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Why Are You Crying?: The Impact of Parental Trauma on the Child

Michael C. Schaeffer
University of St. Thomas, Minnesota

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Submitted by Michael Schaeffer
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MSW Clinical Research Paper

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School of Social Work
St. Catherine University & University of St. Thomas
St. Paul, Minnesota

Committee Members:
Michael Chovanec, PH.D., LICSW (Chair)
Mireille Bardy, LICSW
Birgit Kelly, Ph.D., LICSW

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by Michael Schaeffer

Research Committee: Chair: Michael Chovanec, PH.D., LICSW
                                       Members: Mireille Bardy, LICSW
                                                       Birgit Kelly, Ph.D., LICSW

Abstract

The purpose of this research project was to investigate the impact of parental trauma symptoms on the child. The researcher became interested in this topic over the last few years with the increased reports of post traumatic stress disorder (PTSD) on returning vets from the Iraq and Afghanistan wars. With reports of increase domestic abuse and suicides in this population, the research was curious how these symptoms of trauma impacted their children. The majority of the research reviewed centered around quantitative studies where parents had developed classic single event PTSD symptoms from war trauma (vs. complex PTSD), and how the diagnosis impacted their child on a micro level. The writer conducted a qualitative research project with 8 licensed mental health professionals who worked directly with children and families in private psychotherapy. Most of the findings supported the data in the existing literature. However, a major finding was that in some cases a trauma bond between parent and child existed that was so invasive it replaced any sort of nurturance, security, or love between the parent and child, and yet they remained connected to each other. An implication for social work would be the importance of working from a systems perspective so that the child is not labeled as the sole problem, and that potential new treatments could be developed to work collaboratively with both the child and parent. Future research recommendations include: 1) studying a larger sample in order to generalize the population, 2) Identifying if the parent has a specific PTSD diagnosis in case examples, 3) Studying how the age of the child mediates the impact of the parent's PTSD symptoms.

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Introduction

The journey home from war used to take a few weeks or months. Now it just takes a few days. But really coming home can take a lifetime. As I got older I guess I started to wonder if my Papa was the way he was because of the war. As I started to learn more about what that might mean…there were lots of little things that just seemed like personal preferences. I started to see that they are the same little things that other vets have in common. He always had to sit in the back of a restaurant, in a corner, facing towards the door. When we went to events, he always wanted to leave early to avoid the crowds. He'd get up in the middle of the night… couldn't sleep, and sometimes go hang out at mystic lake casino. While he did play some slots, he mostly went there to buy duty-free cigarettes. And I think it was just a place to be, one of those places that is just silent within all of the noise (Pelecis, 2010).

The above quote is from the documentary film "Souvenirs: Healing After the War." Mara Pelecis talks about her father, a war veteran who suffered from PTSD. He killed himself when she was 30 years old.

Veterans returning from the wars in Iraq and Afghanistan have seen a steep rise in suicide rates. The Department of Veterans Affairs estimates that young veterans, 18-29 years of age, have suicide rates that have increased 25 % from 2005-2007, that's 2-4 times more then any other group (Clifton, 2010). It has been hypothesized that this steep increase in suicide is because of untreated Post Traumatic Stress Disorder (PTSD) (Clifton, 2010).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) first reported in 1980 that PTSD is an anxiety disorder that may develop after a person is exposed to a specific event where they have a real or perceived threat of grave harm or death (American Psychiatric Association, 2000). Some examples of symptoms of PTSD can include flashbacks of the initial traumatic moment, emotional numbing, hyper-arousal, sleep issues, and severe anxiety (American Psychiatric Association, 2000). Van der Kolk, McFarlane, and Weisaeth (2006) describe PTSD as "the result of a failure of time to heal all wounds. The memory of the trauma is not integrated and accepted as part of one's personal past; instead, it comes to exist independently of previous schemata (i.e., it is dissociated)" (p. 7).

PTSD is often linked to returning vets, but it is a disorder that affects many people worldwide who are not in the military. PTSD can result from car accidents, physical and sexual abuse, neglect, loss of loved ones, and threats to life. The National Co-morbidity Survey Replication sampled 9,282 Americans over the age of 18 to study the prevalence of PTSD. The study found that 6.8% of Americans have experienced PTSD at some point in their life (Kessler, 2005). Within this group, 3.6% of men and 9.7% of women will develop PTSD in their lifetime (National Co-morbidity Study, 2005). While these statistics are significant, they only paint half a picture of the problem.

Complex PTSD (C-PTSD), also known as disorders of extreme stress not otherwise specified (DESNOS), appears in "Associated Features and Disorders" section of the DSM-IV (APA, 2000). While the classic definition of acute/chronic PTSD in the DSM-IV requires a specific event, C-PTSD recognizes that psychological injury comes from prolonged exposure to social or interpersonal trauma resulting from captivity or an

inability to escape harm (Herman, 1992). Example of C-PTSD can include repeated and prolonged domestic violence, sexual abuse, torture, and emotional and physical violence. People who are afflicted with C-PTSD share many of the symptoms listed above, but can also suffer from personality changes and somatic disorders (Herman, 1992).

The individual is often the focus of treatment, however growing research has indicated that those who surround the person suffering PTSD (immediate families) have been shown to be affected by the disorder, and in some cases experience vicarious trauma, secondary trauma, and even PTSD.

Those who are most susceptible to secondary trauma stress and vicarious trauma are the young children of those who have experience a traumatic event. Secondary traumatic stress is described as the stress involved when individuals try and help or care for those who have PTSD, but inadvertently feel emotional distress as a result of the original trauma. Vicarious trauma can be used interchangeably with secondary traumatic stress, but the focus is experience of being traumatized through the stories and behaviors of the person with PTSD (Nelson, 2011).   Often, caregivers and key attachment figures in a child's life are not able to respond to the needs of their child if they are debilitated by PTSD. This can be particularly catastrophic to the emotional development of young children as their organization of brain structure depends on an attentive and responsive parent. (Perry et al, 1995)

One of the hallmarks of social work practice is social justice, particularly priority for the poor and vulnerable (NASW, 2008). Children represent a vulnerable population that must be supported and advocated for their rights. Unfortunately, by the time social workers or other mental health professionals are called in to help with issues of acting out

and destructive behavior, the child may have already been suffering for years. Moreover, the success of treating children is tied to an involved parent or guardian who can provide a stable and nurturing environment outside of therapy. This presents a problem when the parent is ill and lacks resources to help themselves.

In this research project, the researcher is interested in the impact of a parent's PTSD symptoms on their child, and what are helpful techniques when working with kids who are exposed to this relational crisis? The researcher will attempt to answer this question through qualitative interviews with mental health professionals who have experience treating children with parents who exhibit post-traumatic stress disorder symptoms.

