

5-2015

The Effects of Parental Response on their Children's Trauma Experience

Carly S. Vaplon
St. Catherine University

Recommended Citation

Vaplon, Carly S., "The Effects of Parental Response on their Children's Trauma Experience" (2015). *Master of Social Work Clinical Research Papers*. Paper 530.
http://sophia.stkate.edu/msw_papers/530

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact ejasch@stkate.edu.

The Effects of Parental Response on their Children's Trauma Experience

by

Carly S. Vaplon, B.S.W.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Masters of Social Work

Committee Members
Karen Carlson, MSSW, LICSW, Ph D., (Chair)
Bonnie Kassen, MSW LICSW
Mark Olson, MSW LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The American Psychological Association defines trauma as the emotional response to a terrible event. An event becomes traumatic when its adverse effects produce feelings of helplessness and lack of control, and thoughts that one's survival may possibly be in danger. The purpose of this study was to collect data from licensed professionals who have experience working with children who have experienced trauma and their parents to determine the effects parental response to their child's trauma have on their child's trauma experience. Eight professionals were interviewed in this qualitative study to determine the effects of supportive and unsupportive parental responses. This study, like other studies on this topic, determined a correlation between a child's response to trauma mimicking that of the parent as well as supportive responses correlating to more efficient recovery for the children involved. Unsupportive responses were correlated with negative behaviors, self-image, emotional disturbance, depression, anxiety, and Post Traumatic Stress Disorder symptoms. The licensed professionals identified the Social Work Implication of needing preventative measures and education to parents about appropriate, healthy, and supportive responses to potentially traumatic events.

Keywords: trauma, parental response, effects, children, post-traumatic stress disorder

Acknowledgments

I first want to start off by extending a profound thank you to Dr. Karen Carlson for being a dedicated research chair and guiding this process so generously. Your kindness, gentleness, and patience was avidly appreciated.

I next want to thank my two amazing committee members Bonnie Kassen and Mark Olson. Bonnie edited my writing with a fine tooth comb and offered insight into aspects of this project that were very real to her. Mark offered a unique perspective to trauma experiences and his knowledge in a trauma background was impeccable. The input you both provided was invaluable.

Third I would like to thank my charitable participants who I am eternally grateful for. I literally could not have done this project without you. Your knowledge, professional opinions, and experiences are irreplaceable. Thank you for sharing so candidly.

Lastly I would like to thank my family and close friends who are always there to support me and encourage me to forge on. Nothing I have accomplished this far would be possible without you.

Table of Contents

Abstract.....	2
Acknowledgements.....	3
Table of Contents.....	4
Introduction.....	5
Literature Review.....	7
Conceptual Framework.....	24
Methods.....	25
Results.....	30
Discussion.....	52
References.....	63
Appendix A (Consent Form).....	67
Appendix B (Interview Schedule).....	70

In the human service fields, the idea and influences of trauma has become a key component that has increased national awareness, recognition, and attention by practitioners especially among clinical social workers. The American Psychological Association defines trauma as the “emotional response to a terrible event” that can vary from an accident impacting the individual to the degree of the impact of a natural disaster on a community and its inhabitants (n.p). The Council on Social Work Education details “an event becomes *traumatic* when its adverse effect produces feelings of helplessness and lack of control, and thoughts that one’s survival may possibly be in danger” (n.p.).

An unfortunate fact is that often times victims of trauma are members of the world’s most vulnerable populations, all too frequently including children, and the trauma leaves a profound and lasting impact that can carry into adulthood and later life. The National Child Traumatic Stress Network reported “in one year, 39% of children between the ages of 12 and 17 reported witnessing domestic violence, 17% reported being a victim of physical assault, and 8% reported being the victim of sexual assault” (n.p.). “Children from ethnic minority groups and those living in poverty are particularly effected by traumatic events as well as children in the birth to 5 age range being disproportionately exposed to traumatic events in relation to older children” (Lieberman, Chu, Van Horn, & Harris, 2011, p. 397). Events known to cause individuals to experience the effects of trauma are identified as “domestic violence, rape, violent crime, community violence, natural disasters, war, terrorism, and the death of a parent, sibling” or watching a loved one endure difficult and stressful circumstances (Cohen, Mannarino, Berliner, & Deblinger, 2000, p.1202). There is also an array of less obvious trauma experiences that include medical illness or procedures, fires, accidents, and other events that produce feelings of helplessness and lack of control.

Based on those facts, it can be said that if everything is defined as trauma, then nothing would be considered trauma and it is true that experiencing trauma is subjective and what is traumatic to one individual or group of people is not always traumatic to another individual or group experiencing the same or similar type of event due to different emotions being experienced by the same event (Gardner, Loya, & Hyman, 2014). It is also true that some victims of trauma “can demonstrate extraordinary resilience in the aftermath of these experiences, but others have significant distress or develop psychological difficulties that can be serious or long lasting (Cohen et al., 2000 p.1203). The differences between a single episode trauma and what is known as complex trauma or cumulative trauma is also vital information to explore as “repeated childhood victimization is associated with more severe symptoms and negative outcomes than one episode or no victimization” (Lieberman et al., 2011, p. 399).

More substantial research is available on how clinical practitioners should respond to trauma and what treatments should be completed or recommended but there is less extensive and adequate research on the importance of parental or caregiver response to trauma and how profoundly influential this can be on children in potentially traumatic situations. For example, a child may subconsciously decide whether an experience is traumatic for them based on how their parent or caregiver responds to the event because children often look to and rely on protective adults in their lives. It is already known that parental or caregiver support is a vital aspect of children's lives, and research on how a parent or caregiver responds to a potentially traumatic event is important in determining how this affects what trauma symptomology the child may then display. This is evidenced by studies showing “parental neglect was most strongly associated with children developing trauma symptoms” (Fusco & Cahalane, 2013, p. 50) when

compared to other risk factors or experiences with the outcome showing the importance of caregiver attention and support.

All in all, the purpose of this research project is to explore how parental response to their child's trauma affects their child's trauma experience.

Literature Review

As stated by Herman (1998) "trauma destroys the social systems of care, protection, and meaning that support human life. In order to recover from said trauma, these systems need to be reconstructed and the disempowerment and disconnection from others needs to be reversed" (p.145). For many children, trauma "interferes with the development of a secure attachment within the care giving system" (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.390). Therefore, caregiver response to trauma, both immediate and long term, plays a vital role in a child's trauma experience.

"Trauma can be contagious, when parents are emotionally overwhelmed by their child's trauma, they may experience a lesser degree of the same terror, rage, and despair" as their victimized child (Herman, 1998, p.145). De Vries, Kassam-Adams, Cnaan, Sherman-Slate, Gallagher, & Winston (1999) go as far as to say "Post Traumatic Stress Disorder (PTSD) is not limited to experiences of direct violence or injury, it may also follow an event that triggers fear, helplessness or horror and a parent/caregiver can develop PTSD after witnessing or learning of his or her child's injury" (p.1293). Survivors of childhood trauma and their caregivers "face the task of grieving not only for what was lost, but also for what was never theirs to lose" which adds another layer of complexity to the already difficult experience (Herman, 1998, p.148).

Complex Trauma

When a child experiences a layering effect of traumas, complex trauma can occur, and parental response can be one of the layers causing additional harm. “Complex Trauma is the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events and these exposures often occur within the child’s care giving system and include physical, emotional, and educational neglect and child maltreatment” (Van der Kolk, 2005, p.2).

“Caregivers with histories of complex trauma may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child’s emotional state” (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.395)

Complex trauma can have countless lasting and negative effects on a child. “Following the identification of an emotional state, a child must be able to express emotions safely and to modulate or regulate internal experience, but complex children show impairment in both of these skills” (Cook, et al., 2005, p.395). This means that these children who experience multiple or prolonged forms of trauma often times “cannot self regulate or self sooth and therefore present as emotionally labile with extreme rapidly escalating responses to minor stressors” (Cook, et al., 2005, p.395). Long term, children and adolescents who have been exposed to complex trauma “such as physical abuse, sexual abuse, or war may present with significant personality trait disturbances, borderline personality, dissociative phenomena such as depersonalization and derealization, self-injurious and suicidal behavior, depression, externalizing disorders, and substance abuse” (Shaw, 2000, p.231).

Parental Response

“Parents are the most important and often the only available support to their children following traumatic events,” which makes their role critical (Gewirtz, Forgatch, & Wieling, 2008, p.186). As discussed by Van der Kolk (2005) “the child’s response is likely to mimic that of the parent,” (p.4) which means there is an opportunity for a parent’s immediate reaction to determine within the child whether an event is more or less, or even at all traumatic. “Children learn to regulate their behavior by anticipating their caregiver’s response to them and the most important information is conveyed by the social rather than the physical environment” (Van der Kolk, 2005, p.4). Furthermore, Gewirtz et al. (2008) relays “young children use information provided by caregivers, such as caregiver’s reaction to an event, to interpret the safety of situations” (p.181). This directly contributes to the need for parent’s to respond to their child’s traumatic, or potentially traumatic event, in a more positive, supportive and helpful way. “Under most conditions parents are able to help their distressed child restore a sense of safety and control through the security of the attachment bond which mitigates against trauma-induced terror” (Van der Kolk, 2005, p.4).

Parental response to their child’s trauma is not cut and dried and can be influenced by a variety of circumstances. Gewirtz et al. (2008) described this as “several variables profoundly influencing the quality of parenting that caregivers provide their child following trauma. These variables include the type of trauma, the number and types of co-occurring adversities, the mental and physical health of the child and caregiver, resilience factors within the family, and the child’s developmental stage” (p.178). Out of the literature specifically on child sexual abuse, “the reactions of non-offending mothers depends on several contextual factors including the presence of domestic violence, financial dependence, substance abuse, age of the victimized

child, and the mother's history of her own sexual victimization which can all contribute to a potentially ambivalent reaction to the child's disclosure" (Knott & Fabre, 2014, p.1).

Positive/Supportive Response. There are several known parental responses to their child's trauma that have been shown to be increasingly beneficial to their child's well-being. Positive parental responses to trauma include providing "predictability and continuity which are critical in order for a child to develop a good sense of causality and for learning to categorize the experience" (Van der Kolk, 2005, p.6). The social environment parents create is suggested to contain "structure, security, emotional warmth, and an environment that addresses the traumatic event" (Gewirtz et al., 2008, p.186). As a helpful habit, it is "important for families to develop positive communication routines at home by setting aside time for important conversations" (Gardner, Loya, & Hyman, 2014, p.86). Parents can engage their child with "neutral, 'fun' tasks and physical games that can provide their child with knowledge of what it feels like to be relaxed and to feel a sense of physical mastery" (Van der Kolk, 2005, p.12).

In conjunction, "effective parenting practices provide a protective environment surrounding children" (Gewirtz et al., 2008, p.181), and the effective parenting practices carried out before the trauma are even more essential to continue after the trauma. "When parents are able to monitor, set limits, encourage skill development, problem solve, and be positively involved, their children are more likely to show resilience in the face of traumatic events ranging from war and natural disasters to community and interfamilial violence and abuse" (Gewirtz et al., 2008, p.181). Harris, Carlisle, Sargent, & Primm (2010) contribute "in addition to the monitoring of safety concerns, the encouragement of consistent feeding and sleeping schedules and the return to normal routines have been shown to improve clinical outcomes of trauma survivors" (p.877).

