being detoured onto someone else (Minuchin & Fishman, 1981; WPIC, 2005). An odd person out (cut off) triad exists when the dynamics between individuals cause another person to be excluded, due to the conflict not being dealt with (Gilbert, 2014; Shazer, 1975; WPIC, 2005). A double bind triad involves both parents being overly involved with the child (Minuching, Reiter, & Borda, 2014; WPIC, 2005). A functional triad characterized by all the individuals involved in the triad having close relationships (WPIC, 2005). Finally, a disengaged (disconnected) triad involves the child being symptom free, but the parents are in constant conflict with one another (Minuchin, Reiter, & Borda, 2014; WPIC, 2005). Any one of these triads could be formed due to a child's traumatic event. These different triads relate to the functioning of the subsystems within the family. Moreover, these dynamics show how childhood trauma relates to the organization of the family system.

Nature of the Study

The nature of this study was qualitative and used a multiple case study approach. The benefits of a qualitative approach for this study is the subjective nature of the topic. The phenomenon I studied was how the caregiver perceives the relational dynamics between the child and the caregiver after the child's traumatic event. In addition, I looked at how the caregivers are responding to the child's traumatic event and what the dyads or triads look like within the child-caregiver subsystem. This information was

obtained through semistructured interviews with the caregiver(s) of a child with a trauma history.

Because the majority of the studies detailed in the articles reviewed were quantitative, a qualitative approach offered something new to this body of work and is also the most appropriate for the topic. Utilizing a qualitative study for the present study allowed for a smaller sample size, which allowed the research to focus more closely on the research questions and my interactions with the participants. In qualitative studies, the validity is more about the meaningfulness and insight gained from the study rather than the sample size (Patton, 2002). Thus, with a qualitative study, I can better understand each participant's beliefs, thoughts, and perceptions about how the child's trauma relates to the family dynamics.

I began the study by conducting an interview with eight caregivers of a child who had experienced a traumatic event. These caregivers were known as the participants. If there were two caregivers in the household the caregivers were both interviewed together as the caregiving unit. If only one of the two caregivers was available I interviewed the available caregiver. The interview focused on the traumatic event of the child and what the relationship looked like after the trauma, all from the perspective of the caregivers. The information garnered from the interview was used to inform and draw structural maps, aid in finding the themes, and aid in uncovering the patterns of the relational dynamics. Once the interview had been completed I completed the drawing of the structural map and shared the structural map with the participant. I obtained the

participant's views on the initial structural map to see if the participant's views are similar to those of mine.

Examining the dyads and triads in a family system was very important in Minuchin's SFT model. These dyads and triads aided in identifying how the family is operating. The interview questions focused on asking systemic questions, which aided in understanding how the subsystems are operating. The information gathered from the interview questions aided me in understanding what the dyads and triads looked like between the child and caregiver(s).

Through data collection I was also able to understand the different dynamics between the child and caregiver(s) from the information gathered from the interviews. The interviews explained whether the caregiver subsystem organized around a child's traumatic event or not. The interviews focused on trauma in a systemic manner, rather than from the individual child's perspective.

Definitions

Attachment: Attachment is important for infants in that it is "a memory template for human-to-human bonds. It is profoundly influenced by whether you experience kind, attuned parenting or whether you receive inconsistent, frequently disrupted, abusive, or neglectful care" (Perry & Szalavtiz, 2006, p. 85). Caregiver nurturance is the most important factor in building the attachment bond (Perry & Szalavtiz, 2010).

Detouring triad: A detouring triad occurs when the conflict between individuals is being deflected onto someone else (Minuchin & Fishman, 1981; WPIC, 2005).

Disengaged triad: A disengaged (disconnect) triad involves the child being symptom free, but the parents are in constant conflict with one another (Minuchin, Reiter, & Borda, 2014; WPIC, 2005).

Double bind triad: A double bind triad involves both parents being overly involved with the child (Minuching, Reiter, & Borda, 2014; WPIC, 2005).

Dyad and Triad: These relational dynamics will form the dyad or triad between the child and caregiver(s) (Gilbert, 2004; Minuchin & Fishman, 1981). The dyads or triads can show that the trauma has created either a detouring triad, an odd person out triad, a double bind triad, or a disengaged triad (Gilbert, 2004; Minuchin & Fishman, 1981; Minuchin et al., 2014; Shazer, 1975; WPIC, 2005).

Odd person out triad: An odd person out (cut off) triad occurs when the dynamics between individuals cause another person to be excluded due to the conflict not being dealt with (Gilbert, 2014; Shazer, 1975; WPIC, 2005).

Posttraumatic stress disorder (PTSD): Posttraumatic Stress Disorder (PTSD) was initially associated with adults who were coming back from combat or who experienced a disaster or accident (Briere & Elliott, 1994). Posttraumatic stress can be viewed as distressing psychological symptoms in response to an adverse experience (Briere & Elliott, 1994). Hyperarousal, adverse thoughts, nightmares, poor sleep and concentration, and isolation from others are all potential symptoms related to a traumatic event, or PTSD (Briere & Elliott, 1994).

Role reversal (parentification): Role reversal, as defined by DiLillo and Damashek (2003), occurs when the caregiver turns to the child to meet the caregiver's emotional needs. This type of role reversal is also known as the parentified child.

Stressor: Stressors can include, but are not limited to, being physically assaulted or abused, sexually assaulted or abused, witnessing domestic violence, being in a motor vehicle accident, being kidnapped or held hostage, being a war civilian, and/or being part of a terrorist attack, as stated by the DSM-5 (APA, 2013).

Structural family therapy: Structural family therapy concentrates on the functioning of the family and is utilized in treatment with children and families (Vetere, 2001, p. 133). Minuchin's SFT model focuses on a system view of the family and problems associated with the family system. Vetere (2001) stated that it is the overt and covert actions that influence the choices and behaviors of the individuals within the family.

Structural maps: Known as family maps, are diagrams of the family organization (Minuchin, 1974).

Traumatic event: Briere and Scott (2013) described a traumatic event as one that is "extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (p. 8). Additionally, the DSM-5 states that stressors can include a variety of events such as physical and sexual abuse, witnessing domestic violence, being held captive, being significantly ill, being in a accident, or even being a civilian during war time (APA, 2013). Traumatic events or

stressors can be anything resulting in a person feeling that his/her life or another person's life is in danger.

Assumptions

There are three assumptions in this study that influenced decisions about data collection and the context of the study.

First, I assumed that the participants in the interviews were honest and truthful when describing their relationship with the child prior to and after the child's traumatic event.

Second, I assumed the caregivers were able to accurately recall the child's traumatic event from their memory.

Finally, I assumed the parent-child dynamics changed after a traumatic event due to what was discovered in the literature.

Scope and Delimitations

The caregiver(s) of a child was interviewed so I could begin to have an understanding of the child-caregiver relationship after the child's traumatic event. The caregiver(s) was asked to describe their relationship with the child and how the child's traumatic experience had influenced the relational dynamics between the child and caregiver. This study addressed the problem that, to date, no researcher had examined how a child's traumatic event is understood in the context of the child-caregiver relationship from the caregivers' perspective. This focus was chosen and the interviews were conducted in a fashion that looked systemically at how a child's traumatic event relates to the relational dynamics between the child and caregiver(s).

The target population was caregiver(s) of a child with a trauma history. The caregiver was defined as biological parent, grandparent, other related legal guardians, or individuals who had adopted children prior to their identified traumatic experience. Individuals that were excluded from the study were those who do not have English as their primary language or are in the foster care system. The target ages of the children who had experienced a traumatic event was between the ages of 3 and 17 years old. However, I worked directly with the caregiver and only the caregiver.

The participants were selected from the Barber National Institute (BNI). These participants were selected from various programming such as Family Based Mental Health program (FBMH), Behavioral Health Rehabilitation Service (BHRS), the psychology department, and so forth. The child was the identified client in one of these programs; however, it is the caregiver that this study will focused on. Permission to invite clients from the BNI had been obtained from the President of BNI (See Appendix A for the letter of cooperation). As the Associate Director for Behavioral Health Programming for the BNI, I did not provide therapy to any of the participants or the children. I also did not directly meet the family prior to this study. The data that were collected was obtained through a semistructured interview.

Limitations

The study had two limitations. Frist, the participants were all recruited from the agency that employs me. Although the study was designed to eliminate prior knowledge of the children and caregivers, the participants were all connected to the BNI. This connection could create a question about my influence over the participants and this was

addressed in the letter to the participants. The letter stated that they were being invited to participate in a research study that does not relate to any services provided by BNI. The separate nature of the research study was also discussed with the participants prior to the interview. A second limitation is the memory of the participants. Particularly when a child's trauma event happened years ago, the recollection of the event may not have been completely accurate. To address this I asked the participants when the traumatic event occurred and made note of it in the results section. The third limitation was the number of participants. I was hoping for 12 participant but was only able to obtain nine.

Significance

This study was unique because it examined an under-researched area of childhood trauma and relationships, specifically examining the relationship between the child and caregivers. The family system is important in the recovery of the child from a traumatic event. Understanding the child-caregiver dynamics after the child's traumatic event means, "experiencing reality as the family members experience it, and becoming involved in the repeated interactions that form the family structure and shape the way people think and behave" (Minuchin & Fishman, 1981, p. 63). Further, the relationship between two or more individuals is one of the core facets of any family system. This study attempted to understand how a child's trauma related to the child-caregiver(s) relationship, and how the dynamics between the child and caregiver developed since the traumatic event, per Minuchin's SFT model.

In addition, this study also informs researchers and clinicians how children and caregiver organize around a traumatic event. The way the child and caregiver organized

around the problem showed the different relationships that existed in families of traumatized children, as they related to the dyads and triads that are formed between the child and caregiver. These dyads and triad showed the potential patterns between the child and caregiver for families that had a traumatized child.

Implications for Positive Social Change

This study attempted to contribute to positive social change. This study was designed to inform researchers and clinicians about how children and caregivers organize around a traumatic event and what types of dyads and triads emerge in the subsystem. Further, this study could help families understand how their child's traumatic event changes the current dynamics of the child-caregiver subsystem. Helping the family to understand these dynamics can potentially aid the child and caregiver in forming more functional dynamics, which may have been in place prior to the child's traumatic event.

Trauma impacts all members of the family, even if only one member is victim to the traumatic event. This is due to the disruptions that occurred within the parenting subsystem and within the attachment between the child and parent (Miller, 1999). With young children, PTSD symptoms are often looked at through the relationship between the parent and child (Scheering & Zeanah, 2001). This is due to the significant role that the parent plays in the child's recovery from the traumatic event. It has been found that parents play a significant and special role in the child's recovery after a traumatic event (Cohen, Mannarino, Berlinger & Deblinger, 2000; van Wesel, Boeije, Alisic & Drost, 2011). Additionally, researchers found the parent-child relationship is always a significant factor at any age, but is even more significant when the child has been

exposed to a traumatic event at a young age (Scheering & Zeanah, 2001). All of this illustrated how the parent-child relational dynamics relate to the child's traumatic event, which was the purpose of this study.

The results of this study have the potential of providing clinical knowledge on how to educate families on how a child's trauma organizes the child-caregiver subsystem. This study also gives insight to clinicians on the need to focus more on the child-caregiver dynamics and treatment, in addition to the needs of the individual child. Figley (1988) discussed that families can either become enmeshed or disconnected after a traumatic event. Looking at these dyads and triads will provide a visual picture of how the relational dynamics changed since the child's traumatic event. This is the result of not only the child being impacted by the child's traumatic event, but the entire family system. Figley stated that families form various types of relationships after a traumatic event, which demonstrate the significance of exploring how the family structures themselves after the traumatic event. There has been a lack of research on the parents' reaction to the child's traumatic event. The parents' reactions to the child's traumatic event was what formed different dyads and triads between the parent and child.

The social change emphasis was on how to not look individualistically, and to look at the interactions of the child-caregiver subsystem. Children are much less likely to respond to individually driven treatment; therefore, making changes in the primary caregiving relationship can give the best chance for improvements in the child's overall symptoms (Scheering & Zeanah, 2001). Additionally, Scheering and Zeanah (2001) discussed that family change that is long lasting in the parental subsystem will better aid

the child in recovery. Per Scheering and Zeanah (2001), attending to the caregiver's symptoms first is often important before beginning to address the child's symptoms and needs, due to the significance of the parent-child relationship. Caregivers who were more emotionally distressed may be less available to the child during a time of need. Therefore, it is important to look at the child-caregiver subsystem rather than just the child after the child's traumatic event. This study provided an alternative systemic perspective to treatment verses looking at the individual child.

Summary

The statistics described the growing problem of children being exposed to traumatic events. It had been reported that 72% of children have experienced a stressor in their childhood, and more significantly 25% of these children had an extreme stressor in their childhood (Costello et al., 2002). The increasing number of children being exposed to trauma is causing more families to be affected and causing different relational dynamics to form between the child and caregiver.

There are many important themes throughout the literature that illustrate the complexity of the issues that can ensue when a child experiences a traumatic event. These themes include childhood trauma and PTSD, caregiver trauma and the impact of trauma on parenting, and trauma and the family system. Even with these major themes there is still a gap within the literature. This gap identified was related to the effect childhood trauma has on the dynamics between the child and caregiver. There has been a lack of research on how the parent reacts to the child's traumatic event. This study helped to fill gap through the use of interviews with the caregivers of children who have a

trauma history. The interview with each caregiver provided an understanding of the caregiver's perspective on the relational dynamics between the child and caregiver after the child's traumatic event. It was important to examine childhood trauma within the context of the child-caregiver subsystem, due to trauma affecting the caregiver and possibly causing the caregiver to feel guilty for not protecting their child (Banyard, Englunch, & Rozelle, 2001; Hiebert-Murphy, 1998). Additionally, this study focused on the need to view childhood trauma through the child-caregiver subsystem, rather than in an individualistic manner.

For this study Chapter 1 included the background of the study; the problem statement and purpose of the study; the research questions and conceptual framework for the study; the definitions of the primary terms related to the study and how trauma relates to the child-caregiver relationship; and the overall nature of the study. Chapter 1 concluded by discussing the significance of the study and the positive social change. Chapter 2 includes a comprehensive overview of the literature related to childhood trauma, PTSD, how a caregiver's trauma history relates to the caregiver's parenting skills, trauma and the family system, and caregiver trauma.

Chapter 2: Literature Review

Introduction

The statistics on the amount of children exposed to a traumatic event seems to be an ever-growing number. Costello et al. (2002) reported that 72% of children have experienced a stressor in their childhood, and more importantly 25% of these children had an extreme stressor in their childhood. Stressors can include, but are not limited to, being physically assaulted or abused, sexually assaulted or abused, witnessing domestic violence, being in a motor vehicle accident, being kidnapped or held hostage, being a war civilian, and/or being part of a terrorist attack, as stated by the DSM-5 (APA, 2013). Children who had experienced a medical procedure or had a medical illness, witnessed traumatic events, or had indirect exposure (hearing of the traumatic event of someone) should also be considered as experiencing a stressor or a traumatic event (APA, 2013). Traumatic events or stressors can be anything in which the child feels that her or his life or another person's life is in danger. Cohen, Berliner, and Mannarino (2010) reported that more than half of United States children and adolescents have been exposed to an event that could be perceived as traumatic, and that some of these children have even developed symptoms of posttraumatic stress disorder. Potential symptoms related to a traumatic event, or PTSD, can be displayed through nightmares or intrusive thoughts, avoidance, isolation from others, jumpiness, poor sleep, and poor ability to concentrate (Briere & Elliott, 1994).