Literature Review

This literature review collects information from a variety of studies focused on trauma, PTSD, and its impact on family unit, specifically children. The literature will be focused on defining trauma and PTSD, attunement, cultural implications, the impact of PTSD on children, and treatment response. The purpose of this review is to identify the current body of knowledge of parental PTSD and its impact on children, and to explore how this knowledge can contribute to a clinical understanding for social workers treating children who have parents with PTSD.

Children of Parents with PTSD

Veterans make up the largest group of people who have both been exposed to trauma and who have developed PTSD. As mentioned in the introduction of this paper, The National Co-morbidity Survey Replication found 6.8% of Americans have experienced PTSD at some point in their life (Kessler, 2005). Veterans, on the other hand, have significantly higher rates of PTSD. The National Vietnam Veterans Readjustment Study (NVVRS) samples 3,016 Vietnam veterans and found rates of lifetime PTSD at 30.9% for men and 26.9% for women (Kulka et al. 1990). At the time of the study, 15.2% of men and 8.1% of females were diagnosed with PTSD (Kulka et al. 1990). During the Gulf War, the rate of soldiers meeting diagnostic criteria for PTSD fell to 10.1% (Kang, Natelson, Mahan, Lee, and Murphy, 2003). In 2008, the Center for Military Health Policy Research sampled 1,938 soldiers from the Iraq and Afghanistan wars and found current PTSD rates of about 13.8% (Tanielian and Jaycox, 2008).

Several studies have looked at Veterans who have PTSD and what the impact has been on their children. Klaric et al. (2008) found negative behaviors in children

associated with parental PTSD, focusing on the volatility of the parent with PTSD as the main cause for emotional pathology. Their study of children in Bosnia and Herzegovina found that the chaotic family environment was a result of the rage outbursts, emotional unavailability, and disorganized attachment patterns of the parent with PTSD. Children in these homes perceived their families as "unsafe and unpredictable," and they developed behavioral and developmental problems as a result (Klaric et al., 2008).

Rosenheck and Fontana (1998) analyzed sample and interview data from the NVVRS (n=1,198) and found links between child behavior issues and veteran's experience of war violence. The researchers narrowed their sample to veterans who had PTSD and veterans who did not have PTSD, but had high combat exposure. Interview data from the veterans and their spouses was analyzed to reveal any relationships between soldiers who engaged in "abuse violence," committing violent acts against children in war, and current child behavior. The researchers found that there was a strong correlation with veterans who harmed Vietnam children and their biological children's scores on the Child Behavior Check List (CBCL). One hypothesis that the researchers speculate may contribute to the negative scores on the CBCL is that veterans who participated in abuse violence in war were troubled by memories of children they had harmed, and may have discomfort making emotional connections to their own children (Rosenheck and Fontana, 1998). Although the researchers did not distinguish between veterans who had PTSD and those that were only involved with high combat exposure, there appears to be a connection between the two. King, King, Gudanowski, and Vreven (1995) researched war stressors and found a direct link between Vietnam abuse violence and severity of PTSD.

Sometimes the war experience of veterans can influence the prejudice in their child. Brown (1984) conducted qualitative research with a female support group of veteran spouses who suffered from PTSD. The research focused on the partners of the vet, but there were several stories that involved how their child was influenced by their father's experience. One woman said that her daughter began to take on negative and aggressive feelings toward Vietnam refugees because of the paranoia exhibited by her father. The daughter confronted her mom (a cafeteria worker) on how she could serve a Vietnamese person food when they were responsible for her father's sickness (Brown, 1984, p. 375).

There are several other specific behaviors that have been associated with children who have veteran parents with PTSD. Parsons, Kehie, and Owen (1990) investigated the link between fathers (vets) with PTSD and their child's social and emotional functioning. Persons (1990) sampling consisted of 107 self-referred Vietnam veterans, 75% of met DSM-III criteria of PTSD. The researchers found that the children of the fathers with PTSD had significantly more issues with self-control of aggression, delinquency and hyperactivity. Moreover, these children also exhibited problems in social situations such as developing and sustaining meaningful friendships (Persons, 1990). These findings are echoed by Bessel van der Kolk, an expert in trauma research. He has found that the children in these families have distorted ideas about how they fit into family conflict. They often fault themselves for the chaos at home, and as a result have difficulty connecting emotionally to other people. They struggle to make sense of the loss and betrayal they have experienced since early childhood (van der Kolk, 1987).

The level of stress a child is subject to when involved with a parent with PTSD can be quite high. Brand, Schechter, Hammen, Le Brocque, and Brennan (2011) looked at the stress levels for offspring from mothers with PTSD. Their research study sampled 815 families that had children who were 15 years old. Interviews were conducted with the mothers and children in their homes. Of these 815 women, 14% (n=46) were determined to have lifetime PTSD (per the DSM-IV). The researchers found that the adolescent offspring reported higher levels of chronic and lifetime stress when compared to families where the mothers did not have a history of PTSD. These higher stress scores were associated with troubled interpersonal relationships but not with academics performance of school behavior (Brand, 2011). The researchers were surprised to see that parental PTSD affected child stress levels in some areas, but not others.

Brain Chemistry and Predisposition

Neuroscience research has shed light on the biological impact of PTSD on brain function and how it impacts the parent-child relationship. Cortisol, a type of glucocortical, is a hormone steroid produced by the adrenal gland. Its role is critical in the development of humans and stress management (van der Kolk, 2003). In terms of trauma, when humans are presented with experiences that lead to severe stress, cortisol is released to control heart rate, energy, and fight/flight response of the brain stem (van der Kolk, 2003). Prolonged exposure to cortisol has been shown to damage areas of the brain (hippocampus) used for new learning and memory function (van der Kolk, 2003).

Yehuda et al. (2000) have investigated the relationship of adult parents who have PTSD symptoms and the cortical levels of their offspring. The objective of their study was to look at cortisol levels in adult children born to Holocaust survivors to see if there

was a relationship to developing PTSD. Thirty-five adult offspring were compared with 15 adults with no Holocaust association. The sample was also separated into two groups that had a psychiatric diagnosis of PTSD in their parents (resulting from the Holocaust) and parents that were exposed to trauma, but did not develop PTSD symptoms. Findings of the study found that there was a clear association of lower than normal cortisol levels in offspring from parents with PTSD compared to parents with no PTSD (Yehuda et al., 2000). The researchers suggested that a parent's PTSD had a significant correlation to their offspring developing lifetime PTSD when compared to the control group.