Often times in combination with their child's therapist and as a long term response, caregivers can help "build their child's and family's protective factors by teaching effective problem solving skills, stress management, ways to give and get support, positive self talk and help to mediate the disruptive effects of stressors" (Gewirtz et al., 2008, p.185). "One of the most important contributions caregivers can make to their child's recovery is to provide empathic support and containment within the child's home environment and provide soothing comfort each time traumatic feelings are triggered" (Coates & Gaensbauer 2009, p.620).

Coates & Gaensbauer (2009) also suggest parents start "explaining to the child why they were not able to prevent the trauma and sharing their own reactions which can often give the child perspective and help reduce the child's anger" (p.620). Overall, a positive and supportive response from non-offending caregivers of children who experience sexual abuse occurs "27%-87%" (Knott & Fabre, 2014, p.2) of the time, though a more specific number cannot be determined due to the complex nature of all the factors included in child trauma. Knowing how to increase the positive response from parents requires further research and knowledgeable awareness.

Negative/Unsupportive Response. On the reverse side of this issue, Van der Kolk (2005) discussed "when caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful, children are liable to become intolerably distressed and unlikely to develop a sense that the external environment is able to provide relief" (p.5). Gewirtz et al. (2008) identifies "parents who are overly critical and/or provide negative feedback may magnify children's avoidant and anxious behavior (p.186). Additional documentation among child sexual abuse survivors displays an "association between negative maternal response and a child's recantation of legitimate abuse as a result of lack of support from the non-offending caregiver"

(Knott & Fabre, 2014, p.7). “Inadequate maternal response to a child’s trauma has also been associated with Child Protective Services involvement and in some cases resulting in removal from the home” (Knott & Fabre, 2014, p.3) which can ultimately be just as traumatizing to the child as the original traumatic event, if not more so.

In regards specifically to child sexual abuse, “families can be a source of tremendous hurt following disclosure or discovery through actions such as disbelief, continuing a relationship with the perpetrator, communicating that the child was at fault, or asserting that the abuse should be hidden or forgotten” (Foster, 2014, p.332) Likewise, trauma is not always exposed immediately and “some children love their abusers and worry that a disclosure would lead to the loss of that relationship” (Foster, 2014, p.333). Parents can do a disservice to their children by not acknowledging that particular phenomenon. In conjunction, families are often very strained following the disclosure or discovery of child sexual abuse for reasons such as “loss of support from family or friends who sided with the perpetrator, reduction of income, involvement in the legal system, relocation, parental guilt, self-blame, anger, and sadness which can be a very frightening and confusing experience for children” (Foster, 2014, p.333) if they are not protected from these new consequences to the fullest extent available.

Parental response is not only a concern in the immediate sense; it is also a crucial factor in the remaining time afterwards. “When children are exposed to reminders or triggers of the trauma such as sensations, physiological states, images, sounds, situations, they tend to behave as if they were traumatized all over again. Unless caregivers understand the nature of such re-enactments they are liable to label the child as oppositional, rebellious, unmotivated and/or antisocial” (Van der Kolk, 2005, p.5). In relation to this, Gewirtz et al. (2008) recognizes further difficulties in “children’s psychopathological outcomes following trauma including but not

limited to distress, acting out, regressive behaviors, anxiety and aggression” (p.179) where children continue to need optimal responses from their caregivers in order to advance their recovery.

Moreover, further harm can be inflicted when other acute and enduring stressors are also introduced following the traumatic event such as “separation from loved ones, physical injuries, loss of home and shelter, resettlement, closing or changing of schools, loss of peer groups, forced inactivity, parental unemployment, fostering of dependency, and loss of community and social supports” (Shaw, 2000, p.234). Without realizing, parent functions meant to be protective can on occasion prove to be the cause of added stress and harm.

Effects on the Child

“A mother’s relationship with her child, including her ability to read her child’s cues and respond effectively to needs, moderates the degree to which the child will become symptomatic” (Coates, & Gaensbauer 2009, p.618). In other words, what happens with the caregiver, specifically with regard to the child’s trauma, has a profound and lasting effect on the traumatized child. De Vries, Kassam-Adams, Cnaan, Sherman-Slate, Gallagher, & Winston (1999) report the correlation between child and parent PTSD scores in their study and recognize its strength by showing child score was best explained by parent score” (p.1295). Shaw (2000) supports this by stating “symptom patterns of children often correlate and parallel those of their caretakers” (p.231).

Further explanation shows “maternal distress associated with their child’s sexual abuse disclosure has been found to exert a powerful influence on the psychiatric symptomology of the victimized child” (Knott & Fabre, 2014, p.4). A supplementary “correlation was found between

non-offending mother's level of depression and PTSD symptomology among sexually victimized children" (Knott & Fabre, 2014, p.5). This indicates that a mother's mental health and consequently her parenting practices influence the prevalence of her child's future development of trauma symptoms. "The child's psychological responsivity is also influenced by the effects of the traumatic stressor on the family, and parental figures may be so emotionally distressed and preoccupied with trauma specific losses that their caregiver activities have been compromised" (Shaw, 2000, p.230).

In relation, "interpersonal or relational trauma that occurs within significant care giving relationships have negative implications for the child including inability to regulate emotions, maintain stable self-concept, trust others, and attribute meaning to events in a coherent and adaptive manner" (Gardner, Loya, & Hyman 2014, p.82). This interpersonal trauma also interferes with a child's capacity for mentalizing, also known as the ability to think and feel with compassion about one's own and others' thoughts and feelings (Gardner, Loya, & Hyman 2014). Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., (2005) contribute "when the primary caregiver is too preoccupied, distant, unpredictable, punitive, or distressed to be reliably responsive, children become distressed easily and do not learn to collaborate with others when their own internal resources are inadequate" (p.392).

On the positive side, there is "additional evidence demonstrating a supportive response from the caregiver is associated with improved mental health and social functioning, better overall adjustment, sustained caregiver attachment, and fewer externalizing and delinquent behaviors" (Knott & Fabre, 2014, p.5). In relation "when non-offending mothers were perceived as supportive, victimized girls reported increased self-concept and diminished depressive symptomology" (Knott & Fabre, 2014, p.5). "Responsive, sensitive caretaking and positive

early life experiences allow children to develop a model of self as generally worthy and competent” (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.395).

Overall, “children are likely to show trauma symptoms when their caregivers are symptomatic because the relationship with their primary caregiver is so important and influential” (Fusco & Cahalane 2013, p.41).

Parental Best Practices

“Parents must not only respond to the child’s state of mind but also must work through their own guilt, anxiety, and remorse regarding the child’s exposure to the traumatic event” (Coates & Gaensbauer, 2009, p.621). Parents benefit from “realizing that what he or she may think is traumatic may not be the traumatic moment for the child” (Shaw, 2000, p.233) and therefore should not exert their fears or concerns on the child and instead let the child be the informative avenue. As a best practice for parents, they should take time to “process their emotions so that they can shift their focus from their own distress to their child’s needs” (Foster, 2014, p.334).

It is recommended that parents “first ensure the child that he or she is safe and provide some clarification as to what happened and what is going to happen” (Shaw, 2000, p.236). This clarification can ease a child’s fear of the unknowing and undeveloped future. Subsequently, parents can “assist the child in understanding their responses to the trauma are inherently normal and expectable, not bad, weird, or unlovable (Coates & Gaensbauer, 2009, p.621). This normalizing can continue to ease the child and aid in diminishing negative thoughts and feelings. “There is often a sense of lost innocence with feelings of grief and mourning and it is essential for parents to be sensitive to the shattering of cherished beliefs systems such as ‘I thought my

powerful parents would be able to protect me, that good triumphs over evil, and I am invulnerable to injury and death” (Shaw, 2000, p.236).

“As long as parents respond with mental calmness, composure, and evenness of temper, the child feels protected and secure (Shaw, 2000, p.231). If parents are unable to respond this way initially to their child’s trauma, there is some room for repair. There is a chance for parents to respond in a more supportive way than the initial response they gave their child and using tools such as “actively listening, responding with affirmation and empathy gives the opportunity for parents to be considerably different than the initial shock, sadness, or rage” (Foster, 2014, p.335) they may have displayed.

As time continues, parents can “help the child develop a more accurate and less overwhelming perspective on his or her experience (Coates & Gaensbauer, 2009, p.621). It is recommended that caregivers “reflect the child’s thoughts and feelings, acknowledge the abuse or event was not their fault, and reiterate that what the perpetrator did was wrong” (Foster, 2014, p.335). Without this acknowledgement, parents may be doing their child a grave disservice. “By minimizing the significance of their child’s concerns, a parent may have intended to console the child by placing the child’s perceived crisis in perspective; however it is likely that a young child would perceive this behavior as invalidating (Yehuda, Halligan, & Grossman, 2001, p.748). Instead it is recommended that parents and children “celebrate achievements” (Collins, Strieder, DePanfilis, Tabor, Freeman, Linde, et al., 2011, p.41) and “at the end of disclosure and/or treatment parents share how proud they are and affirm the child did the right thing” (Foster, 2014, p.335).

Child Risk Factors

There are several child factors that can influence parent and child response to trauma. For instance, despite parental response some children are more likely to be resilient and not develop the trauma symptoms that other children would. "Individual factors associated with resilience include an easy going disposition, positive temperament, and sociable demeanor; internal locus of control and external attributes for blame; effective coping strategies, degrees of mastery, and creativity and spirituality" (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.390).

Just as there are some children who possess attributes that foster resiliency, there are some children who are more at risk. Factors that increase a child's risk of being more effected by a traumatic event include "being female, temporal proximity to the zone of impact, experiencing personal injury, having a family member injured or killed, parental psychopathology, a depressed or irritable family environment and the degree of life threat (Shaw, 2000, p.228). Risk factors for the development of PTSD are an "early history of separation anxiety, neuroticism, family history of anxiety and pre-existing symptoms of anxiety and depression. The most powerful predictor of PTSD is exposure to physical violence and the most frequent stressor is the sudden and unexpected death of a loved one" (Shaw, 2000, p.228).

Age of the child at the time of trauma is also associated with trauma symptomology in both the child and parent. As said by Fusco & Cahalane (2013), "an important factor that contributes to trauma symptomology is age, the younger the child is at the time of the event, the more likely they are to exhibit symptoms" (p.39). De Vries et al., (1999) agree and expand on this by citing "child development of PTSD was associated with a younger child and with the

parent also having PTSD. The development of parental PTSD was associated with their child having PTSD, having a younger child, and with the parent witnessing or being involved in the event” (p.1298).

There are discrepancies in the literature regarding the impact of gender as an associated risk factor related to the child's trauma experience. One study shows that gender does play an influence by stating “extroverted boys with little education who have behavioral problems are at the greatest risk to be exposed to a traumatic stressor while girls, upon being exposed are twice as likely to develop PTSD” (Shaw, 2000, p.228). Fusco & Cahalane (2013) counter that it is “unclear whether females are biologically predisposed to traumatic stress symptoms or in fact are just more likely to be victimized” (pg.40). Another “study did not find gender of a child, race, previous trauma, hospital admission, mechanism of injury, or injury severity to be associated with PTSD in children or parents” (De Vries et al., 1999, p.1298).