Researchers had discussed how families adapt to traumatic events through routines and roles in the family system, and how families organize around the traumatic

event (Kiser et al., 2008). Researchers also discussed the significance of the mother's role in the child's life after a traumatic experience (Dinshtein et al., 2011). Moreover, researchers discussed how a caregiver's own trauma history impacts them as a caregiver to a child who has experienced a traumatic event (Timmons-Mitchell, Chandler-Holtz, & Semple, 2008). In addition, researchers discussed how the mother's coping strategies after the child's traumatic experience had been impacted and what the common coping strategies look like for these mothers (Hiebert-Murphy, 2000; Hiebert-Murphy, 1998). Finally, researchers concluded the effects of secondary or vicarious traumatization of adult children, and the benefits of the mother-child relationship with fathers who had PTSD symptoms (Dinshetin et al., 2011).

To date, there is no research that has examined how a child's traumatic experience is understood in the context of the child-caregiver relationship. A traumatic event is something that not only affects the individual that was traumatized; it is something that affects the caregivers who are close to the child, because they may feel guilt for not protecting their child (Banyard, Englund, & Rozelle, 2001; Hiebert-Murphy, 1998). The purpose of my study was to understand the dynamics of the relationship between the child and caregiver after a child's traumatic event, from the caregiver's perspective.

A review of the literature revealed a significant gap in that no researcher had examined how a child's traumatic experience relates to the child-caregiver relationship. This literature review begins with a discussion about what trauma is. This section discusses the various forms of trauma that children are exposed to and the statistics on childhood trauma. It will then lead into an explanation of childhood trauma and

childhood PTSD. This section will provide a discussion on PTSD, the affects of childhood trauma, and the risk factors. After these narratives I discusses, through the literature review, the significance of caregiver trauma and trauma on parenting. This section discusses the significance of the parent's relationship with the traumatized child. Further, I will provide a narrative discussion on trauma's relationship to parenting, which will discuss the various perspectives on how a child's traumatic event impacts the child-caregiver relationship. This section will also include a discussion on parental stress, satisfaction, efficacy, role reversal, and attachment and disconnection. Lastly, I explored trauma and the family system. This concluding section explores the minimal research that is available on trauma within the context of the family.

Literature Search Strategy

An exhaustive search of the literature was performed utilizing the Walden online library, the Internet, and Google Scholar. Additionally, the database Google was utilized for this extensive search. The key search words included *family dynamics and trauma event, family dynamics in structural family therapy, family systems theory in counseling, child trauma on caregiver relationship, child-caregiver relationship after trauma, childhood trauma, caregiver and secondary traumatization and children, caregiver and trauma history, parental bonding, what is trauma, and family dyads and family therapy.* There was little to no current research (within the past five years) on all topics. There was minimal research on family dynamics after trauma. There were no studies that were conducted that involved looking at the dynamics between the child and caregiver after the child's traumatic event.

Current Literature

When searching for updated articles on childhood trauma, trauma and parenting, and trauma and women parenting, there was nothing found that related to the topic of this study. I was unable to find literature that was up to date and that focused on the topic of this study. When searching for childhood trauma, I found recent articles related to: drug use; how trauma leads to other diagnoses such as depression; borderline personality disorder; and mood disorders (Lopez-Patton et al. , 2016; Williams et al., 2016; Jansen et al., 2016). Through additional searches for trauma and parenting, I found articles on intimate partner violence and child attachment (Ehrensaft, Knous-Westfall, & Cohen, 2016; van Ee, Kleber, Jongmans, Mooren, & Out 2016). Further, when searching for trauma and women parenting I found information on offspring trauma symptoms, trauma effecting the brain, and sexual anxiety (Bigras, Daspe, Godbout, Briere, & Sabouring 2016; Shors & Millon, 2016; Ehrensaft et al., 2016). Other current literature focuses on attachment with children who have experienced childhood trauma (Ashton, O'Brien-Langer, & Silverstone, 2016). Additionally, the current literature also focuses on what models of treatment to use with children who have experienced childhood trauma (Ashton et al., 2016; Wamser-Nanney, Scheeringa, & Weems, 2016; Gonzales, Monzon, Solis, Jaycox, & Langley, 2016).

Unfortunately, there was no current literature found on how trauma can relate to the family system. Much, if not all, of the family therapy work was started back in the 1960s. This was when Minuchin had come out with his Structural Family Therapy

model. It would reflect that the majority of family therapy research was conducted in the 1960s. This points to why the articles in this study are out dated.

As stated above, there is no current literature focusing on childhood trauma and family dynamics. However, there is a large amount of current research that has been done on trauma and psychopathology and trauma and attachment. In an article by Ensink, Begin, Normandin, Godbout, & Fonagy (2016), it was stated that girls that have experienced childhood sexual abuse (CSA) are more likely to experience depressive symptoms during their lifespan. In a study by Marshall (2016), it was discussed that puberty is a vulnerable time for girls and those who experience trauma during this time are more likely to experience psychopathology as well. Girls who have experienced trauma prior to puberty have a greater chance of depressive symptoms (Marshall, 2016); whereas, those girls who experienced trauma during puberty are more likely to experience PTSD symptoms. In an article by Hong and Lishner (2016), childhood sexual abuse leads to diagnoses related to anxiety, depression, PTSD, and borderline personality traits.

In other literature, it was found that those who have psychosis are seen to have less trust with others (Fett et al., 2016). Less trust points to the individual having a weaker attachment to an individual. Exposure to trauma at a young age can cause the individual to have a weaker attachment to the caregiver (Erozkan, 2016). Disorganized attachment is also seen in those who had experience trauma at a young age (Rholes, Paetzold, & Kohn, 2016).

Theoretical Framework

The theoretical framework for this study was Salvador Minuchin's structural family therapy (SFT) model. This model was developed in the 1960s, and one of the core components of this model is the functioning and dynamics within a relationship. "Structural family therapy is underpinned by a clearly articulated model of family functioning, and has been developed and used most consistently in services for children and families" (Vetere, 2001, p. 133). Minuchin's SFT model focused on a system view of the family and problems associated with the family system. Vetere stated that it is the overt and covert actions that influence the choices and behaviors of the individuals within the family. Even though this model is one that is used to drive clinical treatment, it is also one that shows how to look at relationships. This model has specific ways of looking at how relationships affect the functioning of a dyad or triad. The model also has the clinician, or in this case myself, draw specific structural maps that show how the relationships are functioning. The functioning of relationships would be defined as either close, enmeshed, disconnected, conflictual, or close and conflictual. Using this framework allowed me to look at how the parents are responding to their child, and what the dyads or triads look like since the traumatic event.

As noted above, dynamics that can occur between the caregiver and child can either be close, close but conflictual, enmeshed, disengaged, or conflictual (Minuchin & Fishman, 1981). These relational dynamics will form the dyad or triad between the child and caregiver(s) (Gilbert, 2004; Minuchin & Fishman, 1981). The dyads or triads can show that the trauma has created either a detouring triad, an odd person out triad, a

double bind triad, or a disengaged triad (Gilbert, 2004; Minuchin & Fishman, 1981; Minuchin, Reiter, & Borda, 2014; Shazer, 1975; WPIC, 2005). A detouring triad is where the conflict between individuals is being detoured onto someone else (Minuchin & Fishman, 1981; WPIC, 2005). An odd person out (cut off) triad is where the dynamics between individuals cause another person to be excluded due to the conflict not being dealt with (Gilbert, 2014; Shazer, 1975; WPIC, 2005). A double bind triad involves both parents being overly involved with the child (Minuching et al., 2014; WPIC, 2005). Finally, a disengaged (disconnected) triad involves the child being symptom free, but the parents are in constant conflict with one another (Minuchin et al., 2014; WPIC, 2005). A traumatic event could create any one of these different triads. These different triads relate to the functioning of the subsystems within the family. These dynamics are significant to my study because they show how families function after a child's traumatic event. Additionally, these dynamics show how childhood trauma relates to the organization of the family system.

Review of Literature

Section 1: What is trauma?

There are various forms of traumatic events to which children are exposed. The following are all different forms of traumatic events: mass interpersonal violence, natural disasters, large-scale transportation accidents, fire and burns, motor vehicle accidents, rape and sexual assault, stranger physical assault, intimate partner violence, sex trafficking, torture, war, life-threatening medical conditions, and witnessing or being confronted with the homicide or suicide of another person. Briere and Scott (2013)

described a traumatic event as one that is "extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (p. 8). Additionally, the DSM-5 stated that stressors can include a variety of events such as physical and sexual abuse, witnessing domestic violence, being held captive, being significantly ill, being in a accident, or even a civilian during war time (APA, 2013). Traumatic events or stressors can be anything in which the child feels that his/her life or another person's life is in danger.

The statistics on childhood trauma can demonstrate even more concern for what is described as childhood trauma. Costello, Erkanli, Fairbank, and Angold (2002) reported that 72% of children have experienced a stressor in their childhood, and more importantly 25% of these children had an extreme stressor in their childhood. Cohen, Berliner, and Mannarino (2010) reported that more than half of United States children and adolescents have been exposed to an event that could be perceived as traumatic, and that some of these children have even developed symptoms of posttraumatic stress disorder. Hyper-arousal, adverse thoughts, nightmares, poor sleep and concentration, and isolation from others are all potential symptoms related to a traumatic event, or posttraumatic stress disorder (PTSD) (Briere & Elliott, 1994). This research indicates that PTSD is a serious problem that many children are dealing with each year. To date, there is no research that has examined how a child's traumatic experience relates to the organization of dynamics between the child-caregiver relationship.

Section 2: Childhood Trauma and Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) was initially associated with adults who were coming back from combat or who experienced a disaster or accident (Briere & Elliott, 1994). Briere and Elliott (1994) stated that posttraumatic stress can be viewed as distressing psychological symptoms in response to an adverse experience. With children, trauma can interfere with the child's ability to form a secure and appropriate attachment with the child's caregiving system (Cook et al., 2005). Attachment, the bond between the child and the caregiver, plays a significant role in the child's overall wellbeing. Perry and Szalavitz (2010) stated that the parent's relationship with the child aids the child in his/her ability to handle stress appropriately. This statement is important with attachment, as well as with trauma, because the child looks to the parent for nurturing and safety. The child's interaction with the parent becomes stronger through each interaction with the parent. An infant's brain has the unique ability to imprint the early memories and feelings of attachment (Perry & Szalavitz, 2010). Therefore, attachment problems can lead to a child's inability to form meaningful or stable relationships. Attachment problems can impact the child's early development, the child's mental stability, and his/her ability to appropriately express emotions. The parents' relationship with the child can influence the child's development of psychopathology (Blaya et al., 2010). This can be due to the lack of attachment, the caregiver's mental health needs, and the caregiver's emotional availability to the child. All of which can lead to further issues with the child's ability to self-regulate.

Individuals that have been abused are noted to display a large spectrum of psychological and interpersonal problems (Briere & Elliott, 1994). Additionally, Briere and Elliott stated that sexual abuse and other forms of child maltreatment lead to psychological impairments both in the short and long term. Some of these impairments can include the child's ability to socialize with others, the child's ability to adapt to new environments, and the child's overall resiliency. A child can have an increase of emotional difficulties when the abuse of the child occurred at a young age, continued over a period of time, or the child was victimized by a member from the child's nuclear family (Briere & Elliott, 1994).

Child abuse and neglect can lead to an extensive amount of costly medical and psychiatric problems, along with other challenges in later adulthood (Streeck-Fischer & van der Kolk, 2000). Greeson et al. (n.d.) stated that youth who have a history of experiencing an adverse event are more likely to have behavioral concerns, a mental health diagnosis, and display other PTSD symptoms. Children are more likely to live a life full of trauma symptoms if their traumatic experiences are not treated early in their childhood (Streeck-Fischer & van der Kolk, 2000).

When children are in the different developmental stages, they have different capabilities to process their traumatic event (van Wesel, Boeije, Alisic, & Drost, 2011). Children who have a trauma history may struggle with attending school, which will affect their ability to keep long lasting peer relationships (van Wesel et al., 2011). It should be noted that childhood trauma is a complex phenomenon that impacts the child's emotions and behaviors (van Wesel et al., 2011). In summary trauma affects many areas of life

such as the social, emotional, and interpersonal, which all could potentially lead to a less adjusted child.

Risk factors. In addition to symptoms there are also risk factors that are found with children who have experienced traumatic events. Researchers have found traumatic events and those stressors discussed in the DSM to be more common than it is believed to be (Costello et al., 2002). Costello et al. (2002) stated that an average of 6% of children have experienced a traumatic event. Costello et al. (2002) also discussed that poverty can increase the risk for a child's exposure to a traumatic event. However, even those children who are from higher socioeconomic backgrounds are still being exposed to traumatic events in childhood. Researchers have found that both boys and girls are equally exposed to traumatic events; however, those children with families who have mental illness or a history of mental illness are more likely to be exposed to a traumatic event (Costello et al., 2002). Additionally, children whose parents had a criminal background were found to be at higher risk for exposure to a traumatic event (Costello et al., 2002).

Section 3: Caregiver trauma and Trauma on Parenting

Parents play a special role in the child's recovery from adverse events (van Wesel et al., 2011). van Wesel et al. (2011) found that parents either needed assistance in how to parent and support the child who experienced the stressful event or were emotionally detached from the traumatized child. This illustrates the significance of the caregiver's role with the traumatized child. Specifically, children look to their parents for protection and emotional support. Children who are preschool age depend on their parental

caregivers to protect them from danger and to make their environment safe for them (Howell, 2011). Howell states a child's overall mental health foundation can be damaged if the child's parent is not competent to protect the child or is not available or responsive to the child's needs. This is why the parent's role in the child's recovery process is so significant. A child's resiliency can depend on the child's mother's ability to cope and rebound from adverse events (Howell, 2011).

Likewise, research has shown that parents play a significant role in the child's improvement and recovery from trauma symptoms (Cohen et al., 2000, p. 1213). Attending to the caregiver's symptoms first is often important before beginning to address the child's symptoms and needs, due to the significance of the parent-child relationship (Scheering & Zeanah, 2001). Researchers have found that the parents' distress level plays a significant role in the recovery of the child. Caregivers who are more emotionally distressed may be less available to the child during a time of need.

The parent-child relationship is always a significant factor at any age, but is even more significant when the child has been exposed to a traumatic event at a young age (Scheering & Zeanah, 2001). Trauma impacts all members of the family, even if only one member is victim to the traumatic event. This is due to the disruptions that occur within the parenting subsystem and within the attachment between the child and parent (Miller, 1999). With young children, PTSD symptoms are often looked at through the relationship between the parent and child (Scheering & Zeanah, 2001). This is due to the significant role that the parent plays in the child's recovery from the traumatic event.

Children are much less likely to respond to individually driven treatment; therefore, making changes in the primary caregiving relationship can give the best chance for improvements in the child's overall symptoms (Scheering & Zeanah, 2001). Additionally, Scheering and Zeanah (2001) stated family change that is long lasting in the parental subsystem will better aid the child in recovery. The need for the caregiver's treatment along with the child's is generally overlooked. However, it is crucial that the caregivers are treated for their symptoms and response to the child's trauma (Scheering & Zeanah, 2001). Moreover, Scheering and Zeanah (2001) discussed it is important that the child's traumatic responses are understood in the context of the relationship with the caregiver. The child is more successful in treatment when the child's caregiver is in treatment with her/him, because the caregiver can support and aid the child with the child's distressful feelings.

Looking more closely at children, usually by age eight they are able to manage their thought process after a traumatic event (Salmon & Bryant, 2002). However, Salmon and Bryant state parents may avoid the discussion of their child's traumatic experience due to their own distress. This is one potential barrier to treatment when addressing the child-caregiver relationship. Additionally, Salmon and Bryant stated the parent-child conversation about the trauma is important because it will affect the child's memory and the child's ability to cope. If the parent does not validate the child's traumatic event, it can then impact the ability of the child to cope with the traumatic event. Moreover, Salmon and Bryant discussed that the development of PTSD is determined by the way the individual reacts to the traumatic event. Again, this indicates

the need for parental involvement in the treatment process because both children and adults can be affected by trauma.