In a follow up study, Yehuda, Halligan, and Grossman (2001) studied adult children of Holocaust survivors to investigate intergenerational trauma associated with parental PTSD, and the impact on cortisol levels in offspring. The focus of this study was self reported childhood trauma as related to parental PTSD. The sample consisted of 51 adult children of Holocaust survivors compared with 41 adult offspring (control). Researchers found that adult offspring that had parents with PTSD scored significantly higher on the childhood trauma questionnaire (CTQ) compared with the control group. A key finding of this study was that children of parents with PTSD reported significantly higher rates emotional and sexual trauma. The hormonal analysis of this group revealed low levels of ambient cortisol, which has been tied to a higher then normal risk of developing PTSD in their lives (Yehuda, Halligan, and Grossman, 2001).
The difference between the cortisol levels of parents and their children appears to be tied to who experienced the trauma first hand. Parent's who have experience trauma show high levels of cortisol in their brains as a biological coping mechanism. This high level in the parents correlates to offspring that have lower levels. The reason for this is unclear

in the research, but it speaks to the relational aspect of how a parent's experiences can impact the child biologically.

Communication and Attunement to the Child

Attachment theory was introduced by John Bowlby in the late 1950s, and was further developed by Mary Ainsworth and Mary Main. At its most fundamental level, attachment is designed to keep infants safe. With a goal of maintaining a close proximity to a caregiver, the attachment system motivates infants to stay close for protection, and there by offering the best possibility for survival (Siegel, 1999).

When applied to the developing mind, attachment is key to a child's ability to interact in a positive way with the world. An attentive parent will respond to a child when in distress. This helps to establish *a secure base* for the child to explore the world (Bowlby, 1999). A securely attached child has emotional resilience and has healthy anchor points for memory, narrative, object representation, and a state of mind (Siegel, 1999). Conversely, poor care giving can lead to insecure attachments.

Attunement plays a key role in developing a safe and secure attachment of the child to the parent. Mary Ainsworth's research on the attachment styles in the infant-mother relationship did not depend on the amount of care, but rather the quality of the care, "The mother's sensitivity to her infant's signals was of paramount importance" (Wallin, 2007, p.17). This is where attunement come in. Erskine (1998) defines attunement by saying it:

goes beyond empathy: it is a process of communion and unity of interpersonal

contact. It is a two-part process that begins with empathy-being sensitive to and

identifying with the other person's sensations, needs or feelings; and includes the

communication of that sensitivity to the other person. (p. 235)

The notion of caregiver attunement has implications when looking at the parental-child

relationship when the parent is suffering from PTSD.

When children are exposed to distress or traumatic experiences in their lives, it is

vital that parents be able to support and help their children process their experience to

reduce harm and suffering as soon as possible after the event. For an average parent (no

PTSD) this can be difficult. According to Stover, Hahn, Im, and Berkowitz (2010),

parents are not very in tune to a child's perspective when they have been exposed to

either a traumatic event. Stover et al (2010) researched seventy-six youths 7-17 years of

age and their parents who had been exposed to a potential traumatic event (PTE). They

found that parents often underestimate the traumatic experience of the child,

symptomology, and long-term effects. Parent-child communication may be limited

because dissociative qualities in the parent could affect attunement to the child during the

peritraumatic period (the time during or right after the traumatic event) when intervention

is most needed and helpful (Stover et al, 2010).

Parents who have experienced trauma and who have PTSD symptoms have an

even greater challenge of being in-tune with their child's experience and how their own

personal trauma history may affect their child. Mesasham and Rousseau (2010) studied

families that had trauma history to see the impact on their children. Twenty-one children

from West and Central Africa where observed playing to see how their parent's

disclosure of their war trauma would impact their creativity. A child's creativity when

playing was identified as a way to measure well being. Parents were interviewed on their war trauma history and how they talked about their experience with their children. Parents who over-disclose their experience had a drastic impact on a child's ability to play. Children were less creative and flexible in the sand table. Conversely, when parents used an avoidant style of communication (not talking about family trauma at all) children still seamed troubled and had an inability to play with their imaginations in a flexible way. (Measham & Rousseau, 2010) The authors regularly highlighted cases where parents felt that their disclosure or lack there of had little to no impact on the child. An example of this would be a parent discussing a relative's bloody death in the presence of a child, and assuming they understood given the child not asking any questions.

Holocaust survivors also had difficulty attuning to the needs of their children after their liberation. Raalte, Van IJzendoorn, and Bakermans-Kranenburg (2007) researched the young children born to Jews during and after the war. Their sample included 203 participants who were born between 1935 and 1944 in countries that were occupied by the Nazis. The researchers found that as many of these children aged, there was a tendency to have a lower threshold for accumulated stress later in their lives. Moreover, the research indicated a lack of well being in many of these children later in life. One of the reasons for this was a lack of quality child-care after the war ended (Raalte et al, 2007). The parent survivors often had PTSD symptoms mixed with intense grief that limited their insight of how the war impacted their children, and how they could help them make sense of their trauma experience (Raalte et al, 2007).

Cultural beliefs toward mental health also affect how parents deal with PTSD and trauma. Measham and Rousseau (2010) believe that certain cultural groups (Jewish) talk

more openly about family trauma as a way to overcome stress. Raalte et al (2007) agreed that being open about parental trauma experience could be helpful, but highlighted that too much talk can be harmful to children, especially when the caregiver is not aware of the distress these stories can have. Some cultures live and breath their trauma history, and this transparency (opening talking) can make children take on their parent's trauma (Raalte et al., 2007).

Transgenerational Trauma

The trauma of one childhood can bleed into the next generations childhood. As Van der Kolk (1987) reports, the seeds of family dysfunction may be sewed when the parent was a child:

> Mother-child interactional patterns have their origins in the mother's experience in her own family. A history of traumatization producing ego deficits, developmental deviations, and insecure interpersonal relations sets the stage for a maladaptive family environment in the next generation. (pg. 26).

Muid (2006) defines historical trauma as "the subjective experience and remembering of events the mind of an individual or the life of a community, passed from adult to children in cyclic processes as 'collective emotional and psychological injury over the lifespan and across generations" (pg.36). This historical trauma can be passed on to children from parents in several ways:

> …impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; and disconnection and alienation from extended family, culture and society…even where children are protected from the traumatic stories of their ancestors, the

effects of past trauma still impact on children in the form of ill health, family

dysfunction, community violence, psychological morbidity and early mortality.

(Milroy, 2005, p. xxi).

There are many studies that support the transmission of trauma and PTSD to

subsequent generations. One study by Daud, Skoglund, and Rydelius (2005) researched

the effects of parental torture on children in Sweden. Their study compared 15 families

where one parent had experience torture to 15 families where parents experience

violence, but no torture. In the families that had experienced torture, the affected parent

scored very high on PTSD scales compared to the control group. Within these families

where the parent presented PTSD symptomology, the children were found to have more

symptoms of PTSD, attention deficits and behavioral disorders compared with the

control. Atkinson (2002) reported on the ill effects of historical trauma through six

generations of aboriginal families in Australia. Her researched focused on one family's

known memories of trauma dating back to the original colonization of aboriginal islands.