Family Risk Factors

There are several identifiable risk factors associated with child trauma that also influence parental response to trauma. According to Van der Kolk (2005), in one way or another “most trauma begins at home with about eighty percent of those responsible for child maltreatment being at least one of the child's own parents” (p.2). “Since childhood should be a time of adult supervision and protection, prolonged abuse or neglect during this period may be indicative of a larger breakdown in the family, social, or cultural environment that fails to notice and prevent it from occurring” (Yehuda, Halligan, & Grossman, 2001, p.735). This layering of abuse makes the child more susceptible to other forms of trauma and puts the child at greater risk of harm.

Gewirtz et al. (2008) points out that “children living in highly adverse family contexts are at great risk for experiencing multiple forms of traumatic events” (p.180). Ineffective parenting practices, such as poor monitoring and absent care giving, contribute to an increased likelihood that children will encounter an event that could possibly be deemed traumatic. In addition, family factors associated with disorganization and chaos are strong correlates of ineffective parenting (Gewirtz et al., 2008).

Children who experience trauma are “more likely to come from families with significant problems such as parents being arrested, drugs or alcohol in family, and low levels of education” (Yehuda, Halligan, & Grossman, 2001, p.734). “Stressful life circumstances including poverty, health problems, family transitions,” (Gewirtz et al., 2008, p.182) and “lack of an adequate support system” (Foster, 2014, p.337) are known to increase the likelihood of being exposed to trauma and interfere with caregivers ability to provide an appropriate response. Countless “families experience a variety of stressful life events including severe and multigenerational chronic traumas such as family violence, unemployment, drug activity, incarceration, gang violence, failing schools, and personal victimization in the school and/or community” (Collins, Strieder, DePanfilis, Tabor, Freeman, Linde, et al., 2011, p.31). In relation, “economic hardship predicted economic pressure which was related to caregiver emotional distress which in turn is associated with disrupted parenting” (Gewirtz et al., 2008, p.182).

Many of these same risk factors contribute to the development of PTSD in the child. By way of illustration, “family risks such as parental substance use, criminality, parental conflict, and divorce or separation contributed to the later development of PTSD in children” (Gewirtz et al., 2008, p.180). In connection, “children were significantly more likely to show trauma symptoms if their mother experienced intimate partner violence (IPV) and previous research

shows that children who live in homes with IPV suffer symptoms of posttraumatic stress regardless of whether or not the events were directly witnessed” (Fusco & Cahalane 2013, p.50).

A critically important factor affecting parental response is the “battered woman who has failed to protect her child may feel she has committed a worse crime than the perpetrator” (Herman, 1998, p.148) and is also dealing with her own self-blame and victimization. This has a lasting effect on their children which is evidenced by “children exposed to alcoholic parents or domestic violence rarely have secure childhoods; their symptomology tends to be pervasive and multifaceted often including depression, various medical illnesses, as well as impulsive and self destructive behaviors” (Van der Kolk, 2005, p.2). On the equivalent avenue, “children with parents already diagnosed with PTSD reported more emotional abuse and emotional neglect than those without parental PTSD” (Yehuda, Halligan, & Grossman, 2001, p.735). As would be expected, parents who are still suffering the effects of their own personal trauma may actually respond to their child’s trauma through that lens. This reaction, influenced by the potentially hyper vigilant traumatized parent, may perhaps increase the risk of their own child experiencing trauma. The child experiencing the event as a trauma potentially would not otherwise have occurred had the parent not been themselves victimized previously.

“For many families, achieving a feeling of safety is a daily struggle as they strive to maintain physical, psychological, social, spiritual, and financial safety in an often violent environment” (Collins, Strieder, DePanfilis, Tabor, Freeman, Linde, et al., 2011, p.38). “The child who has an otherwise stable and secure environment can identify discrete traumatic events as being unusual” (Yehuda, Halligan, & Grossman, 2001, p.735) and therefore has an enhanced capacity for recovering from this incident. Therefore it is imperative to recognize risk factors associated with childhood trauma and cultivate and unearth ways to “increase families’

protective factors and decrease risk factors” (Collins, Strieder, DePanfilis, Tabor, Freeman, Linde, et al., 2011, p.34).

Culture. “Culture has been shown to influence and modify behavioral and emotional responses to trauma, the cognitive beliefs regarding the trauma itself and the impact of the societal roles of the family” (Harris et al., 2010, p.879). This means that trauma can be experienced, defined, and addressed differently depending on a child and caregiver’s culture and what they practice and believe in. Harris et al. (2010) found that “racial and ethnic minorities are less likely to follow up with traditional mental health providers while experiencing psychological distress and more likely to seek help through family, faith leaders, or through folk medicine” (p.876). Culture can be very positive considering “both perceived social support and strong ethnic identity have been found to foster resilience in children and youth from ethnic and racial minority groups” (Harris et al., 2010, p.879).

There are also other risk factors associated with specific cultures. For example refugees and those forced to assimilate to a new country, and therefore society, “lose their family or their homeland” which in itself can be traumatizing (Herman, 1998, p.147). Another example is that of Asian culture where it was proposed “that beliefs in physical punishment and the value of parental authority were risk factors for physical abuse in this population” (Harris et al., 2010, p.879). Regarding African Americans, Harris et al. (2010) reported “higher rates of maltreatment being associated with higher rates of poverty along with additional risk factors including increased residential instability, residing in violent neighborhoods, experiences with racism, fewer opportunities for mental health care, or inadequate mental health care” (p.872). “Revictimization is also greatest among this population in regards to experiences involving emotional withdrawal by a caretaker, physical neglect by a caretaker, a caretakers failure to

provide protection, sexual abuse by a non-caretaker, and any type of sexual abuse were found to be predictive of future victimization” (Harris et al., 2010, p.872).

Certain cultures are also known to enter the child welfare system at a higher rate than others, which has its own unique impact. “African-American and Latino children are more likely to be removed from their homes and spend more time in foster care which may contribute to more trauma symptoms” Fusco & Cahalane 2013, p.40). Similarly, “biracial children may be more likely to enter the child welfare system and may be more likely to have socioemotional problems with caregivers that have lower levels of social support” (p.50).

Recovery

Trauma affects every aspect of human functioning, and recovery requires treatment to be comprehensive; however treatment has an increased likelihood of being unsuccessful if the child's social dimensions are not addressed (Herman, 1998). Herman (1998) progresses further to state “recovery can take place only within the context of relationships” (p.145) which highlights the necessity of caregiver involvement in the trauma recovery process, specifically children, since caregiver's represent the children's core significant relationships. This can be difficult because certain trauma's damages a child's trust; consequently it is important for parents to be “prepared for the disruptions in relationships that follow upon traumatic experience so they will be far more able to take them in stride” (Herman, 1998, p.146).

Various trauma therapies include writing a trauma narrative, and “parents must develop a tolerance for some degree of uncertainty, even regarding the basic facts of the story” to provide continual support and belief in their child (Herman, 1998, p.147). Speaking to the importance of this, the trauma narrative not only includes the “survivor's emotional response to the event, but

also the responses of the important people in their life” (Herman, 1998, p.147). “Reactions can be changed and recovered, the parents presence in the child’s re-enactment play that mobilizes relieved traumatic feelings in the child allows them to provide comfort in ways that they were not able to do at the time of the original trauma” (Coates & Gaensbauer, 2009, p.622). It is vital that when parents are participating in their child’s treatment and therapeutic relationship that they “accept feedback, manage potentially distressing content, regulate their emotions, and integrate the meaning of experiences adaptively” (Gardner et al., 2014, p.81). One of the most therapeutic experiences for the child is to know that his or her parent not only holds the traumatic experience in mind but also attempts to hold the child’s experience of the trauma in mind (Coates & Gaensbauer, 2009, p.623)

Conclusion

“The significant levels of parent stress and the potential influence of parent responses on child adaptation after traumatic injury highlight the importance of attending to parental reactions” (De Vries et al., 1999, p.1298). Subsequently, “interventions focused on the child-parent relationship is beneficial both for a child’s recovery from traumatic stress and to the parent’s mental health” (Fusco & Cahalane 2013, p.52).

“There is still a lack of understanding of why some maltreated children develop trauma symptoms while others do not” Fusco & Cahalane, 2013, p.38) and this leads to my research question of ‘how does parental response to their child’s trauma affect their child’s trauma experience?’

Conceptual Framework

The conceptual framework for this research will focus on that of Attachment Theory. “According to Bowlby (1969/1982/1977), attachment is a biologically based bond with a caregiver. Because attachment behavior (assuring proximity with the caregiver) serves the survival function of protection, it is universal and is most apparent during periods of stress in early childhood” (Alexander, 1992, p.185). This directly translates to trauma survival in children and how parental response to this trauma can begin a positive or negative chain reaction of effects on the child, starting with attachment. For many children, trauma “interferes with the development or already developed secure attachment within the care giving system” (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.390).

The case is made “diversity of interpersonal, affective, and cognitive symptoms exhibited by abuse survivors is mediated by the attachment experiences of the survivors” (Alexander, 1992, p.188). “Early care-giving relationships provide the relational context in which children develop the earliest psychological representations of self, other, and self in relation to others. These working models form the foundation of a child’s developmental competencies, including distress, tolerance, curiosity, sense of agency, and communication” (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.392).

“For children, expert consensus highlights the importance of the attachment system to overall healthy development” (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.397). “A neglect of one's needs (as is inherently experienced by the abused child) or an active rejection by the parent will necessarily result in a sense of self as unworthy, undeserving, and even bad” (Alexander, 1992, p.191). However, “positive attachment is shown

to be linked to children's resilience in the face of stress" (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.396).

"When the child-caregiver relationship is the source of trauma or an added stratum, the attachment relationship is severely compromised. This is evidenced by 80% of maltreated children shown to develop insecure attachment patterns" (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.392). When attachment becomes disorganized, it is manifested as "the victimized child's need for and fear of closeness. This can trigger a caregiver's own memories of loss, rejection, or abuse, and diminish parenting abilities" (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.395).

Attachment Theory is a useful conceptual framework to expose how "parent-child attachment can account for some of the substantial diversity of effects observed" in trauma survivors (Alexander, 1992, p.192). This phenomenon also explains why "treatment protocols specifically target the caregiver-child dyad (Cook, Spinazzola, Ford, Lanktree, Blaustein, Cloitre, & Mallah, et al., 2005, p.397) due to its essential significance and influence.

Methods

Research Design

Exploratory Qualitative analysis was chosen for this research project because qualitative research asks questions about the essence or nature of specific happenings (Berg & Lune, 2012). Qualitative methods are able to explore a particular phenomenon and provide further reaching, detailed information that promotes vast understanding of the issue. This study employed qualitative methods as a way of understanding how parental response to their child's trauma affects the child's trauma experience.

Sample

The desired sample for this research project consisted of licensed clinicians in the human service field, including Clinical Social Workers (LCSW), Licensed Psychologists, Licensed Marriage and Family Therapists (LMFT), and Registered Nurses. Specifically these licensed clinicians are currently working with or have previous experience in working with children, parents, and families who have experienced trauma. This clinical experience provides a wider berth of knowledge in this particular focus. The stipulation of requiring such experience was predetermined to ensure qualification for being a participant in the study.

Protection of Human Subjects

Protection of human subjects was accomplished through maintaining informed consent, providing confidentiality, and being sure participants had full knowledge of all aspects of the research process throughout the recruitment course and interviewing procedures. Potential participants were provided a copy of the research questions prior to agreement of participation to reduce coercion. This protection of human subjects applies not only to the participant respondents themselves but also to any current or former clients they may have made reference to during the interview. All identifying information was removed to protect the subject's privacy and ensure ethical research. Code names were applied and deleted from final results.