Section 4: Trauma's Relationship to Parenting

The way in which a child's traumatic event impacts the child-caregiver relationship has been researched from several perspectives. Some of these perspectives include studies that specifically examine the impact a child's trauma has on the parent. Other perspectives look at the parents' reaction when their child has experienced trauma and have found that the parent displays vicarious trauma reactions. More importantly, additional studies looked at how other previous trauma experienced only by the parent has influenced parenting styles and techniques. However the results of the studies are similar in that there appears to be a relationship between trauma and parenting, but the studies differ in their approaches to this topic.

Valentino, Berkowitz, and Smith Stover (2010) focused on parenting styles and PTSD symptoms after a child's traumatic event found a significant relationship between parent and child reported PTSD scores. Parents who reported their child's PTSD symptoms to be high also experienced trauma symptoms due to the child's traumatic event (Valentino et al., 2010). There are differences to the way trauma influences the parenting style of the caregiver. This may be due to the trauma of the child and/or the caregiver.

Looking more closely at parenting techniques and behaviors, Valentino et al. (2010) uncovered that parents with a child who reported greater PTSD scores had parented with more coercive and hostile parenting techniques. In a somewhat similar

study Lyons-Ruth and Block (1996) discovered that hostile behaviors towards the infant were found in mothers who had been physically abused. So perhaps the mother's personal experiences from her past, as well as her reaction to her child's trauma, can influence parenting behaviors.

A mother's history of childhood sexual abuse has been seen to relate to how the mother parents the child. A study by Ruscio (2001) focused on parenting styles of mothers that were survivors of child sexual abuse. Ruscio (2001) found that mothers with a history of childhood sexual abuse without penetration were significantly more permissive and that structure, discipline, and expectations were difficult parenting techniques for these mothers. Contrarily, mothers that had experienced childhood sexual abuse with penetration were found significantly more likely to parent more in an authoritarian style (Ruscio, 2001). This study showed the impact of childhood sexual abuse on parenting styles and approaches, in that childhood sexual abuse can be related to struggles for the caregiver with effective parenting. This is demonstrated through the parent, with a history of childhood sexual abuse, either being too permissive or being more authoritarian. The studies have demonstrated a relationship between a history of childhood sexual abuse and parenting difficulties.

Parenting anxiety and intimacy issues with the child are also seen to correlate with caregivers who are survivors of childhood sexual abuse. In a study conducted by Douglas (2000), mothers who experienced contact childhood sexual abuse were found to be more anxious about the intimate factors of parenting, such as washing the baby while giving the baby a bath, and anxious about what is seen as normal parenting behaviors.

These mothers who experienced childhood sexual abuse worried about how other parents may perceive their parenting behaviors (Douglas, 2000). Douglas (2000) believed the anxiety is caused by the fact that engaging in an intimate caregiver activity can cause parents to feel a level of discomfort reminding them of the discomfort they felt when being sexually abused as a child. This demonstrates that the way the mother is parenting her child is based on the mother's history of childhood sexual abuse, as found by Hiebert-Murphy (1998).

These feelings of discomfort and restriction of affect could potentially cause the parent to disengage from the child. Lyons-Ruth and Block (1996) found that mothers with a history of sexual abuse were seen to be the most disengaged from their infant and were found to spend less time in a room with their infant. This may give some insight into why mothers of childhood sexual abuse are more permissive with their children, in that they are uncomfortable with becoming emotionally or physically close with their child due to their own trauma symptoms.

In addition to childhood sexual abuse, other adverse experiences during childhood are seen to relate to how the caregiver engages in parenting techniques. The use of corporal punishment was found to be utilized by parents who had adverse childhood experiences such as sexual abuse, physical abuse, and witnessing domestic violence (Barrett, 2009). It was also found in a study by Banyard, Williams, and Siegel (2003) that parents who were physically abused as children appeared to struggle more with parenting, in that these parents were neglectful and utilized physical punishment with their own children.

DiLillo and Damashek (2003) found consistency with Barrett's (2009) study and Banyard et al.'s (2003) study, in that it was found that childhood sexual abuse survivors struggle with being too permissive and utilizing harsh physical discipline. All of this is interesting in that it contradicts Barrett's (2010) study when it was found that childhood sexual abuse and adulthood parenting are not directly linked. However, adulthood parenting was found to depend on what other forms of adverse experiences and risks the individuals had been exposed to, such as physical abuse and witnessing domestic violence (Barrett, 2010). These findings show how different adverse experiences, not just childhood sexual abuse, can influence the parenting styles of the adult survivors.

Parental stress, satisfaction, and efficacy. Parental stress, satisfaction, and efficacy can also be affected due to traumatic or adverse experiences. Barrett (2009) found that there was no difference in the levels of parental stress for those who were sexually abused as children and those who were not. However, both Hiebert-Murphy (1998) and Douglas (2000) found higher stress levels with survivors of childhood sexual abuse. Childhood physical abuse was also found to correlate with higher parental stress levels in a study conducted by Barrett (2009). Thus, the research suggests that parental stress is related to childhood sexual or physical abuse of the parents. However, social support can mitigate parenting stress levels when looking at families that have experienced trauma. Lack of social support from family members and friends was related to an increase in emotional distress with mothers who were survivors of childhood sexual abuse (Hiebert-Murphy, 1998).

Trauma has been researched to examine how a caregiver's history of exposure to an adverse experience influences the caregiver's parental efficacy. Fitzgerald, Shipman, Jackson, McMahon, and Hanley (2005) specifically examined incest survivors and found that incest history was related to parenting self-efficacy, which created low self-efficacy for incest survivors. On the other hand Hiebert-Murphy (2000) examined maternal history of sexual abuse and found that it did not relate to parenting efficacy or satisfaction. Banyard et al. (2003) appeared to agree with Fitzgerald et al. (2005) by indicating that those exposed to trauma, sexual assault in adulthood, and parents that were physically abused as children all had low parenting satisfaction. With this exception to Hiebert-Murphy's (2000) study, it appeared that adverse childhood experiences can relate to low parenting satisfaction and parental efficacy.

Role reversal. Further looking at trauma's relationship with parenting, a theme that emerged in the DiLillo and Damashek (2003) study was role reversal among childhood sexual abuse survivors. Role reversal, as defined by DiLillo and Damashek (2003), is where the mother turns to the child to meet the mother's emotional needs. Role reversal is also known as the parentified child. In a different study, Teti and Anderson (2000) found that childhood sexual abuse survivors who were unsatisfied with their own personal relationship with their significant other engage in role reversal with their child. Role reversal was also seen in women whose mothers physically abused them as a child (Alexander et al., 2000). It appears that survivors of childhood abuse have an emotional need that has not been filled; therefore, the parent is turning to the child to have this emotional void fulfilled.

Attachment and disconnection. Attachment and child adjustment are important aspects of both trauma and family structure. Parental bonding with the infant takes a lot of practice and needs to be repeated often (Perry & Szalavitz, 2010). Perry and Szalavtiz (2010) also discussed that caregiver nurturance is the most important factor in building the attachment bond. Perry and Szalavitz (2010) discussed that when bonding and nurturing from the caregiver is not consistent it becomes hard for the infant to try to make the attachment connections, eventually causing the infant to give up. Attachment is important for infants in that it is "a memory template for human-to-human bonds" (Perry & Szalavtiz, 2006). It is profoundly influenced by whether you experience kind, attuned parenting or whether you receive inconsistent, frequently disrupted, abusive, or neglectful care" (Perry & Szalavtiz, 2006, p. 85).

Lewin and Bergin (2001) reported that mothers who experienced childhood sexual abuse demonstrated lower levels of attachment behaviors with their child. Interestingly, Lyons-Ruth and Block (1996) found the mother's abuse history was not related to the infant's secure or insecure attachment. However, 88% of insecure infants had mothers who were exposed to violence and were seen with disorganized attachment (Lyons-Ruth & Block, 1996). Further, Lyons-Ruth and Block (1996) noted that mothers of organized avoidant infants often were neglected by their own mothers in childhood. Lyons-Ruth and Block (1996) also noted that disorganized symptoms were found in infants who had insecure attachments to their mothers who were exposed to violence. Neglect was also correlated with a history of physical abuse or witnessing domestic violence (Lyons-Ruth & Block, 1996).

Punamaki, Qouta, and El Sarrj (1997) and Banyard, Englund, and Rozelle (2001) found child adjustment to correlate with parenting behaviors. Punamaki et al. (1997) found that the child's adjustment was related to the parent's intimacy and affection towards the child. Similarly, Banyard et al. (2001) found that increased behavioral symptoms were seen with children who had a mother with a rejecting parenting style. This may shed some light on the significance of the relationship between parenting behaviors and a child's adjustment.

Overall, attachment is a significant aspect of a child's ability to cope with trauma. The caregiver appears to be the key factor in whether the child has trauma symptoms, due to the parenting style the caregiver engages in with the child. For instance a caregiver that is securely attached and nurturing to the child will have a stronger attachment bond with the child, thus allowing the child to turn to the parent for nurturance. However, the opposite could be possible with an avoidant or insecurely attached caregiver. The avoidant caregiver could lead to the child being disconnected from the caregiver. It also appears that the mother's own trauma history is a contributing factor in whether the parent has a healthy attachment bond with the infant. The significance of the bond between the parent and child can lead to the child's overall adjustment.

Section 5: Trauma and the Family System

Exploring trauma within the context of the family is one area that is lacking research. There was minimal research found on this topic, and it was rather dated. The research reviewed how parents respond to their child after the child's traumatic event.

Additionally, the research discussed how the dynamics within the family system may have been altered after a traumatic event.

Figley (1988) discussed the importance of looking at the family system and the relationships within the subsystems of the family. Figley (1988) also spoke to the importance of looking at the dyads and triads within the family. Families can either become enmeshed or disconnected after a traumatic event (Figley, 1988). A family that becomes enmeshed is one that overly uses each other for comfort and assurance, whereas a family that is disconnected will pull away from each other, avoid or isolate (Figley, 1988; Gerwirtz, Forgatch, & Wieling, 2008). However, not all families are either enmeshed or disconnected. Figley (1988) discussed that there are families that are balanced, meaning they are neither overly connected nor disconnected. These families tend to be viewed as "crisis-resistant" (Figley, 1988).

The various types of relationships, enmeshed or disconnected, that families form after a traumatic event shows the significance of exploring how the family structures themselves after a trauma (Figley, 1988). Figley (1988) noted that it not only demonstrates the importance of looking at the hierarchy and who holds the power within the hierarchy, but the importance of looking at the roles, rules, and relationships of all the family members within the various subsystems.

The shift to bonding and nurturing away from control and order is imperative to explore within the parenting subsystem after a traumatic event (Mowder, Guttman, Rubinson, & Sossin, 2006). Mowder et al. (2006) discovered that parents focus more on bonding, nurturing, and protecting after a traumatic event. Additionally, parents who

focused more on bonding and nurturing put less effort into maintaining structure, limits, and discipline (Mowder et al., 2006). This research demonstrates that parents do change their parenting styles after their child has experienced a traumatic event. This may be due to parents wanting to protect their child more because of their own feelings related to the child's traumatic event.

Summary and Conclusions

An exhaustive review of the literature was conducted. I could not find any recent literature regarding childhood trauma and how it relates to the child-caregiver relationship. Only one article was found Figley (1988) which relates to the topic of this study. However, this article is significantly out of date.

The major themes appearing throughout the literature include the definitions of trauma, childhood trauma and PTSD, caregiver trauma and trauma on parenting, trauma's relationship to parenting, and trauma and the family system. There are various definitions for trauma. It is traditionally defined as physical or sexual abuse. However, it is more than just abuse. It can be presented in different forms and contexts. The various forms and contexts can include, but are not limited to, physical abuse, sexual abuse, witnessing domestic violence, being in a motor vehicle accident, being a civilian during war, or witnessing someone else's trauma. All of these relate to the present study in that the study is looking at how a child's traumatic experience relates to the child-caregiver dynamics.

The literature showed how childhood trauma relates to PTSD and other physical and psychological problems. It was seen that childhood trauma can increase emotional

difficulties (Briere & Elliott, 1994), can lead to large medical and psychiatric costs (Streeck-Fischer & van der Kolk, 2000), can impact the child's attachment with the caregiver (Cook et al., 2005; Perry & Szalavitz, 2010), and can impact the child's social growth (Perry & Szalavitz, 2010) to name a few. Within this theme, the risk factors of childhood trauma and PTSD were also discovered. Some risk factors include poverty and being children of families with a mental health history (Costello et al., 2002). Additionally, Costello et al. (2002) stated that children whose parents had a criminal background were found to be at higher risk for exposure to a traumatic event.

Caregiver trauma and parenting trauma is a third theme that was uncovered. This theme showed the significance of the caregiver's role in the child's recovery, and the caregiver's relationship with the child was discussed. It was found that the caregiver plays a large role in the child's recovery and resiliency. Children are found to turn to the caregiver to look for support and protection. Therefore, it is important for the caregiver of a child who has a trauma history to seek mental health treatment. Further, the child's resiliency can depend on the caregiver's ability to cope with the child's traumatic event.

Research demonstrated that a caregiver's trauma history relates to parenting techniques, behaviors, and the parenting style of the caregiver. A parent's trauma history is seen to correlate with the parent's anxiety and intimacy issues with the child (Douglas, 2000). This was seen more so with caregivers who experienced childhood sexual abuse. These caregivers were found to have difficulty engaging in intimate tasks with their child, such as giving the child a bath. Additionally, within this theme, parental stress, satisfaction, efficacy, role reversal, and attachment and disconnection were also found.

These themes were also significant in that they demonstrated the importance of social support to parents who have a child with a trauma history. These themes also pointed to how trauma impacts parental stress, satisfaction, and efficacy. Attachment was found to be an important factor in appropriate child-caregiver relationships. However, there appeared to be a disconnection between the child and caregiver when the caregiver had a history of childhood trauma.

Trauma and the family system was the final theme that was seen throughout the literature. Even though this theme is significantly lacking research, the theme highlighted the potential dynamics of the family after a traumatic event. The research that was found discussed exploring trauma within the context of the family. However, the research was outdated. The overarching theme that was discovered was the importance of looking at the relationships within the family system and subsystems. Trauma is seen to create either an enmeshed or disconnected relational dynamic within family systems (Figley, 1988). Yet, even with this information there is no research on how the child's trauma relates to the dynamics between the child and caregiver after the child's traumatic experience.

All of these themes (trauma, PTSD, caregiver trauma and trauma on parenting, trauma's relationship to parenting, and trauma and the family system) relate to the present study. These themes looked at how the child's traumatic experience relates to the child-caregiver dynamics. Additionally, the various themes showed the importance of looking at childhood trauma with the context of the child-caregiver subsystem. Moreover the

themes showed the importance of looking at childhood trauma in a systemic way rather than individualistically.

Even with these key themes identified there are still areas identified that are not understood. Some of these areas are how a child's ecosystem affects the child's recovery after a traumatic event and how this event may also shift the structure of the family system. An example of this shift in the family system is the child becoming parentified after a traumatic event, because the parents may feel guilt after the child's trauma. Another area that is under researched is how a child's trauma influences the dynamics between the child and the child's siblings or other nuclear relatives.

The majority of the articles found were quantitative studies and had varying sample sizes. For example a study conducted by Ruscio (2001) had a sample size of 45, whereas a study conducted by Barrett (2009) had a sample size of 483. Quantitative studies need to have larger sample sizes to demonstrate validity and reliability. Without validity and reliability the results of the study would not be trustworthy. Validity is about measuring what is meant to be measured (Frankfort-Nachmias & Nachmias, 2008). Reliability focuses on how many times errors occurred when measuring a variable (Frankfort-Nachmias & Nachmias, 2008). Larger sample sizes typically have higher reliability and validity estimate.

Qualitative studies are known to have smaller sample sizes. In qualitative studies the validity is more about the meaningfulness and insight gained from the study rather than the sample size (Patton, 2002). With a small sample size the researchers can focus more closely on the research questions and their interactions with the participants.