She reported that there was, in fact, a link to the traumas perpetrated by the government

over a hundred years ago to increased violence, child sexual abuse, and systemic family

conflict in families six generations removed.

In contrast to the findings that support the transmission of trauma to future

generations, a few studies found that the link was not as strong. Davidson and Mellor

(2001) studied 50 children (ages 16-30) from 50 Australian Vietnam veterans and

compared their questionnaires on self-esteem, PTSD symptoms, and family functioning

to 33 civilian peers. The researchers did not find a significant difference in self-esteem

and PTSD symptoms between the two child groups. However, they did find impairment

in family functioning, especially in how the family experience emotional responsiveness to each other and outside the family. The researchers indicated that the presence of the mother might have buffered the transmission of PTSD symptoms to the child.   Another study by Hauf et al. (2011) did not find any significant psychopathology of children of Vietnamese refuges. The authors' study reported data from a longitudinal, prospective cohort of 50 Vietnamese refuges families who settled in Norway in 1982. Their findings did not show a high correlation of parental PTSD linked to distress in children (ex. 30% of families with one parent with high psychological distress only had 4% children with distress).

Helping Children

Helping children who develop behavior issues as a result of a parent's PTSD can be difficult. Figley and Figley's (2009) paper on the role of family therapy highlights the importance of treating trauma via the family unit. However, they believe that most therapists focus only on the client who has PTSD, and not the impact that PTSD can have on the family as a whole (Figley & Figley, 2009). This attention on the parent often neglects the need for the child's wellbeing. Young children are really at a disadvantage to getting help because they rely on a parent or mental health professional for services. But all too often those providers are focused on "the other" (Measham & Rousseau, 2010). Fortunately, for older children, there may be more opportunities for support according to Stover (2010). The authors hypothesize that adolescents are more resilient then younger children because they can seek help from peers and not have to rely on an ill parent for help.

Several models of therapy that focus on family interventions around parenting have reported to be helpful with parents who have histories of trauma. Circle of Security is an attachment-based model for parents with histories of traumatic childhoods and need help connecting to their young children in healthier ways. Marvin, Cooper, Hoffman, and Powell, (2002) demonstrated that early attachment interventions were helpful to mitigate dysfunctional bonding of parents with trauma histories to their children. Another model of therapy to support children, focusing on parents as the agent of change, is the Parent Management Training- Oregon Model (PMTO). This is a behavioral intervention directed toward parents who are struggling with their child's behavior issues. While not a strict PTSD focused therapy, one of the core components focuses on the caregiver and how their experiences and current mental health (including PTSD symptoms) impact their child (Patterson, 2002).

The developmental repair manual written by Dr. Anne Gearity is a model of therapy to help young children who are experiencing severe behaviors and challenges. It is a relational model for young children ages 3 to 3rd grade who are at risk due to aggressive and disruptive behavior (Gearity, 2009). The model encourages a shift away from labeling children as behaviorally deviant to a more developmental lens of how these behaviors serve a purpose for a survival. (Gearity, 2009) The model identifies how traumatic experiences in the child's life interfere with their development, and proposes systemic interventions with adults and families. While the parent's trauma history is not actively treated along with the child, their participation is encouraged in classes, groups, and in the treatment of the child.

Summary

It is clear from the literature that parents with a diagnosis of PTSD have a profound impact on their child's biology, affective state, and how they experience the world. Children of veterans who have PTSD are more likely to be violent, mood disordered, and have greater difficulty with self control. Biological factors can also lead to predispositions to anxiety and psychological problems in children who have mothers who have histories of trauma. Caregivers who are experiencing flash backs, emotional numbing, and other symptoms of PTSD were shown to have children who had heightened challenges with emotional regulations and feelings of security. Moreover, intergenerational transmission of trauma revealed how children could experience trauma symptoms through their parent's experience.

The majority of the research found in this review centers around adults who have developed PTSD from war trauma, and how the diagnosis impacts their child on a micro level. The researcher had difficulty finding information on the broader view of PTSD (Complex PTSD) on the impact on children. Also, most of the data in the research designs were produced by quantitative measures, often lacking in detail of the child's experience. Lastly, limited information could be found on specific interventions to helping children from systemic perspectives.

The researcher investigated if the findings in the literature can be substantiated by a clinical mental health professional's direct experience. The researcher was curious about how a parent's PTSD symptoms impacts the child and in identifying specific ways to help children from a systems perspective. With this in mind, the research question is broad in nature: How does a parent's posttraumatic stress symptoms impact the child?

Conceptual Framework

Attachment theory lends itself well to this study because it concerns itself with the child/caregiver relationship. Parents with PTSD symptoms often find it difficult to focus and be present in their lives and the lives of their children. Since children rely on their caregivers for safety, mood regulation, and developmental support, the attachment breaks that PTSD may cause can have serious implications in child behavior.

Insecure Attachments can occur when a parent is not able to tend to the child's needs in helpful ways. Marry Ainsworth described two different styles of insecure attachment in her research with child and primary caregiver interactions. An *avoidant style* of attachment usually results from a parent who is emotionally unavailable and neglectful of the child's needs (Siegel, 1999). These parents do not seem to understand or are unaware when a child needs support, and as a result the child learns that the parent cannot be relied upon for help with emotional regulation (Siegel, 1999). Later in life these children often have difficulty with their own emotional awareness and the ability to reflect on other's emotions and states of mind (Siegel, 1999). Parents with PTSD often don't provide the emotional support needed by children because they themselves cannot connect to their own emotional world. Moreover, if the parent is in a state of disorientation (past vs. present) or disassociation, the awareness of the child's experience will be greatly limited.

The second style of insecure attachment that Ainsworth discovered was *ambivalent attachment.* This attachment style is similar to avoidant in that the parent has difficulty picking up on the cues of the child. However, instead of a parent being withdrawn or rejecting (avoidant), the parent is often inconsistent with supplying

emotional support. At times the parent will shower the child with affection when the need is not there, often deregulating the child from their focus on other activities. This can feel intrusive to the child because the parent is projecting their own experience and is not in tune with the experience of the child (Siegel, 1999). These parental patterns are usually a product from "entanglements with their own past… and are independent of the signals sent by their child" (Siegel, 1999). Children with this attachment style often are more preoccupied with their own distress and can be more aroused in the need for a secure base (Siegel, 1999). Later in life, these children have a difficult time self-regulating their internal experience and have a heightened need for comfort from others (Siegel, 1999). Parents with PTSD symptoms can lack consistency in the care of the child. Since the re-experiencing of the traumatic event and intrusive thoughts that are associated with PTSD are uncontrollable by the parent, care and awareness of the child can be attentive one moment, and completely collapsed the next.