Recruitment. Recruitment of participants targeted individual's whose practice consists of clients who have experienced trauma. Initial recruitment was based upon personal professional networks and took on a snowball effect following the initial respondent contact. Snowball sampling is a method in which personal networks are used to share information about the study and potential participants are encouraged to contact the researcher (Monette, Sullivan,

& DeJong, 2008). This method allowed the researcher to make certain the participants were specifically selected for their qualifications and then subsequently referring a new participant the previous subject thought was appropriate for the study. The sample size grew until eight participants were secured through email contact with the researcher.

Confidentiality. Participant's confidentiality was protected by guarding any identifying information, written or electronic, in locked and password-protected files. Assigned non-identifying sub-names were used to protect the respondent's identity. Digital recordings were transcribed by the researcher alone and immediately deleted off the recording device once transcribed. The researcher and research committee were the only individuals with access to the working documents.

Informed Consent. Participants who agreed to be interviewed signed a consent form (Appendix A) prior to participating in the interview. This consent form explains the risks and benefits of the study and requested permission to audio record the interview and use the respondent input provided.

Data Collection

Data were collected through semi-structured interviews, consisting of twenty-five predetermined questions (Appendix B). Clinical practitioners who agreed to be interviewed were allowed to choose an interview site that provided the comfort and safety each deemed necessary. Telephone or Email interviews were not accepted due to the limitations this may have placed on data; therefore the researcher accepted only face to face interviews. Interviews varied from approximately twenty to forty minutes. The formulation of interview questions gave respondents the opportunity to acknowledge and relay their experiences in working with children and

families who have experienced trauma and provide their personal insight into the effects of parental response on a child's trauma experience.

Instrument. The interview schedule was created personally by the researcher and designed to capture relevant data in relation to the study. It originally consisted of twenty-five questions but had the potential to be modified spontaneously during the semi-structured interview as the researcher felt necessary to clarify information or to provide the opportunity to gather new knowledge as information was shared. The questions were developed objectively and designed to be open-ended to maintain the integrity of the research and encourage honest feedback, unhindered by the researcher. Prior to conducting research, the interview schedule was reviewed by the research committee to increase validity.

Process. The interviews were audio recorded on the researcher's personal audio recording device. Once the data was saturated and transcribed into word documents, the audio recordings were deleted from the recording device to protect confidentiality.

Data Analysis Plan

Data analysis in qualitative research is about "identifying themes, patterns, and regularities and, in some cases, stating propositions, causal connections, and developing theories" (Monette, Sullivan, & DeJong, 2008, p. 432). Data collected in this study was analyzed through open coding, theme identification, and grounded theory. Once the data was transcribed by the researcher, open coding was used first to find the themes that accurately reflected participant experiences. The themes drawn from the coding process led the researcher to develop a theory about the effects of parental response on their child's trauma experiences. Grounded theory consists of the notion researchers may have a hypothesis about the findings, but

the ultimate goal is to create a new theory based on what the data shows to develop theories that are *grounded* in the data (Berg & Lune, 2012; Monette, Sullivan, & DeJong, 2008).

Researcher Bias

The study was also assessed for researcher bias. The current bias consists of the idea being true that parental response to a child's trauma can greatly influence the degree to which a child experiences an event as traumatic as well as factors involved in determining a child's trauma experience. Interview questions were examined by the research committee ahead of time to ensure there were no leading questions or questions that had a narrow focus aimed at answers the researcher hoped to acquire. This was also assessed by the research committee during the data analysis and presentation of accurate themes.

Strengths and Limitations

The strengths of this study are that it is an area of research that will offer important insights for the field of social work and for all practitioners working with children and families who have experienced trauma. It has the potential to be used as an educational, preventative measure to inform parents of the impact of their responses to potentially traumatic situations and how these responses can influence and affect their child. In this way, it has the ability to reduce the number of negative effects of trauma experiences in a vulnerable population of children.

The limitations of this study are its small sample size in conjunction with the gathering of indirect data. The data is indirect because it is the perspective of practitioners rather than clients. Professional perspective was chosen for this research study due to the vulnerability of traumatized children and families. This research was conducted during a restricted time frame which also potentially limited both respondent recruitment and data collection.

Results

Eight licensed professionals, all having had experience working with children and their parents either during a traumatic event or following a traumatic event, were interviewed for this research project. All participants were from a Midwestern metropolitan area. Each participant was asked approximately twenty questions during an individual, private interview (Appendix B). Questions were related to supportive parental responses, unsupportive responses, factors related to each response, and the resulting effects on the children who experienced the traumatic event. Results are disseminated below.

Participant Demographics

The participant group was made up of two Licensed Independent Clinical Social Workers (LICSW), two Licensed Marriage and Family Therapists (LMFT), two Licensed Psychologists, and two Registered Nurses. Of the nurses, one has work experience in an Emergency Room and the other is a Nurse Manager for a Pediatric Intensive Care Unit. When all were asked about length of time in their positions, responses ranged from 7 – 20 years. Of the eight participants interviewed, six were female and two were male.

Offending Verses Non-Offending Parents

In cases where children experience a traumatic event, this event may have occurred at the hands of their parental figure and at other times it is the result of an unforeseen circumstance out of parent's control. Each participant was asked if he or she noticed a difference in working with parents who were offenders of the trauma versus those who were not. Most all participants were in agreement that offending parents tend to be defensive or possibly deny what has happened

while the non-offending parents in the general sense tend to be more supportive and more validating of the child.

“With the non-offending, there seems to be a lot of guilt and a lot of shame around that. Most of the offending parents that I have worked with have a really big wall around them and it has been challenging to try and chip away at that wall. The goal is that they don't see you as blaming them but instead see you as trying to be supportive, helpful, and partnering with them on how can they change things or look at things in a different manner. I think both the offending and non-offending have a lot of guilt and shame about the behaviors for not protecting the child or not being more aware or having done something to harm the child.”

“When it is the offending parent, the trauma seems much harder to overcome for the child. When the parent isn't involved in the trauma or they are not a part of the situation, the parents tend to be more empathetic, more understanding, or even if they are not at first, through the Trauma Focused Cognitive Behavioral Therapy (TFCBT) process, you can teach or educate the parents about trauma enough that they can learn the skills they need to be able to communicate with their child better in regards to the trauma. The non-offending parents seem more open to learning.”

Importance of Parental Involvement

When asked about the importance of parental response in regards to a child's trauma experience, the respondents made it clear how vital this piece is. Children may keep trauma a secret or often times for younger children, the first person they may talk to about the trauma is their parents. How parents respond to that initial disclosure can set the course for what is going

to happen after that in terms of reporting, therapy, support or whether this child shares their trauma experience again.

“Parental response is absolutely, completely, one of the most important things. If a child who has experienced something traumatic has supports right away and they have early, immediate interventions, trauma does not turn into Post Traumatic Stress Disorder (PTSD). So having that family support, acknowledgement and recognition of what the child has gone through is really a tragedy and we will help you through it, and you will get through it. Positive thought about the future that is provided right away from some parents can completely change the course of the mental health and status as the child progresses.”

“It is important for the child to be validated and to be heard by people. So in the therapeutic professional relationship a lot of times children feel better after revealing their trauma or talking about it and then they learn the skills and what they can do about it. But they really need the support from their family because those are the people who they are going to return to or those are the people who are going to be around for birthdays and holidays, so they are the ones who have to have those responses that a child needs in order to feel safe and feel comforted and that the parent has their back and can protect them from future harm. So it's really important that they are involved.”

Impact on the Child

The participants were each asked how much impact they felt parental response has on a child who experiences trauma and the results were that it is insurmountable. Respondents discussed how if the family is really supportive, it is going to allow the child to overcome their

symptoms more readily. If the family or parent is less responsive, the child's symptoms could stay the same, they could worsen, or there is simply no recovery for that child.

“Parental response to the trauma has the biggest bulk of impact on the child because children look to parents and adults to figure out what their response should be. Take the example if a child falls off a bike and parents say ‘Oh I’m sorry you got hurt, how does your knee feel, kiss the knee, and get back on the bike.’ The child is like ‘ok I fell off the bike and mom took care of it and I’m riding bike again.’ If the parent is responds with ‘Oh my God you fell off your bike’ and they are really dramatic and they scoop the child up and bring them in the house, the child is not going to get back on that bike. So that response of ‘I’m here for you, I love you, and you can do it so get back out there’ is really important.”

“I feel that parental involvement is imperative for the child to know there is a sense of unconditional love and value that they have between them and their parents and what they have for their relationship. This shows that not only through the good times but also through the bad times, the worst of the worst, that parents are going to be there and children have that secure sense knowing that.”

Common Parental Responses

One research question explored the existence of a common parental response to their child's trauma and the majority of the respondents identified the dichotomies of being either supportive or unsupportive, though some respondents didn't believe there were any specific commonalities of trauma response in families.

“I don't think there is anything that is normal or common. It is all over the board. Some parents deny it, ‘that couldn't have happened to you,’ some parents blame their kid, ‘well if you

hadn't been drinking or wearing that shirt' or whatever it may be. Some parents are really strong advocates and take the reins to help their child and some just have lots of their own trauma responses come up. And so sometimes they become paralyzed and aren't really sure what to do. Some families have the history of shame, 'don't tell anybody about your problems or we haven't got problems' so instead of pursuing help, support, or therapy they take the angle, 'if you don't talk about it, it didn't exist and we will sweep it under the rug.' So it is all over the board, I haven't seen anything that is consistent in any of the families that I have worked with."

"Two of the main ways where parents tend to respond unsupportively is saying, 'why is this a problem? Let's just ignore this and move on' compared to those who think this is such a big problem and it should be bigger. Those parents usually have had a trauma history themselves so they are feeding into their child's trauma. So those are two common ways that can be harmful but then I would say there are also parents who are very understanding and very nurturing throughout that whole time. Meeting the child but also pushing the child forward as well. With the kids who have been traumatized through accidents, storms, or those type of circumstances I more commonly get that response I would say."

Supportive Parental Response

When asked about beneficial, helpful, and overall supportive responses from parents, many participants discussed validation, believing their child, being open to hearing about the trauma, encouraging and allowing their child to speak openly about the event, and being supportive of their child as they move through the recovery process.

"Being open to listening where the child is on the trauma and putting their own feelings aside. That is easier if the parent wasn't involved in the trauma. Even a parent who didn't

offend but still didn't intervene to prevent or stop the trauma because they didn't know anything was going on, often take a lot of blame or try and shield themselves from that blame. If they meet them where they are at and if the parent is often a willing participant in what is going on in therapy it is very helpful. They may be willing to get their child help but they might not always be very willing to be a part of that saying, 'I just bring my child here, you figure it out.' That is not always very helpful because then the child may not always feel that their parent is very safe to go to because of their trauma response or based on things like that. So if they are available, and they are flexible and they also can talk about their own response to the trauma, but not necessarily in front of the child, that can be very helpful too because they very likely too are dealing with that trauma or have some guilt or shame or feelings about what their child has gone through."