Additionally, Patton (2002) states at any time during the study the sample size could be increased if needed to ensure the phenomenon is gaining an adequate amount of research.

With the present study a small sample size is utilized due to my active involvement with the participants. I utilized interviews to look at the events and processes more closely with each participant. Through the smaller sample size I can better understand each participants' beliefs, thoughts, and perceptions about how the child's trauma relates to the child-caregiver dynamics. By utilizing this small sample size in the study it is allowed a more in-depth systemic look at the child-caregiver dynamics through the conceptual framework. This was done by looking at the relationship of the child and caregiver after the child's traumatic event. Structural maps were utilized to show these relational dynamics, which were drawn by me. Additionally, a smaller sample size was needed so that I could have a positive relationship with the participants. This helped me understand the participants' meaning, and hear the participants' viewpoints and beliefs they hold (Creswell, 2009) about the child's traumatic event. The internal validity can also increase due to me being in the natural setting of the participants, because I am speaking directly with the participant and observing the participant's behavior as s/he answers the interview questions (Creswell, 2009). Working directly with the participants aided me in not only understanding the viewpoints of the participants, but also the underlying phenomena (Trochim, 2006). All of this allowed the present study to have a smaller sample size to ensure internal validity.

While the majority of the studies showed how the caregiver's childhood trauma impacted the caregiver's ability to parent, it was not discussed how a child's trauma

relates to the child-caregiver subsystem or the dynamics between the child and caregiver. This is a significant gap in the literature because the relational dyads and triads between the child and caregiver have not been explored. More specifically the research has not looked at how the caregiver views the relational dynamics between the caregiver and the child after the child's traumatic event. Further, the one article that was found that was related to family dynamics and trauma was dated 1988.

This study filled this gap by interviewing the caregivers of children who have a trauma history and discovering how the child's traumatic experience has related to their relational dynamics. Additionally, this study specifically looked at the child-caregiver relationship and the dynamics between the child and caregiver after the child's traumatic event. Moreover, this present study extended knowledge in the discipline by looking at childhood trauma in a systemic manner rather than an individualistic manner.

Chapter 3: Research Method

Introduction

This chapter provided an overview of the qualitative design, which was utilized in this study, and explains why this design was selected. The qualitative design for this study involved utilizing interviews and structural maps. The participants for this study included eight caregivers, each of which had a child who has experienced a traumatic event. Additionally, the population that was utilized will be discussed along with how purposeful sampling will be used to select the participants for the study. Finally, this chapter will cover how the data will be collected and analyzed.

The central purpose of this study was to understand how a child's traumatic event related to the relational dynamics between the child and caregiver. The following research question provided the foundation for the study:

1. What are the relational dynamics between the child and caregiver after the child's traumatic event based on Minuchin's theoretical framework?

Further, this study used the qualitative tradition to look at the caregivers' description of how their child's traumatic event has affected their relationship with their child.

Role of the Researcher

In this study I was responsible for collecting the data and adhering to the ethical codes. The data was collected by conducting semi-structured interviews with caregiver of a child who had experienced a traumatic event I am employed by BNI the community services agency that provided care and service to the participants. However, I did not provide therapeutic treatment to any of the participants. I only supervised the Lead

Clinical Supervisor who supervised the behavioral health programs that the participants were selected. To manage biases, I was mindful of the supervisor/supervisee relationship as well as any personal beliefs that may have interfered with conducting an ethical study.

I believed that a child's traumatic event affected the relational dynamics between the child and caregiver. I believed that the patterns and themes obtained in the semi-structured interviews reflected relational dynamics that are detouring, odd man out, disconnected, and double bind. It was also believed that a child's trauma creates stress within the child's and caregiver's relationship.

I monitored any pre-conceptions or biases to avoid interpretations that do not emerge from my data.

Procedures

Participants were invited to take part in the study through a mailing that was sent out by the administrative assistant for Clinical Services at BNI. The administrative assistant signed a confidentiality agreement to ensure the potential participants are not disclosed. The envelopes were plain envelopes without the BNI logo on them. Additionally, the letter that asked for the individual's participation did not include the BNI logo. Each participant was asked to contact me voluntarily, and an incentive was offered. The incentive included a 15 dollar gas card to a local gas station. This incentive was to be a token of appreciation for the participant's time and for sharing the participant's story with me.

Once the potential participants received the letter they were able to contact me by phone. My personal cellular phone number was included in the letter to the participants. The participants contacted me and I followed the screening tool, developed by myself, to ensure the participants met the requirements for the study. See Appendix B for the screening tool. After the participant was found to be an appropriate candidate for the study I conducted the demographic questionnaire with the participant. See Appendix C. Next, I and the participants selected a mutually agreed upon date, time, and place to meet. Meeting places included a private room at the local library, my office at BNI, or another agreed upon private setting in the community.

Consent forms were signed with me present, and I have kept these forms. Additionally, I collected data and ensured the benefits outweighed the risks to the participants. To ensure the benefits outweighed the risks I explained the study to all participants and also debriefed them after the study was completed. This is explained further later in this chapter. Moreover, I formulated a systemic understanding about the data that was collected to demonstrate the child-caregiver dynamics and how they related to the child's traumatic experience. If a participant were to have a psychological or physical episode I would have discontinued the study and ensured safety of the participant. Additionally, I reviewed the debriefing form, which included contact information for local mental health agencies, with the participant.

Methodology

Within the study I was aiming to answer the how or why questions related to the child-caregiver dynamics after the child's trauma through the use of multiple case study

approach. Therefore, the qualitative method for this study was the use of the multiple case study approach while employing semistructured interviews to obtain the data. I interviewed caregiver(s) of traumatized children. This content provided me with an understanding of the child-caregiver dynamics, from the caregiver's perspective.

The use of the case study approach allowed me to collaborate directly with the participants and it allowed them share their experiences through first person narrative (Baxter & Jack, 2008). More specifically, Baxter and Jack (2008) stated the multiple case study approach examined more than one case and aimed to find the common themes and patterns between the cases. Multiple case studies allowed for more robust and in-depth information regarding each participant (Yin, 2009).

Specifically, multiple case studies allowed me the opportunity to replicate the same study, with different participants (Yin, 2009). Yin (2009) stated this replication of the study will aid in seeing if the results amongst each case are similar or different. Within the present study, I was aiming at exploring the relational dynamics between the child and caregiver after the child's traumatic event.

Further, the context I explored within the multiple case study approach was childhood trauma, more specifically the caregiver and the natural environment. This context provided me with a picture of the child-caregiver dynamics from the caregiver's perspective, while seeking patterns within the data.

Theory is also a significant part of the case study design (Yin, 2009). For this study I assumed that, for each case, childhood trauma had created non-functional dyads or triads between the child and caregiver. Yin (2009) stated it is the theory that guides

the assumption, the data collection, and analysis stages. The guided theory in the current study was Salvador Minuchin's SFT. As mentioned, the data for each case study was gathered through semi-structured interviews. Interviews are guided conversations between myself and the participants (Yin, 2009). Within interviews there were two tasks. Yin (2009) discussed that these tasks included an in depth understanding of answers to follow the interview questions and to have a conversation around the questions. In semistructured interviews the order in which the questions are asked and the manner in which the questions are asked can vary (Wooffitt & Widdicombe, 2006). Wooffitt and Widdicombe (2006) noted that semi-structured interviews aim to look at the participant's views. Additionally, Wooffitt and Widdicombe (2006) stated that semistructured interviews can produce a mix of yes/no answers and informative statements. Moreover, interviews required me to operate by meeting the needs of the study and by presenting in an inviting manner (Yin, 2009). For the current study, I conducted the interviews in a mutually agreed upon location and took up to 90 minutes of the participant's time to conduct the interview.

In the qualitative tradition, data analysis and data collection generally occur at the same time (Baxter & Jack, 2008). Analyzing case study data can often be the hardest part of the study and relies on the style of the researcher (Yin, 2009). Yin (2009) stated the data analysis part of the study should begin slowly by analyzing the questions within the study. Yin (2009) explains that beginning in this manner allows the researcher to find the evidence that addresses the question, which then allows the researcher to move towards formulating a conclusion. This process was to be repeated with each question until they

have all been exhausted. This in depth understanding of each individual research question aided me in better answering the main research question.

As noted by Yin (2009) qualitative analysis can employ software-assisted technology to assist the researcher in organization. These software programs aid with categorizing and coding data. Within this study I used a basic Microsoft Excel spreadsheet to help in organizing my data. The method also required backtracking, which involves the researcher being able to state why each category or code was given to each set of data (Yin, 2009).

The general analytic technique that was used for this study was cross case synthesis. Cross case synthesis is most ideal for the multiple case study approach (Yin, 2009). Yin (2009) noted that this strategy explores each case individually through the framework guiding the study. Further, Yin (2009) discussed that word tables are developed according to the framework to aid in organizing the data. This strategy aided in laying the groundwork for data analysis.

Once the general analytic technique had been established I moved towards addressing the rival explanations and replication. In this study I used literal replication to analyze the common themes and/or patterns among the cases in the study. Literal replication is used when the researcher wants to see or predict similar outcomes within the cases (Yin, 2009), which was true of this study. Further, literal replication allowed the research to continue to be driven by the theoretical framework (SFT).

The qualitative analysis for the case study approach is one of the most difficult, because the researcher had to show that the evidence had been addressed, all the research

questions had been explored, and leveraged as much of the evidence in the data analysis as possible (Yin, 2009). I had to be able to show that I was the expert of the study. Moreover, Yin (2009) stated that the researcher had to rely on prior knowledge or expertise on the topic for the study in order to successfully analyze the data.

Participant Selection Logic

The target population were caregivers of a child with a trauma history. The caregivers were defined as biological parents, grandparents, other related legal guardians, or individuals who have adopted a child. The caregivers were not the identified clients in any form of psychological treatment/therapy at the time of the interview. The caregivers' children may have been in psychological/therapy treatment at the time of the interview, even though the children were not involved in the research. The target ages of the children that had experienced a traumatic event were between the ages of 3 and 17 years old. However, the children were not involved in the research. Additionally, the participants had English as their primary language.

Criterion sampling was used to select participants for the study. A sampling strategy as defined by Suri (2011) ensured each participant had to meet a certain criteria in order to be accepted into the study. Suri (2011) noted that criterion sampling involved each participant meeting pre-determined criteria and having specific inclusionary and exclusionary criteria. Criteria sample can result in a small sample size (Suri, 2011), which was true of this study.

I had secured permission from the President of the BNI, Mr. John Barber, to conduct the study with caregivers who participated in programs through BNI. The

participants were selected from various programming such as Family Based Mental Health program (FBMH), Behavioral Health Rehabilitation Service (BHRS), the psychology department, and so forth. To recruit the caregivers, the administrative assistant for Clinical Services at BNI sent out a mailing to the selected caregivers who had participated in these programs and were asking for their voluntary participation in the my study. This administrative assistant signed a confidentiality agreement. The caregivers who wanted to voluntarily participate in the study responded by calling my personal cellular phone, where I obtained the participants' information and set up a formal meeting with the participants. It was explained that this was for research purposes only and in no way was it meant as a substitution for mental health therapy.

The sample size was small; it involved 9 caregivers. Qualitative studies are known to have smaller sample sizes. In qualitative studies, the validity is more about the meaningfulness and insight gained from the study rather than the sample size (Patton, 2002). With a small sample size, researchers can focus more closely on the research questions and their interactions with the participants. Additionally, Patton (2002) stated at any time during the study the sample size could be increased if needed to ensure the phenomenon is gaining an adequate amount of research. Further, data sufficiency looks at the sample size to ensure that enough evidence has been gained to achieve the purpose of the study (Suri, 2011).

With the present study, a small sample size was used due to my active involvement with the participants. Through the smaller sample size, I could better understand each participant's beliefs, thoughts, and perceptions about how the child's

trauma relates to the child-caregiver dynamics. The small sample size in this study allowed a more in-depth systemic look at the child-caregiver dynamics through the theoretical framework. Looking at the caregiver's perception of the relationship with the child after the child's traumatic event achieved this. Additionally, a smaller sample size was needed so that I could have a positive relationship with the participants. This helped me understand the participants' meaning, and hear the participants' viewpoints and beliefs they held about the child's traumatic event (Creswell, 2009). The internal validity of a study also increased due to the researcher being in the field with the participants, due to the researcher speaking directly with the participant and observed the participant's behavior as s/he answered the interview questions (Creswell, 2009).

Instrumentation

Semistructured interviews were used as the main data collection instrument in this study. Semistructured interviews are most similar to a natural conversation that one would have with another individual (Wooffitt & Widdicombe, 2006). Having a semistructured interview was important to this study due to "the quality of the information obtained during an interview being largely dependent on the interviewer" (Patton, 2002, p. 341). The purpose of interviewing was to uncover what could not be found from observations and to understand the participant's perspective (Patton, 2002).

In this study, an interview guide supported each interview by providing topics, specific questions, and probes (Patton, 2002). The guide for this study ensured that each participant was asked the same set of questions. This allowed me to build a conversation with each participant. An interview guide was also beneficial in helping me utilize the

participant's time to its fullest while keeping the conversation focused (Patton, 2002). For this study I prepared the interview questions prior to interviewing the participants. See Appendix D for the interview guide. The information gathered from the interview was used to inform and draw the structural maps, aid in finding the themes, and aid in uncovering patterns.

To safeguard that the interview questions were free of my biases, and to ensure content validity, I had two professionals who are experts in trauma and family dynamics review the interview questions. See Appendix E for the letter to panel of experts. Having the professionals review the potential interview questions for the study enhanced content validity. Further, this ensured the interview questions related back to the research question for this study.

Procedures for Study

The semistructured interviews aided in forming the structural maps, and finding the relational themes and patterns. The data were collected through the participants that were obtained through the BNI. The participants were screened prior to the start of the study. The screening process occurred over the telephone and involved me ensuring that the participant met the qualifications for this study. These qualifications included the participant having a child that had experienced a traumatic event and the child being between the ages of 3 to 17 years old. Other qualifications included the family's primary language being English, and being part of one of the BNI's programs. Additionally, a caregiver was defined as the child's biological parents, grandparents, other related legal guardians, or the child's adoptive parent. Moreover, the first 9 qualified participants who

contacted the writer to participate were included in the study. Once I obtained the participants, I conducted the semi-structured interview at a mutually agreed upon place, such as a private room at the local library, empty classroom, or my office at the BNI.

The researcher was actively involved in the study and had direct contact with the participants. The data for the study was collected though the use of the semistructured interviews, which included the interview guide. Each participant was asked to participate in one interview for a maximum duration of 90 minutes. The participants were allowed to go over the 90 minutes if they liked to or if they have additional information they felt was important to the interview questions. I kept track of time during the interview. This was done to respect the time of the participant and the procedure of the study. Once the interview was completed, I completed the drawing of the structural map and shared the structural map with the participant. For an example of a structural map see Appendix F. I presented the structural map to the participant in a manner that was nonjudgmental, yet was also inviting for the participant's thoughts and feedback. I obtained the participant's views on the initial structural map to see if the participant's view on the structural map was similar to that of mine. The interviews were audio recorded and transcribed by a hired transcriptionist. The transcriptionist signed a confidentiality agreement to protect the confidentiality of the participants. See Appendix G for the confidentiality agreement. Additionally, I coded each participant with a pretend name. No names were given to the transcriptionist. I obtained the participant's consent to audio record the interview.

At any time the participants could stop the interview or decline to participate in the study. Regardless of whether the participant opted to stay in the study or drop out,

the participants were debriefed prior to exiting the study. The debriefing process included me providing the contact information for local mental health agencies. See Appendix H for the debriefing process. If the participants had additional questions after the interview they were allowed to contact my via phone contact. Additionally, if I had any follow up questions after the interview I asked permission from the participant to contact the participant after the interview.