Mary Main's observations of child attachments found a third style of insecurity that looked very different from avoidant and ambivalent styles. While in the care of the attachment figure, children can display odd behavior, such as engagement and withdrawal, being held without being soothed, and strange circling around the caregiver. A *disorganized attachment* style may be present when the person who is supposed to supply a secure base is simultaneously a source of fear for the child (Main and Solomon, 1986).   Parents who foster this attachment style can be physically, emotionally, or sexually abusive toward their children. However, a child's fear does not necessarily have to be the product of an abusive parent. Fear can result from parents who show disoriented, dissociated, or scared affect (Hesse-Siegel 1999). These children have

challenges of developing a coherent state of mind. They often will experience severe

challenges in interpersonal relationships, affect regulation, attention, and may present

with dissociative behaviors (Siegel, 1999). Parents with PTSD often create fear and

anxiety in their children. At one end of the spectrum, children can be confused and

anxious by their parent's odd behavior. At other times, fear and a breach of security can

result from a parent who has violent outbursts of rage, some of which can be physically

and mentally abusive.

Secure and insecure attachments are almost always decided within the first year of

an infant's life. Moreover, a parent's ability to provide a secure base for a child is often

determined by that parent's early positive and/or negative attachment experiences. The

researcher is interested in how parental PTSD impacts a child's relationship to the

primary caregiver in that first year and beyond. Specifically, does parental PTSD impact

attachments in the child's first year? Moreover, if a child is already securely attached and

a parent experiences a trauma that develops into PTSD, what is it like for the child to

witness a parent who appears to be a different person and how might it affect the secure

attachment. What behaviors, both positive and negative, are attributed to a parent's

PTSD?

Social workers who provide therapy to children focus on the system that

surrounds the child. The *Ecological Systems Theory* (EST) is a core model for social

work practice because it looks at the child in the environment, and how the environment

influences and impacts the child. This theory is the second framework that will guide this

qualitative research project.

Developed by Bronfenbrenner (1990), the ecological systems theory focuses on several layers of the child's environment, and how those different layers affect the child's development. The *micro-system* is the layer that has intimate impact with the child. Examples of the micro system include family the child in the family and other personal relationships. The *meso-system* looks at the linkages between the individual and two or more settings. Examples of the meso-system can be school, social groups, and activities outside the home. Lastly, the *macro-system* is the outermost layer of a persons system. It influences all other layers because it has a societal view. Examples include services, public policy, cultural values and beliefs, and laws (Beck, 2000)

The ecological systems theory is helpful when looking at the impact of parental PTSD because it breaks down the major influences in the child's world. As the researcher investigated this topic, attention was paid not only to the child-parent relationship, but also how parental PTSD impacted the child's social, community, and cultural connections. This framework is especially important to how clinicians work with children because of the emphasis on therapeutic considerations of the child's environment.

Methodology

Research Design

The research design was an exploratory qualitative interview with mental health professionals.   Qualitative research gathers data in the form of language and words (Berg, 2009). "*These* life-words include emotions, motivations, symbols, and their meanings, empathy, and other subjective aspects associated with naturally evolving lives of individuals" (Berg, 2009, p. 16). The researcher was interested in this design because the majority of the literature reviewed used quantitative methods to gather data. The researcher hoped that an interview with clinicians would have painted a more in-depth picture of how children are impacted by their parent's illness.

The majority of reviewed literature on parental trauma and its impact on children involved study samples intimately involved in the trauma (i.e. the trauma victim or partner). These samples, while important for their unique perspective, represented a heavily biased sample group. Parents or caregivers who were directly affected by the trauma where asked to give their observations on their children's behavior. This could lead to problems of data validity if the participant's memory and ability to observe the child had been impaired by their trauma.

Sampling Procedure

The type of sampling procedure the researcher used was a snowball sample. A snowball sample is a helpful way to find research participants when there is a very specific criteria needed for inclusion in the study (Berg, 2009). The researcher sought referrals of possible participants from committee members. Based on those referrals, the individuals or agencies were contacted to see if there was availability and interest in an

interview. Other referrals were generated from these interactions until a sample size of eight participants was reached.

The researcher focused on mental health professionals who had an expertise in providing child and family therapy. Since a formal diagnosis of PTSD in parents was difficult (or unlikely) to ascertain, the researcher sought professionals who could share cases where they recognizing PTSD symptoms in the parent. Psychologists, marriage and family therapist, and clinical social workers that had at least three years of direct clinical practice to this specific population were sought. The sample size was eight mental health professionals.

Protection of Human Subjects

Research participants were only known to the researcher. All personal contact information was secured by password on the researcher's personal computer. When notes were taken, that information was stored in a locked and secure location at the researcher's residence.

When a potential participant expressed interest and availability to participate in a qualitative interview, the researcher provided a copy of the questions. This helped to reduce bias and coercion on behalf of the researcher. Also, an informed consent document was provided to the participant for signature. After reviewing the interview questions and informed consent, the potential participant was asked if he/she would still like to participate.

Following the interview, the researcher checked in with the participants to see if they had experienced any forms of stress from recounting some of their experiences working with these cases. Although rare, it was possible that some of the participants

could experience vicarious trauma in the interview process. No participants reported any problems.

The interview was recorded for transcription by a third party. The digital file was kept in a secured and locked location. The person involved in transcribing the audio data signed a confidentiality agreement. In addition to the transcriber, a research assistant (MSW graduate) provided a reliability check for themes and codes from the transcripts. The research assistant signed confidentiality agreement.

Instrument:

A total of ten questions were used for the interview. The questions were created by the researcher from the perspectives of attachment theory and the ecological systems model. The interview questions focused on the parent-child relationship, PTSD symptoms in the parent, behavior investigation in the child, and implications for treatment in the micro, meso, and macrosphere. All questions were designed to be open ended. The interview questions were reviewed by the research committee members for increased validity and bias reduction. In addition to the interview questions, demographic information of the participants was gathered. The data included: ethnicity, gender, age, years of practice, and licensure.

Data Collection:

Data collection included the following steps:

1. Potential research subjects were identified through a snowball sample. The researcher asked the committee members to provide 2-3 referrals that were licensed mental health professionals with at least 3 years of experience providing psychotherapy to children and family systems (including parents)

2. The researcher followed up with these referrals (individuals and/or agencies) with a template email that introduced the researcher, the study, it's purpose, and how the data would be gathered.

3. Those individuals or agencies that responded with an interest to participate were contacted directly to answer specific questions.

4. Prior to making an appointment, the researcher sent a consent form, a list of interview questions, and demographic form for review. The participants were informed that the interview would take approximately 45-60 minutes of their time and that they should fill out the demographic form prior to the interview.

5. After reviewing the questions, the potential subjects decided if they would like to participate in the research project.