Case Example. *"I have a specific example of one time I feel it was an amazing story. A young lady I worked with several years ago, she was 16 or 17 at the time, and had been a straight A student, was captain of all her sport teams, and she was this stellar kid. And literally overnight she went from all of that to sleeping around, doing drugs, kicked out of all her sports, started failing classes and skipping school and parents did a really nice job of standing by her. Her grandparents stood by her because they were like something has got to be wrong. And Mom and Dad were going through a divorce at the time so they were like 'oh my gosh our divorce is ruining our child what do we do' so they actually sought therapy services first to figure out how to be better about divorcing. Her problems got to be so big that she was placed in residential care, which is where I met her. And she eventually revealed that she had been raped by her best friend's father. The parents like swooped in and were like "thank you so much for telling us. We are so proud of you for sharing this. What a horrible secret to carry." They were so*

amazing and she did three months of trauma therapy after that and went back to being the normal kid she used to be. It was amazing, like one of those holy smokes kind of stories.”

Effects of Supportive Response on the Child

Participants were asked how they felt supportive parental responses affected the child as well as specific details regarding those positive influences that had the power to change trauma outcomes and allow for recovery from said trauma.

“I think it allows the child to continue to move forward in getting the help and support they need. I think it allows them not to blame themselves and be able to mentalize outside influences. I think it also gives them permission to be more open in talking about it and sharing their experiences.”

“Usually the effect is that they get better quicker. They can go to their parent and talk about their trauma responses when they are having them. Their parent is more a part of their network compared to the parent who may not do that.”

“It offers relief for the child. If you can get that support from the parent and the child can feel heard, that is where recovery comes from. The child can go through the process therapeutically, but having validation from that parent and having told their story in their version, that is where the success comes from.”

Case Example Continued: *“She had the support she needed to go through the therapy. She was able to remember that even if my parents are getting a divorce, they are both here for me. I have got these supports. My grandparents jumped in. I did all these ‘horrible things’ and*

they didn't leave me. So I think it just gave her the strength she needed to move ahead and get back to that fun loving, care-free teenager that she used to be."

Factors for Supportive Response

Respondents were asked to discuss factors that increase the likelihood of parents being able to respond supportively to their child's trauma. Several participants identified this as parents being emotionally healthy themselves, having their own support systems, and whether or not they have their own trauma background.

"It will depend on whether or not the parents were involved in the trauma and it will depend on their own mental health, their own support systems, those are the big factors. Some parents are just not ready to hear the story or again have that denial or that defensive piece. They may be in a place in their own lives that doesn't allow them to be open to hearing somebody else's perception, especially that of their child, because perception is difficult for parents. To say I as the parent have this perception and I know what happened and parents want to say it happened this way and that it didn't happen this other way. They want to be able to put it on it being either one or the other. So if they do not have a good support system and they are not stable themselves, they can't be open to that middle ground of 'this is your child's perception. We are not here to say it was right or wrong, not here to say that it happened or didn't happen, we are just here to listen to their experience.' A parent has to be mentally stable to be able to hear that."

"A large part of what affects parental response is parents own stress level and if they can be available. Their ability to have access to social support as well as their ability to have access to things like medical care. I always think of parents' own background and experiences being so

crucial. Even such that if there has been anyone else in the family who has experienced trauma, it can really be an impact. Like older siblings having struggles and parents saying, 'I'm dealing with all with their things now so I don't have time to deal with this other child's trauma' or just their availability as a parent.'

"There are a lot of things that could help parents respond in a healthy way. I think a lot of it is how a parent themselves are raised. If they were raised to be expressive of emotions and encouraged to be confident, speak their mind, and ask questions then I think those parents tend to have a better emotional response and better coping mechanisms than parents that were raised in a traumatic or abusive environment or an environment where children were to be seen and not heard."

Case Example Continued: *"I think parents' own mental wellness is really important. This particular family had a lot of social resources. Each of the parents had their own parents who were actively part of their family and eventually treatment. They had huge support network in their friends so that definitely impacted their ability to do it. This family had a natural positive response meaning they didn't have a shame response to it. In no way, shape, or form did any of them feel like they were to blame or they had done anything wrong and they became really big advocates against rape and sexual abuse to speak up against it. That it is not okay and this man was also a friend of the family and they put their child as number one over 'what are our friends going to think, what will everyone else think?' They dismissed all of that and had support for their child."*

Unsupportive Parental Response

On the reverse side of supportive response, there are also parents who respond to their child in an unsupportive way. Respondents were asked what some of these unsupportive responses may be and most felt it revolved around not listening, not understanding, not believing, or not being attuned to their child and their child's experiences.

“Not believing them. Just flat out saying, ‘my child is lying, they are not telling the truth, or it didn't happen like that.’ Parents can be really defensive and closed off to the idea of an event being traumatizing to the child. I have had a few parents who have had the ‘so what? What is the big deal? That is what happens in our family, or not sure why my child is having such a problem with it.’”

“I have had a couple of situations where parents don't think the child has remembered it so they just don't talk about it. This happens still when clearly there are things going on that would clearly indicate that the child has some memory. I think the other thing is parents may be having their own trauma history so having a hard time talking about it or dealing with their own trauma impacts it. And then certainly in my experience with teenagers especially if you have a teen who is a little rebellious or acting out or parents don't feel like they have been following the rules and then something happens and parents will tend to get upset with them and maybe even blame them. They say ‘well maybe if you weren't in that situation or hadn't dressed like you were...’”

“Blaming the child I would say that is the number one most negative response. ‘You asked for it or you did this and that is what caused your trauma.’ Being neglectful, meaning a parent not putting safety measures in place which causes that child to become re-traumatized or

re-victimized or experiencing that trauma over and over again. Sometimes their own mental health concerns if they are really highly depressed or really reactive or have personality traits can make responses volatile or really challenging as well."

Case Example 2. *"One of the worst things that I experienced was one of the kids that I used to work with had reported that his step father had been abusing him sexually. Mom said 'you are liar, I don't believe you, how could you make up these horrible lies.' She dropped him off at residential treatment and never came back. The county got involved and she then would come to our quarterly meetings, or at least to the first one, and screamed at him about how he ruined her life and now the county was involved because he made up all these lies. It was just such a horrible thing. The treatment team actually told the county and her that she couldn't come back because that wasn't going to be beneficial for him to be blamed for this."*

Effects of Unsupportive Response on the Child

When parents respond in a non-supportive way to their child, this has a profound effect on the child. Respondents believed it often contributes to the child's negative self-image, struggles with relationships and emotions, and an overall inability to recover.

"They stay stuck. They stay where they are at because they are not being able to be heard. And that whole idea of not being able to be validated or understood by their family has a detrimental effect. Not being allowed to have their own perception is really difficult."

"For a lot of teenagers that I have worked with they begin distancing more from their parents. Sometimes it's been their unwillingness to talk about their trauma or to work through the trauma. Sometimes it has led to increased depression, increased anxiety, maybe some suicidal thoughts or ideation, self injurious behavior that goes with self blame or self loathing."

“A lot of times children get trapped in that whole ‘don’t feel’ sort of thing because it is too painful. It causes them to be placed in re-traumatizing, re-victimizing kind of place or patterns. Research suggests that children can often be re-victimized quite a bit and I think some of that is a parent not quite taking appropriate precautions. A lot of times the child gets the message to ‘stuff it,’ which can obviously have a big impact on their attachment to their parent or to friends or to future relationship partners throughout their life and experiences.”

Case Example 2 Continued: *“His siblings also blamed him. ‘You’re breaking up our family, you are ruining everything.’ His parents had different children from different partners so he had multiple siblings. The biological father from one set of the siblings said that his sons could no longer go to that home so his brothers were really mad at him because they couldn’t see their mom anymore. It was just this awful, horrible thing. And so for him there was months and months of him believing ‘I ruined everything. I should have just kept my mouth shut instead of asserting myself and standing up for me, I ruined everybody’s lives because look what I’ve done.’ So there was a lot of blame and he became pretty aggressive. It was very sad.”*

Factors Contributing to Unsupportive Response

Respondents were asked to discuss factors that contribute to parents responding in an unsupportive manner or factors that may hinder parents from responding in a more appropriate, supportive, and healthy way. The factors discussed included financial barriers such as being in poverty, being homeless, being close to the perpetrator, parents having their own mental health issues, or other barriers that parents struggle to overcome.

“Parents’ mental health and the situation they are currently in. I have worked with families who have the mother currently in an abusive situation and the child is trying to process

through an abusive situation, that parent can't be available to the child because that parent is still going through a similar or same situation. So parents experiencing their own trauma symptoms being triggered from their child's trauma."

"If parents are having a lot of stress due to circumstances, financially struggling, or lacking that social support definitely contributes to an unsupportive response. If they do not have a lot of support they may be really just in survival mode and can't always respond."

"I have worked with some families who have really high profile jobs and the idea of something becoming available to the media or having to go through court or having to take time off from work to deal with this problem is an issue. Instead they say 'We will just figure it out on our own, we don't need to go through all of this'. I think for a lot of parents it is just the idea of, 'where did I screw up, what did I do that I couldn't protect my kid. And so there is the denial, 'that couldn't happen because if it really happened that means that I am a horrible person or parent."

"If parents have their own trauma or most certainly if they have their own mental illness that they are dealing with. If there is alcoholism or substance abuse this can affect response greatly. Sometimes if parents in general don't have their own support or a single parent who is overwhelmed or stressed already and try to have this added on to the things they are already trying to deal with and don't have that support for themselves in their lives. I think the other thing is that sometimes if the perpetrator is somebody that is in their household and somebody that they love and respect it might be hard for them to respond in a way that is healthy for the child."

Case Example 2 Continued: *“In this particular case, mom had six or seven children and this man that she was with, the man who was the perpetrator, was financially supporting the whole family. And so for mom to take a stand and support her child, she and all her children would have become homeless. And so for her, I mean in order to survive and have a roof over her head, that was the decision she thought she had to make. So I think financially there is some of that.”*

Trauma Symptoms Directly Related to Parental Response

The researcher asked respondents if they were aware of any particular trauma symptoms that related directly to the response the children received from their parents. In reply, these consisted of symptoms persisting, self-injurious behavior, developing new behavior that was previously uncharacteristic, and an array of PTSD symptoms.

“Symptoms that directly relates to parental response, I think what I see most often is that children get stuck and they get to a point where they just stay in the mode they are in with their symptoms without moving forward. No one believes them so they have that guilt and that shame and that questioning of ‘what is wrong with me, why am I like this? My parent is saying it didn’t happen’ so it just continues to stir the symptoms. I could also potentially see self harm also but mostly it’s that whole experience of the symptoms just being allowed to continue without progressing through them.”

“You know I think some of the self-injury certainly would be. I mean I don’t know if there is anything where you can say ‘yes this is because of parents response’ but I think the combination of the trauma and the parents response, you can end up with children who engage in self-injury, particularly if its sexual trauma, more in areas that they would perceive being

sexual whether that be on their upper thighs or stomach or that sort of thing. And sometimes some other self-destructive behaviors like drinking, maybe even the tendency to put themselves in more dangerous situations. I do think sometimes teens respond if parents aren't supportive and tend to distance themselves more from parents. This was referring to parents not being supportive but not the parents who think the child doesn't remember so they don't talk about it. I think in that case the relationship seems like it's okay but there is still this underlying sense of there being a secret in the family."