Recruitment

As stated earlier, a letter was mailed out to the caregivers asking for their participation in the study. See Appendix I for the letter to the participants. Each participant was asked to contact me voluntarily, and an incentive was offered. The incentive included a 15 dollar gas card to a local gas station. This incentive was to be a token of appreciation for the participant's time and for sharing the participant's story with me.

Data Collection

Upon contacting me to participant in the study the participants were screened, as described earlier. Once the participants had been deemed appropriate for the study, interviews were scheduled with the participants. Interviews were the main tool utilized to collect the data for this study. The interview occurred at a mutually agreed upon place, such as a private room at the local library, empty classroom, or my office at the BNI. The interviews lasted up to 90 minutes. All interviews utilized the interview guide created by me. See Appendix D for the interview guide. Each participant was asked the

same questions. I audio recorded the interviews in order to aid with data collection and data analysis.

Data Analysis Plan

Data analysis is important in qualitative research, as with any type of research. Qualitative research explores patterns, themes, and content analysis. For the present study I looked at the patterns through how the caregivers' were discussing their relationship with their child after the trauma. This study looked to find a pattern and theme among the dyads and triads between the child and caregiver. The themes included detouring, odd man out, functional or double bind triads. Patterns included close-conflictual, enmeshed, and conflictual dyads. The data analysis for this study was deductive in that the information was analyzed through an already existing framework (Patton, 2002).

Patton (2002) stated that the majority of qualitative analysis is inductive. Inductive analysis allows the researcher to revise any hypotheses as the data analysis occurs. Additionally, Patton (2002) discussed that inductive analysis focuses on the researcher uncovering the themes and patterns throughout the data. Patton (2002) stated that this can also involve the researcher's thoughts on the patterns and themes. Inductive analysis involves creating categories for the data based on the themes and patterns found throughout the data, whereas deductive analysis involved having pre-existing categories to place the data into (Patton, 2002). These pre-existing categories were based on a theory or framework. The data analysis for this study was deductive in that the information was analyzed through an already existing framework.

According to Gilgun (2014) a theory or framework guides the research and aids the researcher in maintaining focus. Gilgun (2014) stated that deductive analysis allows the researcher to form hypotheses that can be tested or modified. This type of analysis also involves sensitizing concepts. Gilgun (2014) described sensitizing concepts as the pre-existing categories that the data were placed into. Sensitizing concepts aided the researcher in viewing the data through the lens of the theory or framework (Gilgun, 2014). However, Gilgun (2014) also stated that sensitizing concepts could also prevent the researcher from viewing other categories or patterns. When the researcher cannot find a category for the data to be placed into this is referred to as negative case analysis. There are times when cases can be dissimilar. Negative case analysis comes into data analysis when a case has qualities that are different from the other cases in the study (Gilgun, 2014).

This study relied on deductive analysis through Minuchin's SFT framework. This analysis approach was chosen due to the study involving multiple case studies. Additionally, deductive analysis most appropriately suited this study due to the pre-existing categories of the odd man out, detouring, double bind, functional, and disengaged triads (Minuchin & Fishman, 2981; WPIC, 2005). These categories were part of the sensitizing research that was included in the deductive analysis approach. Negative case analysis was utilized for those situations where the data did not fit into one of the pre-existing categories. I kept the patterns or themes that did not fit the categories organized within the spreadsheet. The data were discussed and how they related to the study and/or future research.

The initial data analysis began with me audio recording each interview. Next, I labeled each completed interview for auditing purposes. These labels remained in place while data analysis was being completed. The computer software, Microsoft Excel, was utilized to keep all information organized.

As I began to find the themes and patterns within the data I stored and organized the data into Microsoft Excel. I pulled apart the information obtained from the interviews and placed them into the appropriate categories within Excel. Additionally, I dissected the information and examined the types of dyads and/or triads that were occurring in each child-caregiver relationship, again placed this information into the Excel spreadsheet. All of this aided me in backtracking, which involved me being able to state why the categories or codes were given to each set of data (Yin, 2009).

The pre-established coding names for the data included detouring triad, odd person out triad, a double bind triad, disengaged triad, or functional triad. These coding names were kept and organized within the existing Excel spreadsheet. A detouring triad was where the conflict between individuals is being detoured on to someone else (Minuchin & Fishman, 1981; WPIC, 2005). An odd person out (cut off) triad was where the dynamics between individuals cause another person to be excluded due to the conflict not being dealt with (Gilbert, 2014; Shazer, 1975; WPIC, 2005). A double bind triad involved both parents being overly involved with the child (Minuching, Reiter, & Borda, 2014; WPIC, 2005). A functional triad was where all relationships between the family members are close (WPIC, 2005). Finally, a disengaged (disconnect) triad involved the

child being symptom free, but the parents are in constant conflict with one another (Minuchin, Reiter, & Borda, 2014; WPIC, 2005).

The general analytic technique that was utilized for this study was cross case synthesis. This aided in laying the groundwork for data analysis. This strategy was the most ideal for multiple case study approach (Yin, 2009). This technique allowed me to look at the data through the SFT framework. The above stated dyads and triads were the word tables that were utilized due to them correlating with the framework used in this study.

Literal replication was also utilized in the data analysis portion of this study. This strategy had been chosen because it allowed the research to continue to be driven by the theoretical framework. Moreover, literal replication assisted me in seeing similar outcomes within each case (Yin, 2009).

Once all the data had been labeled, coded, and placed into the spreadsheet I then found the common themes and patterns that had emerged. Once all this was completed I created a visual product to show these common themes and patterns.

Issues of Trustworthiness

In order to establish trustworthiness of the study, I paid close attention to establishing credibility, transferability, dependability, and confirmability in this study.

Credibility

To ensure the credibility of the present study I conducted member checks. To do this I showed the participant the structural map that had been initially completed at the end of the interview. I explained the structural map to the participants to see if the

participants' view the relational dynamics between themselves and the child were similar to what I had learned them to be through the interview. The manner in which I explained the structural map was inviting and nonjudgmental. I explained that these dynamics were what I was observing and then asked the participant for his or her feedback. This information aided me in beginning to understand the child-caregiver dynamics.

Transferability

To ensure transferability I provided a detailed description of each interview. The detailed description was provided through the transcribed interviews. This description allowed readers to come to their own decisions about the information provided (Houghton, Casey, Shaw, & Murphy, 2013). It also allowed readers to see how it may adapt to other social settings (Houghton et al., 2013).

Dependability

I created a flow chart to outline the steps I took when conducting the study. This flow chart ensured the dependability of the study by acting as an audit trail (Houghton et al., 2013).

Confirmability

Like dependability, confirmability is about auditing the study (Houghton et al., 2013). The way I audited the study was by manually creating a spreadsheet that allowed me to store the data. The coded data were placed in this spreadsheet. Additionally, I was able to filter the common themes and patterns that had been found in the data. It was important to certify that groups of participants had correlating themes to confirm their

thoughts and feelings of how their child's trauma had impacted their relationship (Houghton et al., 2013).

Ethical Procedures

I had obtained verbal permission from the President of BNI to use clients from BNI. I had the President of BNI sign a letter of cooperation for this study. This letter of cooperation discussed my dual role within the BNI. This letter of cooperation confirmed that I would not have provided therapy or had prior direct contact with any of the participants, because of my dual role.

Each participant signed a consent form prior to engaging in the study. The consent form discussed the purpose of the study, the procedures of the study, the voluntary nature of the study, the risks and benefits of being in the study, payment, privacy, my contact information, and the statement of consent. The participants, once reading and having the consent form explained to them, printed, dated, and signed the consent form. Within the consent form I discussed keeping the participants' information confidential.

The information obtained throughout this study was kept confidential by removing the participant's identifying information on all documentation. All materials relating to the study were stored in a locked fireproof box in my home office for a minimum of seven years after the study concludes. After seven years, the documents will either be destroyed or kept to be utilized for future research or publication.

Because I asked caregivers to discuss their child's traumatic experience, the caregiver may have needed to speak to a professional in the counseling field. The

participants in this study were given information on agencies that were able to address the needs of these participants. See Appendix J for the debriefing guide. At any time participants were allowed to withdraw from the study for any reason.

After each interview I debriefed the participants on the nature of the study. The debriefing process included: me informing the participant of what the study found; discussed the nature of the study; informed the participant of what was done with the interviews and how they aided in forming the concept maps; and allowed the participant to ask any additional questions. This debriefing process is located in Appendix H. I allowed the participants to ask questions after the interview so that I could clarify any misconceptions. I also debriefed participants that opted to withdraw from the study.

Prior to engaging in this study I completed an application for the Institutional Review Board (IRB). Walden University's approval number for this study is 08-14-15-0279212 and it expires on August 13, 2016. The proposal of the study had to be approved by the IRB prior to me beginning the study.

Summary

This chapter focused on why a qualitative design was selected for the present study. The chapter discussed the procedures for this qualitative study and the overall design of the study. In addition, this chapter discussed how the participants were selected and how ethical procedures were utilized with all participants. Chapter 4 focused on the data that were obtained from the study. Within Chapter 4 the data was analyzed through the interviews and the concept maps.

Chapter 4: Data Analysis

Introduction

The purpose of the present study was to provide an analysis of a caregiver's perspective on the relational dynamics between the child and caregiver after a child's traumatic event. To accomplish this task, I interviewed nine different individuals to find out how a child's trauma relates to the dynamics between the child and caregiver after the traumatic event experienced by the child. A traumatic event is something that not only affects the individual that was traumatized; it is something that affects the caregivers who are close to the child, because they may feel guilt for not protecting their child (Banyard, et al., 2001; Hiebert-Murphy, 1998). This research showed the significance of looking at the child's trauma through a systemic lens, and demonstrated the purpose and phenomenon of the study, which was to understand the dynamics of the relationship between the child and caregiver after a child's traumatic event, from the caregiver's perspective.

I developed a research questions to begin to understand the purpose and phenomenon of the study. The following was the research question that had been utilized for this study.

RQ1: Based on Minuchin's theoretical framework what are the relational dynamics between the child and caregiver after the child's traumatic event?

This chapter provides a discussion of the study that was conducted, the data that were collected, along with the data analysis, and the results of the overarching study.

Setting

This qualitative study was conducted in the community setting, which allowed me to meet individually with each participant. The majority of the interviews that were conducted were held at the BNI in my confidential office. One interview was conducted in the community at a confidential location, which was a private room within a local library. The settings were both inviting and confidential. There was no known experience that would have influenced the interpretation of the study results.

Demographics

There were a number of different demographics that were collected during this study. Demographics included gender, age, ethnicity, number of children, marital status, caregiver's history of trauma, and caregiver's history of mental health. There were a total of nine participants for this study. The participants included eight female participants and one male. The ages of the participants ranged from 27 to 68 years making the average age of the participants 43.44 years old. All participants were Caucasian. The average number of children per participant was 3.0 children. There was a mix of married, widow, divorced, separated, and single relationship statuses. All nine participants had their own trauma history, but only 75% of the participants participated in their own mental health treatment. None of the participants were noted to be pregnant. All participants for this study were given pseudonyms to protect the identity of the participants.

Table 1

Participant Demographics

Name	Gender	Age	Ethnicity	Children	Martial Status	Abuse Hx
Drew	Male	38	White	5	Married	Physical abuse, father alcoholic
Stacey	Female	37	White	2 (One living, one deceased)	Married	Physical abuse, sexual abuse, death, loved one incarcerated
Jane	Female	49	White	1 bio, 1 step	Married	Sexual abuse, drugs
Sue	Female	68	White	1 deceased, 2 living, caregiver to 1 child	Widow	Death- no stress
Mary	Female	42	White	4 (1 deceased, 1 guardianship)	Divorced	Physical abuse, sexual abuse, emotional abuse
Beth	Female	38	White	3	Separated	Physical abuse, sexual abuse
Ellen	Female	49	White	4	Divorced	Emotional abuse
Allison	Female	27	White	2	Single	Emotional abuse
Julie	Female	43	White	1	Married	unknown

Data Collection

Over the course of this study, data were collected on how a child's traumatic event relates to the child-caregiver relationship. All participants had at least one child

who had encountered a traumatic event. Additionally all of the children, who experienced the trauma had been in a program at the BNI and were between the ages of 3-17 years.

I collected qualitative data through interviews with each participant. Each interview began with a review of the consent form. The interviews were audio recorded per approval by each participant. After review of the consent form and discussion of the audio recording I collected demographics from each participant. Next, I explained the interview process that was going to take place. From here I conducted the interview while utilizing the interview guide that was created by me. The interviews took no longer than 90 minutes. At the end of the interview I spoke with the participants about the relational dynamics, which were discussed during the interview. This information was used to draw the structural map with each participant at the end of the interview. I drew out the structural map and discussed it with each participant to ensure accuracy. Once the interview was completed and structural map was drawn, I completed the debriefing process with the participant. Each participant was debriefed and given an information sheet with names and phone numbers of local mental health agencies. To conclude I thanked the participants by giving them a 15 dollar gas card. I had the audio-recorded interviews transcribed by a transcriptionist.

I then began an analysis of each interview that was conducted. I began to uncover themes and patterns. To keep the data organized I created a spreadsheet. To analyze the data I placed the data into the spreadsheet.

There were two variations in the data that were collected. Originally, there was no plan to have a parent talk about sibling trauma and how the dyads and triads would look from one child to the next. Therefore, one variation was having one of the caregivers speak about all three of her children. This was due to the caregiver having three children who were subjected to a traumatic experience.

Data Analysis

Data analysis is important in qualitative research, as with any type of research. Qualitative research explores patterns, themes, and content analysis. For this study I looked at the patterns that emerged as the caregivers are discussed their relationship with their child after the trauma. This study looked to find a pattern among the dyads and triads between the child and caregiver. The patterns included detouring, disengaged, odd person out, functional or double bind triads. Themes included close-conflictual, enmeshed, close, distant, cut off, and conflictual dyads. The data analysis for this study is deductive in that the information is analyzed through an already existing framework (Patton, 2002).

The general analytic technique that was used for this study was cross case synthesis because the study used a multiple case study approach. Categories were developed to correlate with Minuchin's SFT framework, which was utilized for this study. Literal replication was used to aid in predicting outcomes. Replication allowed me to have the opportunity to conduct the same study, but with different participants to see if the results in each case are similar or different. Replication of the interviews allowed me to continue to be driven by the theoretical framework.

I explored the different patterns and themes for this study. I began the interview by allowing the participants to discuss their relationship with their child after the child's traumatic event. From this discussion, I was able to begin to uncover patterns and themes among the dyads and triads between the child and caregiver that would be the basis of the structural map. These patterns included a close-conflictual, enmeshed; close, conflictual, distant; and cut-off relationship among the child and caregiver. Once the interview was concluded, I, along with the participant, completed the structural map. The structural map was able to clearly show both the participant and myself what types of relational patterns were displayed since the child's traumatic event. From there, I moved into deductive analysis.

The data analysis for this study was deductive analysis, which allowed this study to be analyzed through an already existing framework. This form of analysis allowed me to form opinions that can be tested or modified. Sensitizing concepts are the pre-existing categories that the data were placed into. These themed categories included: detouring; odd man out; disengaged; functional; or double bind triads. I was able to use the pre-existing categories to code the data. I took the information from the completed structural map and placed the data into the pre-existing categories. All patterns and themes were able to be placed in a pre-existing category.

Table 2

Coding

Participant	Interview Excerpts	Coding

Stacey	"Unfortunately, we cannot see him. There is no physical visitation. It has been really really hard because he had such a close relationship with my husband. He definitely misses him and there are some weeks where he only gets to talk to him twice a week."	Odd man out
Jane	"It is close, I mean he has a close relationship with his father, and his father loves him. But, he is more detached than I am at this point. It's not a detachment it is more of, it is not of a nurturing …"	Detouring
Ellen	"It is not normal because we are more distant than I would like him to be."	Disengaged
Mary	"Maybe, it does, he just wants time alone. He does not want to be bothered… It just started so I'm not sure if he just doesn't want to be around me, you know what I mean? I'm not sure if I really am the cause of that."	Odd man out

Evidence of Trustworthiness

To ensure that the trustworthiness of the study was established, I paid close attention to establishing credibility, transferability, dependability, and confirmability in this study.