6. The researcher met with the participant at his or her office.

7. The interview participant was given a full disclosure release to sign. The researcher went over the release verbally so that the interviewee understood his/her rights   and how the data was to be used.

8. The interview was audio recorded for transcription purposes.

9. The researcher checked in with the participant of his/her experience of the interview.

10. The researcher and a research assistant performed an independent open code of the transcripts to increase reliability of theme identification.

Data Analysis Procedure

To analyze the data, a qualitative data analysis was conducted using grounded theory methods. A content analysis was used to identify patterns of codes, meanings, and themes in a specific document (Berg, 2009). The process of analysis was inductive. The

transcript was reviewed, line-by-line, and then codes and themes were listed to help

interpret the information. As interesting and important concepts were revealed in the

transcripts, the researcher noted them in the margins. The first pass of the transcript was

unrestricted and generated many codes. In the next pass, the researcher went through the

codes and looked for themes (2 or more codes pertaining to the same idea) and made

notes of these. Themes were supported by 2-5 quotes from the interview subject. In

addition to the researcher's data analysis, a research assistant was also used to open code

the transcript for themes. The assistant's review of the transcript was done independently

from the researcher. The research assistant was instructed to perform an open code the

same way that was described by the researcher. Only the quotes and themes that were

shared between the researcher and research assistant were used.

Findings

Sample

The sample for this research project consisted of eight mental health professions. The sample design was a snowball, so the initial participants were referrals from the project committee members. The other referrals were generated from the participants after the interview sessions. There were a total of twelve referrals made, with eight agreeing to participate in this study.

All of the participants were licensed independent clinical social workers except for one licensed professional clinical counselor (PsyD. approval). There were a total of six female participants and two male participants. Six of the participants all had over 20 years of direct practice experience with children and families, and two had between 3-10 years of experience. All participants identified themselves as white- Caucasian except for one who identified as Hispanic.

Interview data was gathered during a two-week period in February 2012 in the Twin Cities Metro Area. All interviews were conducted at the participant's place of work in a private office. The duration of each interview fell between 30 minutes and 45 minutes, depending on how much the participant had to share.

Observations of Child with a Parent who has PTSD

Participants were asked to share cases where they had a parent with PTSD symptoms and what they noticed in their child client. The participants reported five themes: *acting out behaviors, isolation, emotional regulation problems, parentified kids*, and *taking on the symptoms of the parent*. The collection of themes in this section speaks to the research question proposed because it seeks data on what impact parental PTSD

has on the child. Themes were identified by at least two participants identifying the same

idea. Both the researcher and research assistant reviewed the transcripts independently

and followed the same protocol for coding- an initial open code to identify ideas, and

then a second pass to create themes made up of at least two participants' quotes. Only

the themes and quotes that both the researcher and research assistant identified

independently were used.

Acting Out Behaviors

Three of the eight participants reported acting out behaviors in children where the

parent had PTSD symptoms. Acting out behaviors were described as impulsivity, lying,

manipulation, disruptive behaviors and violence. These "acting out' behaviors were

often the reason children were identified with a need to have therapeutic support and

intervention.

Table 1. Participants' Responses to Acting Out Behaviors Theme in Clients with Parents who have PTSD Symptoms

Theme	Quotations
Acting Out	*She had a fair amount of acting-out behaviors, she was very impulsive, and very…strong willed, but to the point where she would lie and manipulate to get her way with her mom* (Interview 4, Page 2, Line 27)
	She had more disruptive behaviors in school…where her older sister was very shut down, she more acted out. (Interview 7, Page 2, Line 31)
	The kids were very aggressive towards her (mom). They targeted her a lot. Prior to coming her, they had kicked her in the face, hit her with ice skates, really big violent stuff. (Interview 2, Page 2, line 5)

Isolation

Four out of eight participants spoke of isolation in the child. There were various

reasons for this isolation. Some participants commented that parents make it difficult for

the child to connect outside of the family because they themselves had a hard time making connections with others. Sometimes the behaviors of the child made it difficult for them to make friends. Another participant talked about these kids feeling alone, so there was no comfort out there.

Table 2. Participants' Responses in Regards to Child Isolation in the Community

Theme	Quotations
Isolation	*Here we have a 12-year-old who's obese, can't bring friends home, is bossy and controlling to everybody she's around…is unable to become part of a greater community.* (Interview1, Page 4, Line 27) *There's a lot of shame that goes with these families and so I think often they don't step into the community a lot. I think they isolate themselves quite a bit, so there's not a lot of comfort in the community.* (Interview 2, Page 4, Line 44) *In the community it can be really isolating for the kid in the community, so that they're not really engaged in the community.* (Interview 3, Page 4, Line 203) *Well, I think a lot of the time parents who've had their own trauma, they tend to be less trusting. A lot of families will tend to be very insular, even though it's not logical.* (Interview 4, Page 3, Line 92)

Emotional Regulation Problems in the Child

Three out of the eight participants reported emotional regulation problems in their clients who had parents with PTSD symptoms. Participants identified children who vacillated in states of hyperarousal, anger, or intense worry. There didn't seem to be a middle ground. One participant linked this inedibility to moderate their emotional life because the parent didn't model it. As a result they didn't have a way to connect to themselves and they [child] was not able to read the emotions of others.

Table 3. Participants' Responses for Emotional Regulation Problems Theme in Clients who have Parents with PTSD Symptoms

Theme	Quotations
Emotional Regulation Problems	*Two constellations of responses; one is kids who are very worried about their parents and sort of hyperfunction because they're... afraid to go to school because mom might not still be there or be alive when I come home. They won't articulate that, but that's a very typical symptom, truancy, when there's been trauma to the adult... But the other can be that kids themselves has temper tantrums, has a lot of difficulty with self regulation and regulating their own emotions; they're sort of in a state of hyper arousal. So it's sort of some variation of these two responses; they either fall apart or they over-function.* (Interview 8, Page 1, Line 46) *They (children/siblings) couldn't read emotions well, I think because again, Mom's stuff was so incongruous that they couldn't tell what was going on with people. So then when you're trying to link their own feelings to stuff, they were just clueless as to what was going on within them, what was going on with someone else.* (Interview 2, Page 1, Line 39) *Emotional reactivity is probably the biggest one and the one that probably is there in some way shape or another always. So either it's a fear response or anger response.* (Interview 8, page 1, Line 30)

Parentified Kids

Three out of eight participants reported parentified traits in their clients who had parents with PTSD symptoms. This theme showed up in a few different ways based on the data. Some kids would take over as a way to control the situation for their parent who may be checked out. One client was reported to slip into this role to protect the siblings when the parent was unable to provide security. One participant spoke of a client who used this role to replicate the violence in the family and to target the parent who was suffering with PTSD symptoms.