"Some of those symptoms such as trying not to think about it, trying to stay away. If a child had a negative thing happen, the parent may try and tell them to stay away or require them to stay away from things that might remind them of it. Sometimes, a harmful response to some scenarios is when children are having trouble remembering the trauma but the parents fill in the details. This may lead to children having less interest in what they used to and the parents' response is 'why aren't you doing this anymore' and not understanding the trauma is affecting their interest. In relation, feeling cut off from people, their parental response can definitely contribute to feeling cut off from people. I don't know if it has impact on feeling less, it may have kind of a numbing impact from their parents response but I think it is more likely indirect to the parents response. Life is shorter or will be shorter, emotional issues, I think all those kind of indirectly can be impacted. Sleep, moodiness or anger, attention, hypervigilance. Sometimes parents can definitely contribute to that directly. Being jumpy maybe a bit too. So yeah I think it can affect most all of those symptoms."

Case Example 3. *"There is a young lady who was neglected by her mother because when she was born, her mother basically abandoned her to her father. Her father was a fairly decent parental figure and a few years ago he began drinking and using drugs so he became*

violent and he physically assaulted the child. So the courts found mom and brought her back in and the girl started acting out in school and started beating people up. She was doing things that were completely uncharacteristic of her. While in treatment, other residents would say things to her or make comments about the scars she has from her physical abuse and then she would just attack. She now lives with mom or visits her on weekends, but Mom's response to everything is "suck it up, pull yourself up by your bootstraps, big whoop, I used to get whooped by my Dad, I don't understand why this is a problem to you, if kids say anything mean to you just whoop their assess." So she would come back from her home passes and literally walk in the door swinging. Anybody looked at her funny, she would swing. So we made a decision with the team here and with her county to say she can't go on any more passes because Mom's response to her trauma is to say "every kid gets whooped, big deal, and you are only going to get through life by fighting." And she became a fighter and we were like 'whoa this is not in her character.'"

Over-Reaction or Extreme Parental Response

In some cases, parents may have a response to their child's trauma that is perceived as an over-reaction or extreme reaction to the situation. At times, this parental perception is not consistent with the child's perception of the event. This type of parental response can cause several new and developing issues for the child in addition to the traumatic, or in some cases, potentially traumatic event.

"Some of those things would be trying to protect their child to the point that they can't go to any sort of normal activities again afterwards. Telling their child they can't do certain things. Assuming that is going to be too hard for the child and communicating that. 'You are going to have a trauma response.' They don't say it quite like that but basically saying something is

going to be too hard for them. Continually focused on some of the trauma symptoms. Saying they aren't sleeping, they aren't sleeping, and being frantic but then you talk to the child and the child says 'no I didn't have any nightmares, yes I slept.' So it's almost like focusing on that. Sometimes you get this sense of the parent being so frantic and the kid being so indifferent to the experience. I can't say that's always having a negative impact but then eventually over time they tend to start believing like their parent does. So thinking 'maybe there is something really bad about this.' I think sometimes children feed off that response as in they were fine one minute but then the parent comes in and then they may be that much more elevated emotionally."

Case Example 4. *"Back when I was in day treatment I met a kid who was going along in life and his grandfather ended up punching him and getting physical. The boy was kind of dealing with it on his own however it was that he was dealing with it but parents found out about it and sounded the alarms. They put this kid in outpatient services and threw him in our day treatment program and put everything over the top. I remember the kid, who was eleven, sitting with me in therapy and saying 'what the heck is going on? Am I supposed to be scared, am I supposed to be upset? I don't get this because I didn't like it.'" I remember this conflicted and tormented look on his face as he pondered that he must be a bad kid because he didn't have a bad response to what happened. So then we had to start talking about how he wasn't a bad kid and he didn't need to think that. What became more traumatic for the kid was that he 'didn't have feelings. I must not be a feeling person if I don't think that this is a big deal' and so we had to spend all this time in therapy not on the issue but what the parents made the issue was 'how do you not tell us about this, it was a big deal' so that became a problem for him."*

Type of Trauma Verses Particular Parental Response

Respondents were asked if they perceived an association between the type of trauma and a particular parental response. Several denied a correlation and sited system issues, others sited age or behavior of the child before the traumatic event, and others identified a correlation between sexual abuse and issues of parental response.

“I don't think there is a direct correlation between one trauma and a parent's response but it's going to be the entire system. What is happening in the system, what are the beliefs of the system, what is the functioning of that system, it is all going to impact on both sides of recovery and response.”

“I think it depends on the age of the child. When I have worked with older teenage girls particularly, if there has already been some behavioral problems in the family, I think parents may initially tend to respond a little bit more blaming and more wanting to correct the child in what they are doing. This gives the child a sense of blaming versus if a child has more of a physical sort of trauma, their response may be a little different or if it is an accident they may respond in a more understanding way. This depends a lot on circumstances; I am just thinking some of my own experiences how I have seen parents respond in different situations.”

“The one thing I have noticed is that it appears that there is a difference in a child who is molested by a family member verses a child who is raped by a stranger. It is not like one hundred percent response one way or another but it's like there tends to be more of a support around a stranger rape or a date rape or something like that. Whereas, when it is something that is inside the family, the response is very defensive or what the family does is so unpredictable. It brings on all of these components like 'who am I, what is going on' from the

child. I have, well she is now an adult, but a woman that I worked with many years ago. She was molested by all three of her brothers as a child and she told her parents repeatedly that she was being molested, that she didn't feel safe, that she wanted a lock on her door and they dismissed it and didn't do anything about it. She was raped after prom in high school and her parents swooped in to save the day and she was like 'I am not interested in your help, I got this.' Because their response to inside the house and how they dismissed it, 'oh I think you might be over-exaggerating, you know your brothers are touchy-feely,' they down played everything. So her adult memories of that are 'I wasn't important, I am not valuable, they cared more about my brothers.' They never denied it was happening, they never said you are lying, but they just didn't do anything about it. And then as an adult she found out her father was molested by her uncle and her mother was molested by her grandfather, so it went back in both sides of the family. So to mom and dad, this was kind of normal to them. She said 'well it would have been nice if somebody would have told me what the norm was because then I would have figured out how to move out.'"

Changing Parental Response

The question of whether or not parents were able to change the trauma response they initially gave to their child was asked of respondents and all believed it can be done and should be done if the response was unsupportive. It can be very reparative to tell your child "I'm sorry I didn't believe you when you said this was happening and I really feel bad about that." Others also acknowledged that as time passes, the way parents interact with their child about the trauma can also change.

“I think it is important for us to remember that if a parent gives an initial unsupportive response, that does not dictate that everything is going to turn into PTSD or be horrible. Parents have multiple chances and opportunities to change the messages sent to their child. Even if the trauma happened a year and half ago and now they are in therapy and the parent is upset like ‘this is what I said!’ I think as a therapist it is always our role to say ‘yep and you can’t change what you said but you can change your response now. You can say I am really sorry that when you first told me, this is how I responded. What I wish I would have said was this...’ It is really powerful for a child to know that their parents can admit they made a mistake and that if they could do it again that they would have a different response. Our role as therapists in that is to help people be okay with making apologies and trying to do things over. And to realize, ‘yep you’re right I said that.’ Your child will never forget that you said that. But they can forgive you.”

“Going back to normal life is also just as important. Parents don’t have to be over-focused on the trauma. ‘Well how are you today about it?’ What they may be doing is checking in with their child a lot more about those things initially after the trauma but as time passes there is less of that that needs to be done. Especially as trauma symptoms and intensity is going down.”

Parental Best Practices

The respondents were asked about advice given to parents in the interest of best practices during their child’s trauma experiences. Before a responding to the trauma they are encouraged to take a deep breath to center themselves and emotions, then once the child shares they are encouraged to thank the child for sharing and offering apologies for what happened to them.

Parents can also have their own PTSD from their child's event in addition to what their child is going through so it is important for parent's to process this independently from their child as to not interfere or worsen outcomes for the child.

"I think it's really important for parents to just listen to their children and know that their child could see a situation as traumatic even though they didn't. Because the shame and the guilt and those negative feelings that surround a trauma a lot of times are really intense for a child and that child has so many conflicted ideas and feelings about 'did I do this, did I deserve this? What happened, did I do something wrong?' And I think any positive response and validation from a parent is going to help that. When kids sit with shame and guilt the outcome isn't great. They don't have strong self esteem, they don't have worthy goals, they don't have that feeling that 'I am a good person and I can do this.' That is the biggest thing to listen to your kid and where they are coming from regardless of what you are feeling and believing."

"Parents should watch their own response and should offer warmth and support immediately. Parents can acknowledge remembering the trauma differently without negating the child's perception and should avoid the sort of things that create more division and less connection with the child. If parents have multiple kids, they should recognize everyone who experiences the trauma may have different responses. Just because your one child is really reacting doesn't mean your other children will and not every child who has had a potentially traumatic experience will develop a trauma reaction."

"Parents should try and have some idea and understanding of what trauma is. That way they can normalize for the child and say 'its normal for you to feel this way. It's normal for you to be scared. But the best way to get over that is by going into situations that are going to be

safe and aren't going to cause problems for you.' So they are encouraging their child to do normal things but not getting angry or reactive if they can't. Parents need to be supportive of where their child is at. I think that helps stop them from developing further symptoms or just reducing the intensity of symptoms experienced."

"Immediately after a trauma, parents need to be offering validation but also be curious about what happened and aware of what their child went through. Because everyone experiences trauma different and what is one person's trauma is not necessarily another person's trauma. So for example if a child experiences a house fire and there are four children, one child could have PTSD over the fire and the other three could be just fine. So it's really important for the parent to be curious and to be aware of how that child is immediately after. Be talking to them, finding out how they feel, what are they thinking, what is going on. And being attuned and tuned into them because not everybody is going to respond the same. I think that is the hardest part for parents when they have more than one child they just make an assumption that everyone is ok or everyone is devastated or everyone feels this way and that is not the case. A child needs that individual attention after the trauma to say 'how are you?' You need to be talking about it. Saying 'this made mommy really sad, are you sad because this happened?' Or 'wow that was really scary, was that scary for you? It was scary for mommy.' You know so really talking about the emotions, the thoughts, the feelings, surrounding the situation and what happened."

"Knowing your child and knowing 'do we need to talk about this again, is it sneaking up, is it an issue right now' and just being aware because children can have triggers later on even when they complete the therapy process. Later on they can have triggers and having that parent

know what might be a trigger for their child and having that awareness and paying attention is really important.”

“When trauma happens with younger kids, parents tend to be more permissive than they were previously and more coddling where instinctually that seems like the right thing to do but also kids feel safest if they have routine, structure, and expectations. So trying to find that balance between how do you be supportive but how do you keep those things in place that will help them feel safe and secure.”

Discussion

Research in this study focused on the effects of parental response on their child's trauma experience from the perspective of licensed practitioners in practice with said children and parents. Banyard, Rozelle, & Englund, (2001), remind those in trauma practice that “trauma, by its very nature, is a stress that overwhelms the normal capacity to cope” (p. 84). This highlights “the need to involve parents in a child's treatment, attend to parent's reactions, and provide parents with education” to give families an opportunity to find success in the wake of trauma experiences (p. 80).

Themes and the Literature

The themes discovered in a review of the literature matched closely with the themes derived from the wealth of practice knowledge provided by the research participants. This speaks to the fact that in regards to this relationship of parental response and child trauma experiences, what is in the literature aligns closely to what is witnessed and experienced in the field. These themes included the overall importance of parental involvement in responding to their child's trauma, the benefits of supportive response, the challenges faced by unsupportive

responses, factors that increase and decrease the likelihood of supportive or unsupportive responses, the idea that initial responses are able to be changed from unsupportive to supportive, and parental best practices that should be employed following a traumatic event. All of these themes revolve around the core belief as presented in the literature by Bolen & Lamb (2004), as most importantly, “children of more supportive non-offending guardians have more optimal outcomes” following their trauma exposure (p. 186).