Credibility

To ensure the credibility of the present study, I conducted member checks. I reviewed the structural map that had been collaboratively developed at the end of the

interview. I explained the structural map to the participant to assure the participant's view of the relational dynamics between themselves and the child were aligned with my conclusion. I explained the dynamics that were observed and asked the participant for his or her feedback. This information furthered my understanding of the child-caregiver dynamics.

Transferability

In order to ensure transferability I had each interview transcribed. These transcriptions allowed me to review the interviews in their entirety. Additionally, the description allowed me to come to my own decisions about the information provided (Houghton, Casey, Shaw, & Murphy, 2013). Portions of the actual interviews are found within this chapter allowing readers to form their own opinions and beliefs about the data. Further, this allows readers to see how the study may adapt to other social settings.

Confirmability

Like dependability, confirmability is about auditing the study (Houghton et al., 2013). I audited the study by manually creating a spreadsheet that allowed me to store the data in different columns. This allowed me to go back through the data for rechecking purposes. I was able to filter through the data to find the common themes and patterns. This spreadsheet also allowed me to form opinions about the data.

Results

The following was the central research question for this study.

RQ1: Based on Minuchin's theoretical framework what are the relational dynamics between the child and caregiver after the child's traumatic event?

This central research question involved uncovering the patterns and themes between the child and caregiver after the child's traumatic event. The main relational pattern that was found was that all triads showed a strained relationship between at least one caregiver and the child. The strained relationship was shown in the structural map by patterns of conflictual, distant, and cut off dyads. This pattern helped identify the themes of a detouring, odd man out, double bind, functional, or disengaged triad.

Interviews

In this section I will discuss the information obtained through the interviews. Additionally, I will discuss the observed dyads and triads found during the interview.

Participant Profiles

Below are the participant profiles. Pseudonyms are used to protect the participants' confidentiality.

Drew. Drew was a married 38 year-old white male who has 5 children. Drew grew up with an alcoholic father and was a victim of physical abuse as a child. Drew did express a history of receiving mental health treatment. Drew spoke about one of his children who had experienced trauma. He stated that his son had witnessed many traumatic events including witnessing his mother being raped, witnessing his mother attempting to commit suicide, and witnessing his mother attempting to kill someone.

Drew stated that he has a close relationship with his children and that he treats all of his children the same. He reported that after the trauma his son relied on him more and that he and his son had a closer relationship after the trauma. Drew reported that the trauma occurred prior to Drew obtaining custody of his son.

Stacey. Stacey is a 37 year-old white married female. Stacey has two children, one living with her and one deceased. Stacey has a history of trauma including physical abuse, sexual abuse, loss of loved ones, and a loved one being incarcerated. Stacey is not currently pregnant and has received mental health treatment in the past.

Stacey spoke of her son who experienced multiple traumatic events. These traumas included being born 16 weeks early, having a twin brother that died when he was a month old, having a great uncle die very unexpectedly when he was 4-years-old, having multiple major surgeries due to physical and mental health problems from being born early, and Stacey's husband being incarcerated for murder. Since the traumatic events Stacey explained that she has "a lot more time to spend with her son". She also reported that her relationship with her son is a lot closer than prior to all the traumatic events. When asked if she felt she had an enmeshed relationship with her son she stated "it is closer". When asked how the relationship was after the trauma Stacey stated:

> Right after the event it was extremely hard because he didn't understand what happened and I didn't know how to explain it to him….I had to really change the way I interact with him and make really complex problems much simpler.

Before the trauma occurred Stacey stated, "I didn't know how to communicate with him" She also expressed that she felt there was distance prior to the trauma

Jane. Jane is a 49 year-old, married, white female with one biological child and one stepchild. She experienced sexual abuse as a child and has a history of receiving mental health treatment. Jane's biological child has a history of childhood trauma. The trauma is identified as going through medical treatments and being in the hospital for a

major surgery. When asked if the relationship between Jane and her son has changed since the traumatic experience her response was:

> I get very, now I have a sense of guilt. I feel guilty, how could I ever look at my son and think the things I thought. You know, I think that it's, I became over protective, I became more sensitive to his needs, and it has even changed the relationship with my husband and I, because before where we were just hanging on as a couple.

Sue. Sue is a 68-year-old white female who is a widow. Sue has 3 children, one of which is deceased. Sue is also the caregiver for her deceased daughter's son. Sue has experienced the loss of her mother and other loved ones. However, Sue stated none of the deaths were stressful. Sue does not have a history of mental health treatment.

The identified trauma for her grandson is the death of his mother. When asked if the relationship has changed since the traumatic event Sue stated: "I feel more motherly than grandmotherly.....In the respects that instead of being happy go lucky grandma, I am the authoritative parent". When asked about her relationship with her grandson and if they were close Sue stated, "very close"

Mary. Mary is a 41 year-old white female who is divorced. Mary has a total of 4 children. Of the four children Mary bore, one is deceased and only one child in her guardianship. Mary has a history of being physically, sexually, and emotionally abused as a child and has a history of receiving mental health treatment.

Mary's child has several identified traumas. These include when he was visiting his father he drank gasoline and they had to pump his stomach; he recently lost his

father;; he has fallen off his bike and cut his head; his brother put a rock in a sock and threw it at his head; and Mary's stepfather punched him. When asked if her relationship has changed since the traumatic event Mary answered, "he [the child] blamed me for his death, his father's death. He thought I killed him, but I didn't".

Beth. Beth is a 38 year-old white female who has 3 children. Beth is separated from her husband and has a trauma history of being physically and sexually abused as a child. Beth does not have a history of receiving mental health services. Additionally, all of Beth's children have a history of trauma. The first child that Beth speaks of is her oldest. His trauma was identified as his father being deployed for the army. When asked if her relationship has changed since the traumatic event, Beth answered:

> He is a little more distrustful, and he doesn't, um, he keeps things more inward whereas before he probably would have come to me for more, but because of the deployment and actually coincided deployment and dad kind of taking a step out of his life in more of a official capacity….he is much more guarded now and you have to really try to get information out..

The second child that Beth speaks of is her middle child. The trauma is identified as having a late diagnosis of Autism. When asked if her relationship has changed since the traumatic event Beth stated, "It is better. Even during it [diagnosis] I tried to keep some kind of connection with him…Very close [relationship]".

Beth's youngest child has an identified trauma of the parents becoming separated. When asked if her relationship has changed since the traumatic event Beth stated, "Very

close…Sometimes I feel like she is trying to cross boundaries because she is struggling to figure out what her relationship is".

Ellen. Ellen is a 49 year-old white female who has four children. Ellen is divorced and has a trauma history of being emotionally abused. She has a history of receiving mental health treatment. Ellen has a child who has experienced a traumatic event. The trauma is identified as being sexually molested by his older brother. When asked if her relationship has changed since the traumatic event Ellen stated:

> Yes, tremendously…..He actually was unable to talk about it for a long time, and then he was hospitalized up at Millcreek Community Hospital several times because of his violent outbursts and dangerous activities…..There was some distance [between the mom and child] because he was so violent and so volatile.

Allison. Allison is a 27 year-old white female with 2 children. Allison is single with a trauma history of emotional abuse. Allison did state that she has a history of receiving mental health treatment. Allison has a child that has experienced a traumatic event. The event was identified as the mother's uncle hitting Allison and hitting the identified child. When asked if her relationship with her son has changed since the traumatic event Allison stated, "I think we became closer, yeah. I got him out of the situation. I got us out of the situation and did what I had to do".

Themes

The themes in this study were derived from Minuchin's SFT theoretical model. These themed categories included detouring, odd man out, disengaged, functional or double bind triads. Table 3 shows the name of the individual, the triad that was found,

and the caregiver's abuse history. The results are in order of significance. The most commonly found triad is discussed first.

While conducting data analysis it was found that the caregiver's trauma history seemed to play a role in the type of triad that was formed. All but one caregiver who had an odd man out triad had a history of physical abuse. The physical abuse appears to correlate with an odd man out triad. This was something that emerged while conducting data analysis.

Triads

Odd person out (cut off). This triad is where the dynamics between individuals cause another person to be excluded due to the conflict not being dealt with (Gilbert, 2014; Shazer, 1975; WPIC, 2005). This was the most commonly found triad. A pattern that was found within this theme was the caregiver's history of physical abuse. All but one of the participants that had relationships that qualified for the odd person out triad had a history of physical abuse.

Allison has a history of emotional abuse. She has an odd person out triad within her relationship with her child and the father. The child and the mother have a close but conflictual relationship. The child and the father have a distant relationship. The mother and father have a cut off relationship. These dynamics form the odd man out triad.

"I let my son talk to him but I don't care to talk to him" (Allison).

Drew had an odd person out triad. Drew's relationship with his child after the traumatic event became enmeshed. The child's relationship with the mother is distant. The relationship between the mother and father is close. This could be seen as the child

disconnecting from the mother due to the distant relationship. Drew also has a history of physical abuse.

"No a lot, we don't talk about it, it happened a long time ago so I think he has pretty much moved on" (Drew).

Stacey has a history of physical abuse, sexual abuse, experiencing the death of a loved one, and her husband being incarcerated. Stacey also had an odd person out triad. The child and the mother have an enmeshed relationship while the child and the father have a conflictual cut off relationship. The mother and father are close yet distant. She stated:

> I mean we have a legal system in the middle that is preventing that like phone calls he might get at night at a time my husband is out of lock down. Last night the soonest my husband could call was 9:49 and Jason was already asleep for about an hour and on the weekend sometimes it is easier to talk with Jason and sometimes Jason will talk to him and sometimes he is just mad. He does not know. I think he is mad at his father, it's he won't talk to him… Yes, there is definitely a disconnect. We still talk but the problem is we have to be careful what we say because it could be misconstrued and I have asked him to call only once a day now for my own wellbeing as well as for his. So, it is a little strained.

Mary was the next participant that had an odd person out triad. Mary has a history of physical abuse, sexual abuse, and emotional abuse. There was only one caregiver in this triad due to the father's death; therefore, I looked at the relationship with the siblings as well. The child and the mother have a distant relationship. The child and the siblings

have a close but conflictual relationship. The mother and the siblings have a conflictual relationship. These dynamics formed an odd person out triad.

"He blames me for his father's death. We were separated and then we were divorced. His father talked badly about me and you know how it goes. I knew that made an influence on him maybe" (Mary).

Detouring triad. This is where the conflict between individuals is being detoured on to someone else (Minuchin & Fishman, 1981; WPIC, 2005). There was one detouring triad found in this study. This triad was found with Jane. The mother and the child have an enmeshed relationship; the mother and the father have an enmeshed relationship; and the child and the father have a distant but close relationship. Due to the mother being enmeshed with the child and the father, the triad shows that the child is at fault. This is due to the father's relationship with the child.

Double bind triad. This triad involves both parents being overly involved with the child (Minuchin et al., 2014; WPIC, 2005). This triad was seen with Beth's daughter. Beth stated that her daughter acts as the parentified child in the household. The child and the mother have an enmeshed relationship, while the child and the father have a close relationship. The mother and father continue to have a distant relationship. She stated:

> Sometime I feel like she is trying to cross boundaries just because I think she is struggling right now to figure out just what her relationship is now that we are a separate unit. It is like she tries to get a little bit too entangled.

Disengaged. This triad involves the child being symptom free, but the parents are in constant conflict with one another (Minuchin et al., 2014; WPIC, 2005). The

disengaged triad was found within Ellen's family, where the child had been molested by the older brother. Ellen's own history was one of emotional abuse. The relationship between the child and the mother is close but distant. The child and the father have a distant relationship. The mother and father have a distant relationship as well. All members of this triad are disengaged with each other. The child appears symptom free, yet the parents are not working together.

"It is not normal because we are more distant than I would like him to be" (Ellen).

Functional triad. This triad is where all the individuals involved in the triad have close relationships (WPIC, 2005). There was one triad that demonstrated a functional triad. This was seen with Sue. Sue did not have a history of significant abuse. She did experience the loss of loved ones; however, she stated that this did not cause any unusual stress. All the relational lines in the triad were close. The child and the caregiver had a very close relationship. The caregiver and her daughter, who is now deceased, also had a close relationship. The child had a close relationship with his mother prior to her death.

"I think we are still pretty close. I think we are keeping it so far on a pretty even Steven level" (Mary).

Additional findings. Beth participated in the study with all 3 of her children. The first born and second born children have an odd person out triad with the mother. Both of these children are boys. The mother has a double bind triad with the daughter. With the first boy the mother and the child have a very close relationship, whereas the child and the father have a conflictual and distant relationship. The mother and the father have a very conflictual relationship. These dynamics form the first odd person out triad. The

second boy had similar dynamics. The mother and the second boy's relationship is very close. The child's relationship with the father is distant. The mother does continue to have a distant relationship with the father. Beth stated:

"Well, he is very guarded. The relationship is as close as it can be with him being guarded. He is very protective because he has been hurt".

Table 3

Themes

Name	Triad	Caregiver Abuse Hx
Drew	Odd Man Out	Physical abuse, father alcoholic
Stacey	Odd Man Out	Physical abuse, sexual abuse, death, loved one incarcerated
Jane	Detouring	Sexual abuse, drugs
Sue	Functional	Death- no stress
Mary	Odd Man Out	Physical abuse, sexual abuse, emotional abuse

Beth	Odd Man Out (Child 1)	Physical abuse, sexual abuse
	Odd Man Out (Child 2)	
	Double bind (Child 3)	
Ellen	Disengaged	Emotional abuse
Allison	Odd Man Out	Emotional abuse
Julie	Odd Man Out	Did not disclose

Summary

There were four main themes uncovered within this study. The first theme that was found is the most significant in this study. This theme was an odd person out triad. What was seen in these triads was a distant or cut off relationship between the child and at least one caregiver. An example of this is seen in Beth's interview when she explained that her oldest child became distrustful after the traumatic event. Additionally, this shows that the child's trauma creates a distant or cut off relationship between one of the caregivers if not both. A pattern that was found within the odd person out triads was that all but one caregiver had a background of being physically abused. Different relational patterns were found with those caregivers that were not physically abused as a child. This change in pattern created a change in the type of triad that was formed.

Other themes that were found were a detouring triad, a disengaged triad, a functional triad, and a double bind triad. The significant pattern found in these was the caregivers' history of trauma. The trauma history of the caregivers' within the detouring triad involved sexual abuse and drug abuse. The functional triad had a caregiver trauma history of death within the family. The double bind triad had a caregiver trauma history of emotional abuse.

Two other patterns were found. First, it was found that all but two children had a strained relationship with at least one of their siblings. Second, all of the children in the odd person out triad were boys. Beth had two boys both of whom experienced an odd person out triad. However, when her daughter was discussed a double bind triad was found. This points the significance of the gender when working with traumatized children.

All of the data that were obtained through the participants were able to be placed into a pre-existing category. Therefore, there were no discrepant cases. Minuchin's theory seemed to contain all types of dynamics presented, even though there were only eight participants.

Additional Findings

Outside of Minuchin's SFT model there were additional findings. A mother's history of childhood sexual abuse has been seen to relate to how the mother parents the child. A study by Ruscio (2001) focused on parenting styles of mothers that were survivors of child sexual abuse. Ruscio (2001) found that mothers with a history of childhood sexual abuse without penetration were significantly more permissive and that

structure, discipline, and expectations were difficult parenting techniques for these mothers. Contrarily, mothers that had experienced childhood sexual abuse with penetration were found significantly more likely to parent more in an authoritarian style (Ruscio, 2001). This study showed the impact of childhood sexual abuse on parenting styles and approaches, in that childhood sexual abuse can be related to struggles for the caregiver with effective parenting. Within the present study the parent's history, usually the mother's, of sexual abuse seemed to create a close or enmeshed relationship with the child (Table 4). The close or enmeshed relationship between the mother and the child points to the permissive parenting style.