Table 4. Participants' Responses for Parentified Kids Theme in Clients who have a Parent with PTSD Symptoms

Theme	Quotations
Parentified Kids	*So you could see it in them, just a lot of confusion and that shifting to become real parentified, they'd take over because of her vulnerability that would be showing up.* (Interview 2, Page 2, Line 25) *She was also very much the protector, because her older sister would be sexually aggressive with the younger children and she would- my client would be, "No, you can't do that. That's not okay. I'm getting mom." And just very parentified.* (Interview 7, Page 2, Line 34) *So what I would see in the child, again, was that taking over, becoming parentified with her, being powerful, replicating that domestic violence piece even though he (child) didn't ever witness it....* (Interview 1, Page 2, Line 40)

Taking on the Symptoms of the Parent

Three out of eight participants reported clients taking on the PTSD symptoms of

the parent. These symptoms included sleep difficulty, anxiety, anger and fight responses,

and sometimes dissociation. Participants framed these symptoms as being connected to

the parent. Two participants specifically said that the clients were taking on the PTSD

symptoms of the parent when no other direct trauma incident to the child had occurred.

Table 5. Participants' Responses for the Theme of Taking on the Symptoms of the Parent

Theme	Quotations
Taking on the Symptoms of the Parent	*A lot of anger, and in both of those cases as well, definitely saw the kids having similar symptoms to the parent. Difficulty of sleep, high levels of anxiety, tendency to have reactivity out of the blue. Just get triggered very easily, get into a real defensive fight stance for the most part.* (Interview 2, Page 3, Line 50) *So I noticed that the child then would often go into PTSD symptoms, as well as the mom was triggered… then the child would often go into anger and a fight defense, and eventually there would be some disassociation… Then I just saw patterns , lots and lots of patterns of*

	issues, of symptoms of PTSD in the kids, as a result of mom. (Interview 3, Page 3, Line 7)
	What I see a lot of the times is that then the child really starts to mirror a lot of the defensiveness of the parent or a lot of the PTSD symptoms of the parent. (Interview 3, Page 4, Line 32)

Impact of PTSD Symptoms on Parent-Child Relationship

Participants were asked to what extent do parental PTSD symptoms impact the parent child relationship. All participants said that a parent's PTSD symptoms had a *huge impact* on that relationship. Other themes that emerged were *trauma bond* and *lack of regulation from the parent*.

"Huge Impact"

Eight out of eight respondents all agreed that the impact of a parent's PTSD symptoms had a sizable effect on the family relationship. Several respondents noted a disruption in how consistently a child's needs can be met by the suffering parent. Several commented that the bond of the parent and child is limited. One participant even suggested that a parent's ability to keep the child safe and to prevent harm was compromised

Table 6.   Participants' Responses on the Huge Impact Theme of the Parent-Child Relationship

Theme	Quotations
Huge Impact	*I think the impact is huge. In a preventative view, I think it makes the parent blind to what's happening because they don't have access to their emotions, and detection system.* (Interview 1, Page 3, Line 42)
	I think it's significant. I think that there's a lot of difficulty with parents and children bonding when PTSD is going on. I think

	that parents, at times, have a harder time being nurturing to their kids and being predictable and keeping a schedule. (Interview 2, Page 3, Line 10)
	Hugely. I would say at the basic level, the capacity for the parent to hold the child's experience is really disrupted. (Interview 3, Page 3, Line 15)
	Yes, it's major. It makes it incredibly difficult for the mom in this case, but in a lot of cases just for parents in general, to assist their child in developmentally developing a sense of self. (Interview 4, Page 2, Line 21)
	There's no question in my mind that the impact is broad and very intrusive. (Interview 6, Page 3, Line 82)
	They (PTSD symptoms) can have a huge impact on the relationship. (Interview 7, Page 3, Line 87)
	I mean usually if there's a pretty profound affect on the parent it permeates that child's life. It's not discrete in any way. (Interview 8, Page 4, Line 10)

Lack of Regulation from Parent

A lack of regulation from the parent was a theme supported by three out of eight participants. This speaks to the importance of the parent helping the child deal with stress in difficult times. Participants talked both of the parent's ability to regulate the child, but also the parent's ability to regulate the self in order to be present for the child. One participant spoke of a parent who had difficulty stepping away from their experience to attune to the child's needs. This miss-attunement makes it really challenging for the child to develop a healthy sense of self from the connection to the parent.

Table 7. Participants' Responses Regarding a Lack of Regulation in the Parent-Child Relationship

Theme	Quotations
Lack of Regulation	*I think about regulation and I think about attachment a lot, so attachment is that biological function of when you're holding the stress of a child and helping them experience it in digestible bits they can manage. That teaches self-regulation through the experience of a caregiver doing that. Now if you have a caregiver who, in the face of strong emotion, disassociates or becomes aggressive, we don't have that capacity for that caregiver to hold that child's experience and give them that very necessary co-regulating experience.* (Interview 1, Page 2, Line 1) *I think one piece that is real hard is for the parents to discern what is their own stuff from this prior trauma that's occurred to them versus what's going on in the moment with the child. The parent has a hard time stepping out of their stuff to be able to attune to their child, and give them the kind of nurturance and response that they need to develop a healthy attachment.* (Interview 2, Page 1, Line 4) *So since they're in survival mode all the time, neither the kid or the parent's able really to connect, and the parent can't regulate the kid enough for the kid to develop a sense of self and get to explore who they are as a person.* (Interview 3, Page 3, Line 28)

Trauma Bond

When there is a parent with PTSD symptoms, sometimes the relationship to the child can shift to a new way of connecting, something that goes beyond a normal developmental relationship. Three out eight participants talked about how trauma and PTSD symptoms can form a cycle of trigger/re-trigger of PTSD symptoms in both the parent and child. The trauma bond was noticed in cases where the parent's behavior and actions (stemming from the PTSD) created a traumatic experience for the child. This experience led to the child experiencing PTSD symptoms. This cycle could be so invasive and ingrained that it becomes a new identity for the relationship.

Table 8. Participants' Responses Regarding the Trauma Bond Between the Parent and Child

Theme	Quotations
Trauma Bond	*They [parent and child] had a real cycle of just things- they just repeated this trauma over and over. They interacted with each other in a trauma way. I think they had a real trauma bond.* (Interview 1, Page 1, Line 40)
	They were very powerful children and I think they were aware of her getting triggered, and their response to that was to get bigger and to become scary and controlling. (Interview 2, Page 2, Line 17)
	There's a real relationship with the symptoms of the parent and the child. They influence each other. I see families where the kids trigger the mom and the mom triggers the kids. They all share this- they exist together. (Interview 8, Page 2, Line 21)

Child Sibling and Peer Relationships

Not only did the parent-child relationship suffer in some way from a parent's PTSD symptoms, there were also implications for sibling relationships and their peers. Participants reported that siblings were noted to be more *violent* with their brothers and sisters. In contrast, some participants also highlighted that they also could find *support* in one another. *Role confusion* was the last theme to emerge in respect to siblings. In regard to relationships to peers, a *superficial relationships* theme was reported.