That being said, there are some themes that require further attention and discussion as they are present in the literature yet were given less emphasis by respondents involved in this research study. These themes are the effects of parental mental health, culture, and attachment between the parent and child.

Parent Mental Health. The mental health of a parent who is responding to his or her child's trauma has a considerable presence in previous research and was also mentioned by the majority of the research participants in this study. Parent mental health influences the trauma symptoms that are experienced by the child. This is evidenced by the finding that “maternal depression and children's perceptions of a rejecting parenting style were associated with increased symptoms in the child survivor (Banyard et al., 2001, p. 77).

In addition, there are several confounding factors present regarding parental state of mind. As mentioned in the results and the literature, “parents often have feelings of guilt for not having protected their child and in response may become overprotective of children” (Banyard et al., 2001, p. 77). A surprising finding from the literature though that was not discussed by any of the participants was that “non-offending fathers often blamed their wives in part for the victimization. This indicates that stress in the marital relationship may also be a consequence of

trauma disclosure that is related to problems with social support” (Banyard et al., 2001, p. 78).

What's more, is that “parents may have conflicting feelings toward their children including anger, questions about the child’s role, particularly older children, and concerns about the child’s sexuality following sexual abuse” (Banyard et al., 2001, p. 77). These confounding factors contribute to the mental state of parents and can produce unsupportive or perceived unsupportive responses by the children.

An interesting remedy for issues of parental mental health can be addressed by parents seeking their own mental health services. A fraction of the participants also discussed the benefits of parents receiving services and the literature accentuates “mothers who received treatment in conjunction with their sexually abused child or even instead of their sexually abused child reported increased parenting skills and decreased child behavior problems and depression when compared to mothers whose children only received trauma treatment” (Banyard et al., 2001, p. 79). It is found to be beneficial for providers to encourage parents to seek their own, individual mental health treatment following their child’s trauma if they were not already seeking treatment prior to the trauma.

Culture. The literature mentions that “recovery after trauma is a process connected to the family, social, and cultural contexts in which people live” (Gewirtz, Forgatch, & Wieling, 2008, p. 177). Culture has been identified as an important piece of any given family unit, however, throughout this research, cultural considerations were not mentioned by the majority of participants. One participant individually mentioned a scenario regarding culture represented in the following:

“I experienced a baby that came in to the Emergency Room right before Christmas. It was a ten month old in cardiac arrest and it was an African-American family. And that culture is very family oriented. The siblings, the mother, grandmother, aunts, uncles, and cousins all came in. However, you can't have multigenerational families in the trauma room when you are trying to keep a patient alive. In this instance, this aspect of the culture was very negatively impacting because we had to have security here to enforce only two family members can be in here at time. When families are in the way or yelling and screaming at you, it gets in the way of the safety of the child.”

This also seemed to be a more negative representation of the effects of culture and fails to highlight that culture can be very positive considering the literature states “both perceived social support and strong ethnic identity have been found to foster resilience in children and youth from ethnic and racial minority groups” (Harris et al., 2010, p.879). The only cultural intervention discussed by one participant was the use of interpreters to overcome language barriers in trauma situations. A language barrier can promote panic and increased terror for parents and children as well as a lack of understanding between provider and clients. As one respondent affirmed, *“it is very necessary to use an interpreter in these situations to reduce the stress, chaos, and fear during trauma.”* Future research on trauma response may benefit from identifying specific beneficial cultural interventions.

Attachment. “The emotional transactions of secure attachment involve a parent’s emotionally sensitive responses to a child’s signals, which can serve to amplify the child’s positive emotional states and to modulate negative states” (Siegel, 1999, p. 67). A child and their parent will have formed an attachment prior to the traumatic event and when parents are emotionally attuned to their children, this attachment is often secure. “In particular, the aid

parents can give in reducing uncomfortable emotions, such as fear, anxiety, or sadness enables children to be soothed and gives them a haven of safety when they are upset” (Siegel, 1999, p. 67). In this way, the attachment bond can mitigate the symptoms of trauma and allow the child to return to a feeling of safety. A small number of participants discussed attachment despite it being an invaluable and profoundly impactful aspect of any parent/child relationship. The following beneficial phenomenon was provided:

“It is a really helpful experience if the parent and child can really experience that trauma together in therapy and afterwards the parent being very level about it. This will show the child that the parent can handle what is going on and they still appear to the child as a haven of safety. When this is followed up by encouraging normal behavior and sustaining that attachment through behaviors that bring closeness it can allow trauma to be something that re-enforces a secure attachment and reminds the child their parent is always going to be there for them.”

When a traumatic event happens and parents are unable to respond supportively, it can damage the attachment relationship between parent and child. “If circumstances change, a securely attached child can become insecurely attached, or vice versa, an insecure attachment can become secure” (Siegel, 1999, p. 72). The loss of a secure attachment can be avoided by the repair process. This aligns with the opportunity for parents to apologize for their initial unsupportive response and provide the child with an attuned, supportive response as mentioned by the majority of respondents. In the literature this is described as “times of disconnection, which can be followed by repair and reconnection. If attempts at connection are consistently infrequent and un-soothing, there is no repair” (Siegel, 1999, p. 116). This idea expands that parents must provide a consistent, soothing response to their child over time regarding the trauma.

Implications for Social Work

There are several implications for Social Work practice that this research project gives rise to. The first and more foremost is to increase resources available to parents. Banyard et al., (2001) states “support of caregivers can be a protective factor” for children who experience trauma and families as a whole (p. 79). These resources would aim to reduce barriers parents face with the ultimate goal of increasing their ability to have a positive and supportive response when dealing with their child's trauma. Some of these resources would consist of adequate mental health therapy and services, domestic violence resources, housing and financial resources, as well as general education. According to Bolen & Lamb (2004), “interventions that allow non-offending guardians to resolve their relational losses and stress might be appropriate” (p. 206) in helping parents to manage their child's trauma. The resources should also have a “psycho-educational component to provide information and skill development to support positive coping strategies, and a supportive component that attends to the parents' emotional needs and reactions” (Bolen & Lamb, 2004, p. 207).

In the words of one of the research participants, the respondent would like to see increased “*general education around marriage, and possible divorce situations, and how to respond to your child. General education about what it is like to raise this generation of kids. The experiences they have and because of this they are more likely to be exposed to things we were never exposed to in the parent generation. And if your child comes to you, this is what you can say to make them more comfortable sharing things with you. This is what you can do to start establishing that level of trust so they feel like they can go to you if anything happens.*”

Several participants felt that parents become paralyzed as if they simply do not know what to do to respond to their child's trauma. *"They don't know what the heck to do. No one gives the parents a hand manual."* This sparked the idea that parents may benefit from general informative tips about first steps to take when responding to their child's trauma that include information about the importance of their own behavior and reaction. In addition, preventative measures, prior to a family ever experiencing anything traumatic, may prove to have useful results. *"Let's say if there was trauma prevention class out there for parents that say 'someday your child might be involved in a trauma experience and to prevent worsening trauma symptoms or PTSD, you should do the following.'"*

In addition to preventive measures, one participant touched on the lack of education, lack of communication, and assumptions that can occur with parents during their child's traumatic event. *"I don't know that people really talk to parents about their response or even that it can be traumatic to their child. I don't think they do. I think that it is more of an assumption that parents know hospitalizations and other events are really hard for kids. But I don't see our providers talking to families' about it. I think it's out there as a known thing but I don't know that we have an educational piece to parental response and trauma experiences which I think would be really helpful. If nurses, social work, or other support staff were able to tell families things they could do to help mitigate those effects of prolonged hospitalizations and chronic conditions it would be great but I don't think people talk openly about it in my sense."*

Several respondents discussed the most effective ways that practitioners can address parental response and the effects this has on their child and their child's trauma experience. *"Why would that reaction be damaging? I will educate them on that."* Parents often are unaware that their response can be damaging and practitioner insight can assist in overcoming

this barrier of a lack of understanding. Another participant elaborates with specific intervention strategies for practitioners:

“I think giving parents time alone really helps them be able to process and reflect on their behavior and trauma reaction more effectively than talking to parents with their child present. At times, talking to them about their reaction specifically gets them more defensive if the child is present. Saying ‘you are doing it wrong’ is not received well with parents and can create more anxiety, tension, and worry on top of the trauma. There is a nice way to couch it for parents by saying ‘you know we see this in kids when parents respond a certain way and this is what happens when parents respond this different way. How do you think you are responding?’ There is ways to couch is so that parents can hear it, accept it, and not take it personally. Even making observations of parent behavior can be helpful. Saying ‘I’ve noticed that when you are with your child this happens. Do you notice that too?’”

Strengths and Limitations

The strengths of this study were vast and invaluable. Clinicians working with children and parents who experience trauma have an exceptionally unique opportunity to look into the lives and experiences of their client population. Emotionally vulnerable children and parents share information with their trusted therapist that they may not have shared with anyone else. This creates an unprecedented window for these therapists to view their clients' experiences from. These clinicians are able to provide an outside perspective that is informed by the direct source and processed with the clinical lens developed by the practitioner through professional knowledge, education, and experience.

A second strength of this research stems from the ability of this researcher to look at the effects of parental trauma response through the lens of licensed professionals from various backgrounds and practice settings. This researcher was able to interview two clinicians trained in Trauma-Focused Cognitive Behavioral Therapy which requires parental participation as well as addresses parental response. A third participant was an Emergency Room Registered Nurse who is on the front line of traumas that result in injury and who has the opportunity to gather a distinct perspective on initial stages of trauma. A fourth participant has decades of experience working specifically with child sexual abuse which appears to be a breed of its own in the realm of trauma. Having these varying perspectives and experiences enabled this researcher to gain a wide range of perceptions of the insurmountable issue of childhood trauma and parental response.

Despite the many strengths founded in this research project, there are also several limitations. The main limitation was the source of information provided. By only interviewing clinicians who have experience working with children and their parents who have experienced trauma, the perspective of the actual children and parents being discussed is absent. The study was limited because this researcher was unable to gather the direct experiences of parents whose children experienced trauma and the children themselves who experienced trauma first hand. As a result, the information collected was from a secondary, outside source. The clinicians were able to offer experiences, stories, case studies, research, and direct observations but were not in the role of directly responding to the traumatic event or experiences that these children and their parents were involved in. Future research may benefit from gathering the direct perspectives of children and how their parental response influenced their trauma experience.

A second limitation was less exploration around the differences in parental response and behavior between parents who are offending versus those who are non-offending. This question was briefly addressed in the study but the phrases of offending and non-offending were not defined. There appears to be a strong difference in the response parents provide based on whether they were in part responsible for the trauma or whether the trauma occurred through an outside source or person. Future research would benefit from exploring this area further and addressing parent interactions and behavior toward their child when they occupy the offending and the non-offending roles independently.

Similar to the idea of offending versus non-offending, the final limitation involves the failure to provide distinction between parental response to complex trauma versus single event trauma. The research was not designed to address the differences in parental response regarding whether the traumatic event was a series of on-going events or not. It may be beneficial for future research to address parental response to complex trauma to determine if these responses differ from those of single event trauma and how this, in turn, affects the child. Along those same lines, exploring the impact of and parental response to trauma that occurs inside the home versus that which occurs outside the home may also provide a valuable research opportunity with the ability to better assist traumatized children and families.