The studies have demonstrated a relationship between a history of childhood sexual abuse and parenting difficulties.

Table 4

Parenting Difficulties 1

	Child and Mom	Child and Dad	Mom and Dad	Example of Permissive Boundary
Stacey	Enmeshed	Conflictual and cut off	Close and distant	"We still talk but the problem is we have to be careful what we say because it could be misconstrued and I have asked him to call only once a day now for my own wellbeing as well as for his. So, it is a little strained".
Beth (child 1)	Close	Conflictual and Distant	Conflictual	"Well, he is very guarded. The relationship is as close as it can be with him being guarded. He is very protective because he has

been hurt".

Beth (child 2)	Close	Distant	Distant	"It is better. Even during it [diagnosis] I tried to keep some kind of connection with him…Very close [relationship]".
Beth (child 3)	Enmeshed	Close	Distant	"Sometime I feel like she is trying to cross boundaries just because I think she is struggling right now to figure out just what her relationship is now that we are a separate unit. It is like she tries to get a little bit too entangled".
Julie	Enmeshed	Distant	Close and distant	"He's very tight with me, but very angry…my voice is low, so he thinks I'm yelling at him all the time."

Looking more closely at parenting techniques and behaviors, Valentino et al. (2010) uncovered that parents with a child who reported greater PTSD scores had parented with more coercive and hostile parenting techniques. In a somewhat similar study Lyons-Ruth and Block (1996) discovered that hostile behaviors towards the infant were found in mothers who had been physically abused. These themes have been discovered in the present study (Tables 5 & 6). Parents, particularly mothers, that were physically abused as a child had distant relationships with their children. This was demonstrated through the distance in the relationship between the mother and the child. Distance can signify hostile parenting, a disconnection, or space due to conflict. It

appears that the mother's personal experiences from her past can influence her parenting behaviors.

Table 5

Parenting Difficulties 2

	Child and Mom	Child and Dad	Mom and Dad	Example of Distance in Parenting
Drew	Distant	Enmeshed	Close	I did not obtain the structural map. However, from the interview and the interactions I had with the father it appeared that the father was the primary caregiver and there was distance with the mother.

Table 6

Parenting Difficulties 3

	Child and Mom	Child and Sibling	Mom and Sibling	Example of Distance in Parenting
Mary	Distant	Close and conflictual	Conflictual	"he [the child] blamed me for his death, his father's death. He thought I killed him, but I didn't".

Summary

To summarize the present study provided an analysis of a caregiver's perspective on the relational dynamics between the child and the caregiver after the child's traumatic event. In this study it was found that the majority of caregivers have a distant/cut off relationship with their child. This study looked at trauma from a systemic standpoint rather than an individualistic viewpoint. The purpose and phenomenon of the

study was to understand the dynamics of the relationship between the child and caregiver after a child's traumatic event, from the caregiver's perspective.

In chapter 5 I interpreted the findings within the study and within the literature. This chapter also discussed the limitations of the study, any recommendations I have and concluding remarks.

Chapter 5: Summary, Conclusion, and Recommendations

Introduction

The number of children exposed to a traumatic event seems to be continuously growing. Costello et al. (2002) reported that 72% of children have experienced a stressor in their childhood, and more importantly 25% of these children had an extreme stressor in their childhood. Traumatic events or stressors can be anything in which the child feels that the child's life or another person's life is in danger. Stressors can include, but are not limited to being physically or sexually assaulted or abused, witnessing domestic violence, being in an accident, being kidnapped or held hostage, being a war civilian, and/or being part of a terrorist attack, as stated by the DSM-5 (APA, 2013). Children who have experienced a medical procedure or had a medical illness, witnessed traumatic events, or had indirect exposure (hearing of the traumatic event of someone) should also be considered as experiencing a stressor or a traumatic event (APA, 2013).

The purpose of the present study was to provide an analysis of a caregiver's perspective on the relational dynamics between the child and caregiver after a child's traumatic event. Thus, the study looked at how a child's trauma related to the dynamics between the child and caregiver after the traumatic event experienced by the child.

The nature of this study was qualitative and used a multiple case study approach. The benefits of a qualitative approach for this study were the subjective nature of the topic. The phenomenon I studied was how the caregiver perceives the relational dynamics between the child and the caregiver after the child's traumatic event. In addition, I looked at how the caregivers are responding to the child's traumatic event and

what the dyads or triads look like within the child-caregiver subsystem. This information was obtained through semistructured interviews with the caregivers of a child with a trauma history.

The key findings of this study include a child's traumatic event creating an odd man out triad between the child and at least one of the caregivers. Within this study caregivers with this type of dynamics between them and their child have been seen to have a trauma history of physical abuse.

In this chapter I will discuss the interpretation of the findings, the recommendations for future research, the limitations of the study, and social change.

Interpretation of the Findings

Much of the literature that was found on children with trauma histories discussed the important role the caregiver plays in the child's recovery. van Wesel et al. (2011) found that parents either needed assistance in how to parent and support the child who experienced the stressful event or were emotionally detached from the traumatized child. All but one triad explored for this study showed a stressful relationship between at least one of the parents with the child. There was only one triad that did not show this. This is believed to be due to the caregiver not having experienced a significantly stressful traumatic event.

A mother's history of childhood sexual abuse has been seen to relate to how the mother parents the child. A study by Ruscio (2001) focused on parenting styles of mothers that were survivors of child sexual abuse. Ruscio (2001) found that mothers with a history of childhood sexual abuse without penetration were significantly more

permissive and that structure, discipline, and expectations were difficult parenting techniques for these mothers. Contrarily, mothers that had experienced childhood sexual abuse with penetration were found significantly more likely to parent more in an authoritarian style (Ruscio, 2001). With each one of the triads, in this study, the mother had a strained relationship with another family member.

Parenting anxiety and intimacy issues with the child are also seen to correlate with caregivers who are survivors of childhood sexual abuse. In a study conducted by Douglas (2000), mothers who experienced contact childhood sexual abuse were found to be more anxious about the intimate factors of parenting, such as washing the baby while giving the baby a bath, and anxious about what is seen as normal parenting behaviors. In this study there was no discussing of not feeling close to the child due to the traumatic event. In most cases the participants expressed more of a connection with their child after the trauma.

Figley (1988) discussed the importance of looking at the family system and the relationships within the subsystems of the family. Figley (1988) also spoke to the importance of looking at the dyads and triads within the family. Families can either become enmeshed or disconnected after a traumatic event (Figley, 1988). It is also possible that some families can be resilient and continue to have a functional family. However, a family that becomes enmeshed is one that overly uses each other for comfort and assurance, whereas a family that is disconnected will pull away from each other, avoid or isolate (Figley, 1988; Gerwirtz et al., 2008). This is significant in that I found that the majority of the participants interviewed had an odd man out triad. This means

that one of the caregivers, if not both, is disconnected from the child. In this study the disconnection was found after the child experienced trauma.

I learned that caregivers with a trauma history of physical abuse had at least one cut off relationship between the child and one of the caregivers. The most common triad that was found was the odd man out triad. This triad involved the pattern of having at least one cut off relational dynamic. I also learned that trauma relates to the functioning of the family. For instance, those families with no caregiver history of trauma had a functional triad. The families with caregiver trauma had some type of strained relationship.

The theoretical framework for this study was Salvador Minuchin's SFT model. This model was developed in the 1960s, and one of the core components of this model is the functioning and dynamics within a relationship. "Structural family therapy is underpinned by a clearly articulated model of family functioning, and has been developed and used most consistently in services for children and families" (Vetere, 2001, p. 133). Minuchin's SFT model focuses on a system view of the family and problems associated with the family system. Vetere (2001) stated that overt and covert actions influence the choices and behaviors of the individuals within the family.

While this model is one often used to drive clinical treatment, it is also one that explores relationships in families and among family members. This model has specific ways of looking at how relationships affect the functioning of a dyad or triad. The model has the clinician, or in this case myself, draw specific structural maps that show how the relationships are functioning. Dynamics that can occur between the caregiver and child

can either be close, close but conflictual, enmeshed, disengaged, functional or conflictual (WPIC, 2005; Minuchin & Fishman, 1981). These relational dynamics will form the dyad or triad between the child and caregiver (Gilbert, 2004; Minuchin & Fishman, 1981).

This framework provided a way to look at how the parents were responding to their child and what the dyads or triads looked like after the traumatic event. Utilizing this framework allowed me to interpret the finding through a systemic lens. I was able to find common themes and patterns while utilizing this theoretical framework. The patterns included a close-conflictual, enmeshed, close, conflictual, distant, and cut off relationship among the child and caregiver. The themes included detouring, odd man out, disengaged, functional, or double bind triads.

Limitations of the Study

As with any study, there were some limitations with the present study. The study had two limitations. Frist, the participants were all recruited from the agency that employs me. Although the study was designed to eliminate prior knowledge of the children and caregivers the participants were all connected to the BNI. This connection raised a question about my influence over the participants. This was addressed in the letter to the participants. This letter stated that this is a research study and does not relate to any services provided by BNI.

A second limitation is the memory of the participants. Particularly when a child's trauma event happened years ago, the recollection of the event may not be completely

accurate. To address this I asked the participants when the traumatic event occurred. This question was asked during the first part of the interview.

A third limitation to the study was the number of participants. Originally, I had wanted a total of 12 participants. Unfortunately, I was only able to obtain 8 participants. I feel that more data could have been collected if more caregivers were willing to participate. Therefore saturation was not achieved with 8 participants. Common themes did begin to emerge; however, it would have been beneficial to see if the pattern continued with more participants.

You didn't reach saturation because some of your findings could not be corroborated with other cases. For example, you only had 1 participant who didn't have a trauma history (Sue); and it was this only participant who seemed to have a functional relationship. You should have kept looking for more participants to confirm/disconfirm this pattern.

Recommendations

The findings of this study suggest that caregivers with their own trauma history, along with having a child that has experienced trauma, have strained relational dynamics within the family system. Throughout the course of this study, a few recommendations for future research and practice were identified.

Recommendation 1: Research and Practice

Exploring the social supports of children who have experienced trauma should become part of standard clinical practice. This would include examining the social, family, natural, and professional supports of the child and/or family. The purpose of this

would be to look at patterns in the social and community relationships for a child that has experienced trauma. Implementing this into standard practice would allow for a more detailed understanding of what has and has not worked for the child and/or family regarding social and community supports. This recommendation would explore the positive or negative social supports and their relationship to the family system after a child's traumatic event. Thus, future research studies may consider looking outside the child-caregiver dynamics and examining how the social supports impact the relational dynamics within the family system.

Recommendation 2: Research

Parenting techniques would be another recommended area for future research. Looking at how the parents have disciplined the child prior to the trauma and then how they discipline after the trauma is essential in understanding how the relationship, dynamics, and structure has changed in the family system. The purpose of this would be to know if the parenting techniques have changed due to the child's traumatic event. Thus, future research studies may consider how parent discipline has changed since the child's traumatic experience. This will show how the child's trauma has influenced the discipline style of the caregiver.

Implications of Social Change

This study was designed to inform researchers and clinicians about how children and caregivers organize around a traumatic event and what types of dyads and triads emerge in the subsystem. Further, this study will help professionals understand how a child's traumatic event has changed the current dynamics of the child-caregiver

subsystem. Helping the family to understand these dynamics can potentially aid the child and caregivers in forming more functional dynamics, which may have been in place prior to the child's traumatic event.

Trauma impacts all members of the family, even if only one member is victim to the traumatic event. This is due to the disruptions that occur within the parenting subsystem and within the attachment between the child and parent (Miller, 1999). With young children, PTSD symptoms are often looked at through the relationship between the parent and child (Scheering & Zeanah, 2001). This is due to the significant role that the parent plays in the child's recovery from the traumatic event. It has been found that parents play a significant and special role in the child's recovery after a traumatic event (Cohen et al., 2000; van Wesel et al., 2011). Additionally, researchers have found the parent-child relationship is always a significant factor at any age, but is even more significant when the child has been exposed to a traumatic event at a young age (Scheering & Zeanah, 2001). All of this illustrates how the parent-child relational dynamics relate to the child's traumatic event, which was the purpose of this study.

The results of this study will have the potential of providing clinical knowledge on how to educate families on how a child's trauma organizes the child-caregiver subsystem. This study also gives insight to clinicians on how to focus more on the child-caregiver dynamics and treatment, in addition to the needs of the individual child. Figley (1988) discussed that families can either become enmeshed or disconnected after a traumatic event. Looking at these dyads and triads will provide a visual picture of how the relational dynamics have changed since the child's traumatic event. This is due to not

just the child being impacted by the child's traumatic event, but the entire family system. Figley (1988) states that families form various types of relationships after a traumatic event, which demonstrates the significance of exploring how the family structures themselves after the traumatic event. There is a lack of research on the parents' reaction to the child's traumatic event. The parents' reactions to the child's traumatic event is what forms different dyads and triads between the parent and child.

The social change focused on shedding light on how to not look at the child individualistically, and to look at the interactions of the child-caregiver subsystem. Children are much less likely to respond to individually driven treatment; therefore, making changes in the primary caregiving relationship can give the best chance for improvements in the child's overall symptoms (Scheering & Zeanah, 2001). Additionally, Scheering and Zeanah (2001) discussed that family change that is long lasting in the parental subsystem will better aid the child in recovery. Per Scheering and Zeanah (2001), attending to the caregiver's symptoms first is often important before beginning to address the child's symptoms and needs, due to the significance of the parent-child relationship. Caregivers who are more emotionally distressed may be less available to the child during a time of need. Therefore, it is important to look at the child-caregiver subsystem rather than the child's individual traumatic experience. This study provided an alternative perspective on how to look more systemically verses looking at the individual child.

Conclusion

The statistics describe the growing problem of children being exposed to traumatic events. It has been reported that 72% of children have experienced a stressor in their childhood, and more significantly 25% of these children had an extreme stressor in their childhood (Costello et al., 2002). Due to the number of children being exposed to trauma it is causing families to be affected and different relational dynamics to form between the child and caregiver.

The purpose of the present study was to provide an analysis of a caregiver's perspective on the relational dynamics between the child and caregiver after a child's traumatic event. Looking at trauma through the child, rather than the family system, leaves an individualistic impression on the child's traumatic event. A traumatic event is something that not only affects the individual that was traumatized; it is something that affects the caregivers who are close to the child, because they may feel guilt for not protecting their child (Banyard et al., 2001; Hiebert-Murphy, 1998). This points to the significance of looking at the child's trauma through a systemic lens. This also demonstrates the purpose and phenomenon of the study, which was to understand the dynamics of the relationship between the child and caregiver after a child's traumatic event, from the caregiver's perspective.

This study filled this gap by interviewing the caregivers of children who have a trauma history and discovering how the child's traumatic experience has related to their relational dynamics. Additionally, this study specifically looked at the child-caregiver relationship and the dynamics between the child and caregiver after the child's traumatic

event. Moreover, this present study extended knowledge in the discipline by looking at childhood trauma in a systemic manner rather than an individualistic manner.

From this study I learned that caregivers with a trauma history of physical abuse had at least one cut off relationship between the child and one of the caregivers. The most common triad that was found was the odd man out triad. This triad involved the pattern of having at least one cut off relational dynamic. I also learned that trauma impacts the functioning of the family. For example, families with no caregiver history of trauma had a functional triad and the families with caregiver trauma had some type of strained relationship. This is proven by the distant and cut off relationships that occur between the child and at least one of the caregivers. It is important to work with the entire family when working with a child who has encountered a traumatic event. Keeping an individualistic lens will only increase the risk of a distant or cut off relationship between the child and caregiver(s).

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Appendix A: Letter of Cooperation

Letter of Cooperation from a Research Partner Approving Opt-In Data Collection when Researcher has Dual Roles

Barber National Institute
100 Barber Place
Erie, PA 16507

November 10, 2014

Dear Rochelle Von Hof,

We are pleased to work with you in your capacity as the Lead Clinical Supervisor for Clinical Services who will be providing direct weekly supervision to the Program Managers within the various programs under Clinical Services as part of our organization's operations during Monday through Friday from 9:00am to 4:30pm. We agree to supervise and assume responsibility for these activities within the scope of our regular operations.

We understand that you will also be undertaking a Walden University student researcher role that is separate from your supervisory role. In your student researcher role, I authorize you to: send letters to clients who have completed either the Family Based Mental Health Program or Behavioral Health Rehabilitation Services to recruit participants; interview the voluntary participants; have the Family Based Program Director and Supervisor review the interview questions, the transcribed interviews, and completed concept maps; and to analyze the results. Individuals' participation will be voluntary and at their own discretion.

We understand that you will allow participants to volunteer and decline in order to minimize conflicts of interest and other potential ethical problems.

We understand that our organization's responsibilities include: Providing supervision to the researcher. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

John J. Barber
President of the Barber National Institute

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix B: Screening Tool

Name of Potential Participant: _____

Child-Caregiver Screening Checklist

Read <u>Only</u> Italics to Individual:

Thank you for contacting me and for your interest in my study. In order to ensure that all participants meet the criteria for the study I have a few questions to ask. I would like to take a few minutes to ask you a few questions to make sure you are an appropriate candidate for my study. I am going ask the question, and then you will need to respond with a YES or NO. If you need the question repeated, please ask. I will repeat the question.

Question	Yes	No
1. Do you have a child between the ages of 3 and 17?		
2. Has your child experienced a traumatic event?		
3. Has your child participated in a program through the Barber National Institute?		
4. Is English your primary language?		

Thank you.

Criteria for participation in study:

1. The participant must have a child between the ages of 3 and 17 years old.

2. The participant must have answered YES to having a child that experienced a traumatic event.

3. The participant must have answered YES to question 3.

4. The participant must have English as the primary language.

IF THE INDIVIDUAL MEETS CRITERIA TO PARTICIPATE: *Based on your responses to the questions, you may participate in my study. I would like to send you a consent form either through the US mail or through email. Which would be the best way for you to receive the consent form?*

Method of Consent form delivery:

Home or e-mail address:

Thank you. The consent form will be sent out to you. The interview for this study will be 90 minutes. The interviews will take place at a mutually agreed upon place. What would be the best place for us to meet and complete the interview together?

Designated place:

Address:

Before we end this call, do you have any questions regarding the study at this time? I will review the consent form with you during the beginning part of our meeting. Please bring the consent form I will be sending with you.

IF THE INDIVIDUAL DOES NOT MEET CRITERIA: *In order to be considered for my study the participant needs to meet specific criteria. Unfortunately, based on your answers the criteria have not been met. Thank you for taking the time to contact me and your willingness to participate.*

Appendix C: Demographics Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

Read only italics to participant:

I would like to take a moment to collect some basic demographic information from you.

Demographic	Answer
Gender	
Age	
Ethnicity	
Number of Children	
Martial Status	

I would now like to take a moment to collect further demographic information from you. Please answer only what you are comfortable answering.

Demographic	Answer
History of trauma and the type of trauma	
Currently pregnant	
History of mental health	

Appendix D: Interview Protocol

Research and Interview Questions

Read Only Italics

I would like to thank you for participating in my study on how a child's traumatic event relates to the dynamics between the child and caregiver. The purpose of this study is to obtain a caregiver's perspective on how the caregiver's child's traumatic experience has influenced the relationship between the child and caregiver. This study looks at the child's traumatic experience through the family system rather than just through the child. This interview will take up to a maximum of 90 minutes. Please feel free to ask questions if there is anything that may be confusing to you. If there are questions that are uncomfortable for you to answer you may ask to skip them. The skipped question(s) will not be held against you. You may also stop the interview at any time. I am only interested in understanding how a child's traumatic event relates to the family dynamics. Do you have any questions? Let's begin.

Interview Questions:

1. *a. Has your child encountered a traumatic experience?*

   b. What was your child's traumatic experience?

   c. How long ago did this event occur?

Central Question #1: What are the relational dynamics between the child and *caregiver after the child's traumatic event?*

2. *Tell me about your relationship with your child.*

3. *Tell me whether you observed changes in your relationship with your child after the traumatic event occurred.*
4. *Did your relationship with your child change after the traumatic event? How so?*
5. *How do you see you and your child interacting with each other after your child's traumatic event?*

   Researcher probes about either of the following:

   -Rely significantly on each other?

   -Close relationship?

   -Conflictual?

   -Distant?

   -Cut off?
6. *Do you feel that there is anything that is related to your child's trauma that has created difficulties between you and your child?*
7. *Tell me about what your relationship with your child was like before the traumatic event.*
8. *Tell me about what your relationship with your child is like now, after the traumatic event.*
9. *How do you see you and your child interacting with each other before your child's traumatic event?*

   Researcher probes about either of the following:

   -Rely significantly on each other?

-Close relationship?

-Conflictual?

-Distant?

-Cut off?

10. What has been the most difficult part of your relationship with your child after the traumatic event?

11. What was the most difficult part of your relationship with your child before the traumatic event?

Appendix E: Letter to Panel of Experts

Dear Ms. Punsky,

My name is Rochelle Von Hof, and I am a Ph.D. student at Walden University. I am currently in the process of completing my dissertation, which includes a study focusing on how a child's traumatic experience relates to the relational dynamics between the child and caregiver. I am writing to you in hopes you will serve on my panel of experts. I have chosen you to be one of the experts for my study due to your background in trauma and Structural Family Therapy (SFT).

The number of traumatic childhood events is ever-growing. Traumatic events can include physical abuse sexual abuse, emotional abuse, being bullied, witnessing a car accident, the loss of a loved one, and a medical procedure. It has been found that trauma not only affects the child who was directly impacted by the trauma, but also impacts the family members. This study is designed to look at how a child's traumatic event relates to the child-caregiver relationship.

The purpose of this study is to obtain a caregiver's perspective on how the caregiver's child's traumatic experience has influenced the relationship between the child and caregiver. This study looks at the child's traumatic experience through the family system rather than just through the child.

Being part of my panel of experts will involve reviewing and providing feedback on the interview questions for this study. I know that you will be taking time out of your day to review my work, so as a token of my appreciation I would like to give you a gift card to Romolos.

I will need to know if you are willing to be part of my panel of experts by July 25, 2015. If you are willing to be part of my panel of experts please contact me at (814) 874-5526.

I have attached my interview questions for you to begin reviewing. There are a total of 11 interview questions and some with sub-questions. The interviews are to be 90 minutes total.

As you review the interview questions I would appreciate your feedback on the following:

1. Appropriateness of the research and interview questions;

2. Overall tone of the questions;

3. Wording of the questions;

4. Alignment of questions with topic of the study.

There is an area in the attached table for your comments and suggestions on the interview questions.

Thank you for taking the time to consider being part of my panel of experts. I look forward to hearing from you on or before March 10th.

Sincerely,

Rochelle Von Hof
General Teaching Psychology PhD Student
Walden University
rochelle.vonhof@waldenu.edu

Panel Instructions:

Please review the research and interview questions and write your comments in the space provided. Please provide feedback on:

1. Appropriateness of the research and interview questions;
2. Overall tone of the questions;
3. Wording of the questions;
4. Alignment of questions with topic of the study.

Interview

I would like to thank you for participating in my study on how a child's traumatic event relates to the dynamics between the child and caregiver. The purpose of this study is to obtain a caregiver's perspective on how the caregiver's child's traumatic experience has influenced the relationship between the child and caregiver. This study looks at the child's traumatic experience through the family system rather than just through the child. This interview will take up to a maximum of 90 minutes. Please feel free to ask questions if there is anything that may be confusing to you. If there are questions that are uncomfortable for you to answer you may ask to skip them. The skipped question(s) will not be held against you. You may also stop the interview at any time. I am only interested in understanding how a child's traumatic event relates to the family dynamics. Do you have any questions? Let's begin.

	Questions	**Panel Feedback**
	Has your child encountered a traumatic experience?	
	What was your child's traumatic experience?	
	How long ago did this event occur?	
Central Question #1	What are the relational dynamics between the child and caregiver after the child's traumatic event?	

1	Tell me how the relationship with your child is.	
2	Tell me whether you observed changes in your relationship with your child after the traumatic event occurred.	
3	Did your relationship with your child change after the traumatic event? How so?	
4	How do you see you and your child interacting with each other after your child's traumatic event?	
	*Researcher will probe on:	
	-Rely significantly on each other?	
	-Close relationship?	
	-Conflictual?	
	-Distant?	
	-Cut off?	
5	Do you feel that there is anything that is related to your child's trauma that has created difficulties between you and your child?	
Sub-question #1	What do the dyads or triads look like between the caregiver(s) and child, per the guardian's perspective, before and	

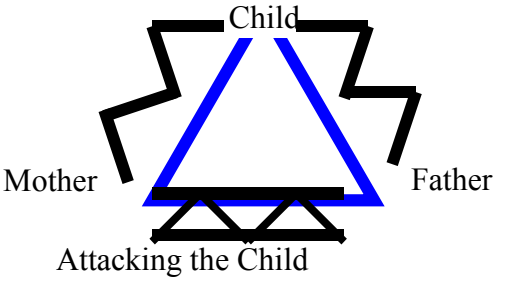
	after the child's traumatic event?	
6	Tell me about what your relationship with your child was like before the traumatic event.	
7	Tell me about what your relationship with your child is like now, after the traumatic event.	
8	How do you see you and your child interacting with each other before your child's traumatic event?	
	*Researcher will probe on:	
	-Rely significantly on each other?	
	-Close relationship?	
	-Conflictual?	
	-Distant?	
	-Cut off?	
9	What has been the most difficult part of your relationship with your child after the traumatic event?	
10	What was the most difficult part of your relationship with your child before the traumatic event?	

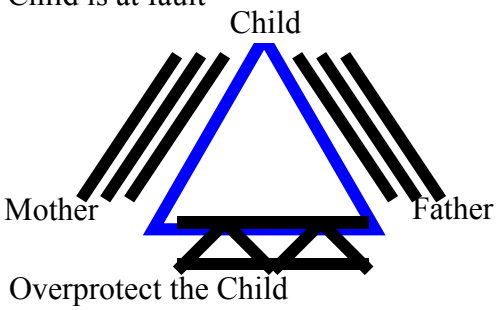
Appendix F: Triadic Relationship

TRIADIC RELATIONSHIPS

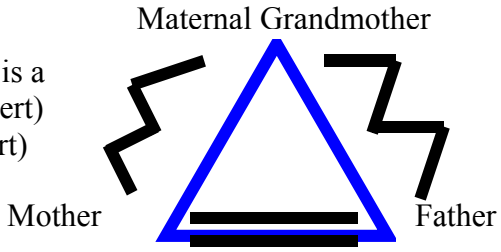
Triads are often the building blocks of family rules, prescribing who is with whom, who is against whom, how decisions are made, what secrets are kept and by whom, etc.

- **DETOURING OF CONFLICT**: Message is: "Child is at fault"

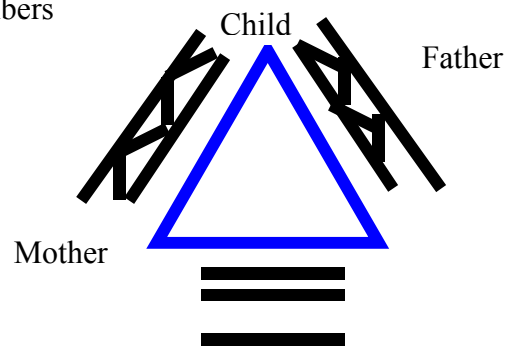




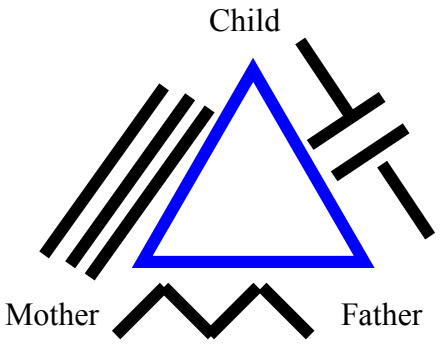
- A + B versus C is a **COALITION** (covert) **ALLIANCE** (overt)



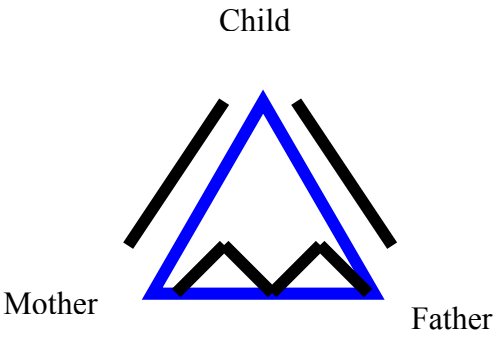
- **DOUBLE BIND**: Each parent demands child's loyalty. Both parents are overly involved. A family member, usually a child, exists in covert coalition with other family members who are in conflict with each other



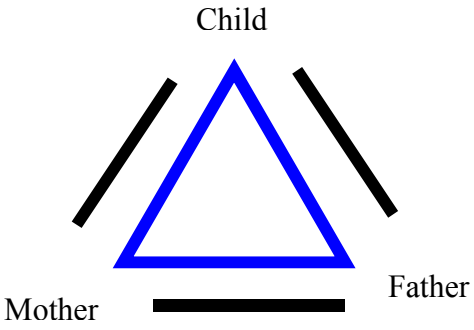
• **ODD PERSON OUT:** Conflict between the parents,
one parent over involved with the child, conflict not dealt with.
A parent and child ally against the other parent,
undermining marital, parental, and sibling sub-system boundaries.



• **DISENGAGED:** Conflict between parents.
Child is symptom free.



FUNCTIONAL: Parents are aligned; there are clear boundaries between generations



Triadic Relationships WPIC. (2005). Triadic relationships. [Training handout reproduced with permission from Patricia Johnston, WPIC]. Family based training, WPIC, Pittsburgh, PA.

Appendix G: Confidentiality Agreement

Name of Signer:

During the course of my activity in collecting data for this research: "A Multiple Case Study Qualitative Design of a Caregivers' Perspective on How Childhood Trauma Relates to the Child-Caregiver Relationship" I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access. I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement. I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

Appendix H: Debriefing Process

Read Only Italics to Individual:

Thank you for participating in this study about how a child's traumatic experience relates to the child-caregiver dynamics. The purpose of this study was to explore with each participant what the child's traumatic experience was, what the relationship was between the child and caregiver prior to the child's traumatic event, and what the relationship is between the child and caregiver after the child's traumatic event.

If at any time after this study you feel that you need professional help please contact one of the following mental health agencies:

Crisis Services:

2560 West 12th Street, Erie, Pa 16505

Phone: (814) 456-2014

Safe Harbor Behavioral Health:

1330 West 26th Street, Erie, Pa 16508

Phone: (814) 459-9300

Family Services of Northwestern PA:

5100 Peach Street, Erie, PA 16509

Phone: (814) 866-4500

Stairways Behavioral Health:

2910 State Street, Erie, PA 16508

Phone: (814) 454-5686

These agencies are the same that have been provided to you through your community. Please do not hesitate to call if you experience stress or upsetting feelings regarding what we have discussed.

Before we go on, do you have any questions regarding the study that you participated in?

Time will be taken at this point to answer the participant's questions.

Say only if necessary: *I would like your permission to ask you a few follow up questions regarding the interview.*

Time will be taken for the researcher to ask the questions and allow time for the participant to answer. Once both parties question have been completed:

I would like to provide you with my contact information. The phone number you can reach me at is (814) 874-5526. This is my work phone number, but please feel free to leave a message asking me to call you back if you receive my voicemail. Additionally, my email address is rochelle.vonhof@waldenu.edu.

Again thank you for taking the time to participate in this study.