Conclusion

The purpose of this research project was to determine the effects of parental response on their child's trauma experience. This goal was accomplished by conducting interviews with various licensed professionals, asking questions that explored supportive responses, unsupportive responses, factors that contribute to this and confounding factors to determine the effects of

parental response during and following child trauma. Real life case examples were utilized to process information provided and to endow with unique insight into interview participants' experiences.

Themes that emerged from the interviews performed included the overall importance of parental involvement in responding to their child's trauma, the benefits of supportive response, the challenges faced by unsupportive responses, the idea that initial responses are able to be changed from unsupportive to supportive, as well as identifying parental best practices in response to a child's trauma experience. Previous literature has identified many of these same core components regarding child trauma and parental response, but research throughout this study has identified a lack of parent education and support to promote a healthy response. There are many confounding factors that hamper a parent from responding to their child's trauma in a supportive, healthy way and methods and interventions to overcome these barriers more effectively have not been identified.

References

Alexander, P. C. (1992). Application Of Attachment Theory To The Study Of Sexual Abuse..

Journal of Consulting and Clinical Psychology, 60(2), 185-195.

Banyard, V. L., Rozelle, D., & Englund, D. W. (2001). Parenting the traumatized child:

Attending to the needs of nonoffending caregivers of traumatized children...

Psychotherapy: Theory, Research, Practice, Training, 38(1), 74-87. DOI: 10.1037/0033-

3204.38.1.74

Berg, B. & Lune, H. (2012). *Qualitative research methods for the social sciences*. United

States: Pearson.

Bolen, R. M., & Lamb, J. L. (2004). Ambivalence of Nonoffending Guardians after Child Sexual

Abuse Disclosure. *Journal of Interpersonal Violence, 19(2), 185-211. DOI:*

10.1177/0886260503260324

Coates, S., & Gaensbauer, T. J. (2009). Event Trauma in Early Childhood: Symptoms,

Assessment, Intervention. *Child and Adolescent Psychiatric Clinics of North America,*

18(3), 611-626. DOI: 10.1016/j.chc.2009.03.005

Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000). Trauma-Focused Cognitive

Behavioral Therapy For Children And Adolescents: An Empirical Update. *Journal of*

Interpersonal Violence, 15(11), 1202-1223. DOI: 10.1177/088626000015011007

Collins, K. S., Strieder, F. H., DePanfilis, D., Tabor, M., Freeman, P. A., Linde, L., et al. (2011).

Trauma Adapted Family Connections: Reducing Developmental and Complex Trauma

Symptomatology to Prevent Child Abuse and Neglect . *Child Welfare*, 90(6), 29-47. ISN:

0009-4021

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., & Mallah, K. (2005).

Complex trauma. *Psychiatric Annals*, 35(5), 5.

De Vries, A. P., Kassam-Adams, N., Cnaan, A., Sherman-Slate, E., Gallagher, P. R., & Winston,

F. K. (1999). Looking Beyond The Physical Injury: Posttraumatic Stress Disorder In

Children And Parents After Pediatric Traffic Injury. *Pediatrics*, 104(6), 1293-1299. DOI:

10.1093/sw/swr001

Foster, J. M. (2014). Supporting Child Victims of Sexual Abuse: Implementation of a Trauma

Narrative Family Intervention . *The Family Journal*, 22(3), 332 - 338. DOI:

10.1177/1066480714529746

Fusco, R. A., & Cahalane, H. (2013). Young children in the child welfare system: what factors

contribute to trauma symptomology?. *Child Welfare*, 92(5), 37-58.

Gardner, S., Loya, T., & Hyman, C. (2014). FamilyLive: Parental Skill Building for Caregivers

with Interpersonal Trauma Exposures . *FamilyLive: Parental Skill Building for*

Caregivers with Interpersonal Trauma Exposures , 42(1), 81-89. DOI: 10.1007/s10615-

012-0428-8

Gewirtz, A., Forgatch, M., & Wieling, E. (2008). Parenting Practices As Potential Mechanisms

For Child Adjustment Following Mass Trauma. *Journal of Marital and Family Therapy*,

34(2), 177-192. ISSN: 0194-472X

Harris, T. B., Carlisle, L. L., Sargent, J., & Primm, A. B. (2010). Trauma And Diverse Child

Populations. *Child and Adolescent Psychiatric Clinics of North America*, 19(4), 869-887.

DOI: 10.1016/j.chc.2010.07.007

Herman, J. L. (1998). Recovery From Psychological Trauma. *Psychiatry and Clinical*

Neurosciences, 52(S5), S145-S150.

Knott, T., & Fabre, A. (2014). Maternal Response to the Disclosure of Child Sexual Abuse:

Systematic Review and Critical Analysis of the Literature . *Issues in Child Abuse*

Accusations, 20, 1-7. ISSN: 1043-8823

Lieberman, A. F., Chu, A., Horn, P. V., & Harris, W. W. (2011). Trauma in early childhood:

Empirical evidence and clinical implications. *Development and Psychopathology*, 23(02),

397-410. DOI: 10.1017/S0954579411000137

Monette, D. R., Sullivan, T. J., & DeJong, C. R. (2008). *Applied social research: A tool for the human services*, 7th ed. United States: Thomson Wadsworth.

National Child Traumatic Stress Network Complex Trauma Taskforce. (2003). *Complex trauma in children and adolescents*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress

Shaw, J. (2000). Children, Adolescents and Trauma . *The Psychiatric Quarterly*, 71(3), 227 – 243. DOI: 10.1023/A:1004630127000

Siegel, Daniel J. (1999). *The Developing Mind: How relationships and the brain interact to shape who we are*. New York: The Guilford Press.

Van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35(5), 401-408.

Yehuda, R., Halligan, S. L., & Grossman, R. (2001). Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion. *Development and Psychopathology*, 13(3), 733-753. DOI: 10.1017/S0954579401003170

Appendix A – Consent Form**CONSENT FORM****UNIVERSITY OF ST. THOMAS****The Effects of Parental Response on their Children's Trauma Experience**

[670189-1]

I, the researcher, am conducting a study about how parental response to children's trauma exposure influences and affects their child's trauma experiences. I invite you to participate in this research. You were selected as a possible participant because of your experience related to child and family trauma. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Carly Vaplon under the Committee Chair member, Karen Carlson, as part of the Masters of Social Work Degree Program.

Background Information:

The purpose of this study is to explore how parental response to their child's trauma affects their child's trauma experience. Attachment Theory will be the conceptual framework utilized to explore parental response influences on their child through a trauma experience. The method used will be an exploratory qualitative study where the researcher will interview clinical practitioners regarding their experiences and observations working with children and families in the trauma field. The hypothesis consists of believing the way a parent responds to their child's trauma has an immense impact on the child's trauma experience and potentially determines whether the child registers the event as traumatic to begin with. This research is beneficial because it has the potential to be used as an educational, preventative measure to educate parents on the importance of their responses to potentially traumatic situations and how these responses can influence and affect their child. In this way, it has the ability to reduce the number of negative effects of trauma experiences in a vulnerable population of children.

Procedures:

If you, the participant, agree to be in this study, I will ask you to do the following things: Contact the researcher with an approximate hour long time period where an in person interview can be scheduled. At our initial contact, you will be asked to review and sign a consent form to begin your participation. You will be asked to answer openly and honestly and apply knowledge from your experiences to the best of your ability. The interview will be recorded on the researcher's personal audio recording device and will later be transcribed by the researcher personally. The length of participation will consist through the end of the interview, which is approximately one hour. Any follow up questions will be addressed immediately before the interview concludes.

Risks and Benefits of Being in the Study:

The study has some degree of very minimal risks. First is sharing information about past and present client experiences while second is the potential to be identified through information provided. These risks will be minimized through removing identifying information such as participant name, agency, or other identifying factors. Information provided will be used in a broad sense and in conjunction with other research participants to reduce the risk of being identified or client experiences being recognized by those examining the research results.

The direct benefits you will receive for participating are: No direct benefits to the participant.

Confidentiality:

The records of this study will be kept confidential. In the published report, I will not include information that will make it possible to identify you in any way. The types of records I will create include audio recordings and transcripts. The researcher alone will have access to the audio recordings, which will be stored on the researcher's personal devices. Once transcribed, the audio recordings will be immediately erased. The transcriptions will be completed in a word document on the researcher's personal computer that is password protected. The transcriptions will be deleted from the computer by June 1st, 2015. In addition, the hard copies of this signed consent form that are produced will be kept at the researcher's home office in a private lock box that the researcher has sole access to.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until one week after the conclusion of the scheduled interview that has taken place. In choosing to withdraw, you can do so by calling and informing the

researcher directly at the phone number listed below. Should you decide to withdraw data collected about you; the data will not be used and will be destroyed immediately. You are also free to decline to answer any questions I may ask and have complete control over what information you choose to provide and what you do not.

Contacts and Questions

My name is Carly Vaplon. You may ask any questions you have now. If you have questions later, you may contact me at 507-450-3050. As an additional contact my student research Chair Member, Karen Carlson, may be reached at 651-962-5867. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to being audio recorded through the means of the researcher.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

Semi-Structured Interview Schedule

Interviewer: Carly Vaplon

Interviewee:

Code Name Assigned:

Agency:

Credentials/Years of Experience:

Research Question: How does parental response to their child's trauma affect their child's trauma experience?

1. What are some of your experiences in working with children who have experienced trauma?
2. What are some of your experiences in working with parents of children who have experienced trauma? Offending and non-offending?
3. How important do you feel parent involvement is in responding to trauma? In what ways?
4. How much impact, do you feel, parental response to their child's trauma has on the child?
5. In your experience, what are some of the common ways parents tend to react to a child's trauma?
6. How does this (Q.5) affect the child?
7. What are some of the most helpful or beneficial ways that you have experienced parents responding to a child's trauma?
8. How do you feel this affects the child?
9. What factors do you feel may increase the likelihood of a parent responding more supportively to a child's trauma?

10. How does this (Q.9) affect the child or what is the child's response?
11. What are some of the most stressful or negative ways that you have experienced parents responding to a child's trauma?
12. How does this (Q.10) affect the child or what is the child's response?
13. What factors do you feel may hinder a parent from responding supportively to a child's trauma?
14. How does this (Q.13) affect the child or what is the child's response?
15. Are there any trauma symptoms that a child develops that you feel directly relate to parental response? If so, what are they?
16. Are there any specific aspects or outcomes of the trauma that you feel may not have been present if the parent would have responded differently? If so, what are they?
17. Have you worked with a child whose parental 'over reaction or extreme reaction' to the trauma created more of a trauma to the child than may have been there initially? What were the parents' reactions?
18. In what ways can a parent's reaction make a child's experience into something traumatic?
19. How does this (Q.18) affect the child?
20. In what ways can a parent reaction help a child avoid developing trauma symptoms or experiencing something as traumatic?
21. How does this (Q.20) affect the child?

22. In your experience, what reaction do children need to receive initially after being exposed to trauma? What, if anything, changes as time passes?
23. Are there any connections you notice between the type of trauma and a particular parental response? If so what are they?
24. If you could tell a parent anything you felt they needed to know before they responded to their child's trauma, what would it be?
25. What is your plan, if any, for educating parent's on the potential effects of their response to their child's trauma and the resulting impact on their child?