Sibling Violence

Six out of eight participants reported on violence between siblings. Most responses fell into the category of parents not providing an environment that was safe or that didn't teach social skills. Participants talked about family systems where conflict was never resolved, so tension built until it turned violent. Another participant talked about how the siblings dysregulated each other to the point where they lost a safe connection with each other. Two other participants reported that siblings can get so

competitive for their parent's attention that it leads to violence. This really speaks to how

difficult it is for parents' with PTSD symptoms to really "see" their children and be

present for them. Both participants spoke that when parents have so little to give, the

intensity of the sibling relationship is heightened because they will do anything to be

noticed.

Table 9. Participants Responses in Regards to Sibling Violence

Theme	Quotations
Violence	*They're [parents] are not engaged in teaching social skills among the siblings. So we have a lot of families where the siblings are very violent towards each other.* (Interview 4, Page 5, Line 20)
	I've seen siblings perpetrate on each other because there's no foundation for them to just be children and engage in that. (Interview 7, Page 4, Line 54)
	If there's a lot of anxiety and tension in the family then conflict doesn't usually get resolved as well and kids are likely to beat each other up or really torment each other and stuff like that. (Interview 6, Page 5, Line 14)
	There's a lot of animosity with one another as they trigger each other. So there's a lot of disconnection between the siblings. (Interview 3, Page 4, Line 21)
	Particularly with siblings, I see there's this vicious Kill-or-be killed sense of who's gonna get the parental attention. 'There's only a little bit left, so I've gotta grab it as fast as I can and there's never enough for both of us.' (Interview 2, Page 4, Line 90)
	The kids get very competitive for the parents' attention, and so you see a lot of sibling conflict going on because they're really struggling to get morsels of time and connection in the attachment relationship. (Interview 1, Page 3, Line 23)

Sibling Support

A few participants (two out of eight) found that siblings are not always violent

with each other. One participant said that even though there can be violence in the

relationship, they can also be protective and caring for each other at the same time.

Another participant added that sometimes the siblings have to rely on each other because

the parent can't meet their needs in a consistent way.

Table 10. Participants' Responses in Regards to Sibling Support

Theme	Quotations
Sibling Support	*Within that though, they (siblings) are also very connected. So it's an interesting mix of they may be volatile and fight and conflict with each other, but they also are protective of each other and watching out.* (Interview 2, Page 5, Line 8) *Kids rely on their siblings because they can't always rely on their parent. Siblings will sometimes, I think, look out for each other, be more protective, I think, if the parent might be a little bit more unpredictable.* (Interview 5, Page 3, Line 87)

Sibling Role Confusion

Sibling role confusion was a theme found in four out of eight participants.

Different roles that were identified were the parentified child, the disciplinarian, and

problem child. Participants felt that it didn't really matter what role the child had, but

rather that these roles were developmentally inappropriate.

Table 11. Participants' Responses in Regard to Sibling Role Confusion

Theme	Quotations
Role Confusion	*That the boy sees himself as the parent and his job is then to let sister know, "You've crossed the line and stop that sniveling and I'll give you something to cry about,"... all the roles get mucked up.* (Interview 1, Page 3, Line 20) *One child will bite the bullet for the rest of the family, and so they will either take on all the symptoms and be the problem child. Or there's a caretaker role that develops where one sibling really focuses on taking care of the others...* (Interview 3, Page 3, Line 30) *Like I say, one child is parentified, and then there's one child who's identified as the problem child who acts out and allies with the perpetrator.* (Interview 7, Page 3, Line 17)

	I mean it's more likely to be the oldest kid who becomes parentified but not always. I've seen second kids do it. (Interview 8, Page 3, Line 4)

Superficial Peer Relationships

Peer relationships were said to be superficial by three out of eight participants.

Common responses were that the child may have many friends that they know a lot

about, but that the friends know very little about the child or the family. Also, the child

can make friends, but the longevity of the relationship isn't there.

Table 12. Participants' Response in Regards to Superficial Peer Relationships

Theme	Quotations
Superficial Peer Relationships	*There are no peer relationships other than superficial relationships.* (Interview 1, Page 1, Line 11)
	I've witnessed that they have a lot of friends, but the friends don't know anything about them. They know everything about all of their friends… they are very closed to their own situation. (Interview 5, Page 2, Line 32)
	A lot of times kids who are anxious are good at making friends but maybe not keeping them because they might be outgoing but something will happen. (Interview 6, Page 1, Line 52)

Helpful Therapeutic Techniques for Child and Parents

Participants were asked about what helpful techniques are used for treating

children and parents. Three themes were generated by the participants' responses. These

included: *Psychoeducation, developing regulation*, and *engaging the parent and child*

together.

Psychoeducation

Four out of eight participants' said that psychoeducation was a helpful technique

for both the child and the parent. Psychoeducation ranged from how helpful regulation

can be for both the parent and child's reactions to symptom identification. Participants

talked about how this technique can be normalizing to the parent's experience of himself

or herself, and how it can reduce fear and anxiety in the child if they have an

understanding of what is going on with the parent.

Table 13. Participants' Responses in Regards to Psychoeducation

Theme	Quotations
Psychoeducation	*I give them a lot of psychoeducation about how helpful it is for them to be able to regulate themselves in the face of their children's dysregulation.* (Interview 3, Page 6, Line 20) *Definitely we do the psychoeducation in the parent group* (Interview 4, Page 5, Line 47) *With kids, I think that doing some psychoeducation about how parents might be reacting to trauma, and how sometimes they can recognize that in their parent and teaching some coping strategies for that. With parents, if they do have PTSD symptoms I think, again, with parents, psychoeducation is really important and helping them learn some self-soothing techniques, some ability to manage their emotions.* (Interview 5, Page 7, Line 25) *I use psychoeducation with not only the child but also the entire family, because when it comes to Latino families, they have a lot of children, and so family is a big issue.* (Interview 6, Page 6, Line 5)

Developing Regulation

Four out of eight participants said developing an ability for the child and parent to

regulate themselves was important. Sometimes the regulation of the individual carried

over to the other person. One participant said that if he could get the child to regulate

himself better, then that could regulation could translate to the parent. Another

participant said that if he could get the client to calm down, then they could actually start

to talk to one another, and that would bring about a connection between parent and child.

One participant spoke of using the therapeutic relationship as a way to introduce

regulation into treatment.

Table 14. Participants' Responses in Regards to Developing Regulation

Theme	Quotations
Developing Regulation	*I'm thinking about ways in which therapy can become a place where there is regulation occurring.* (Interview 1, Page 6, Line 23)
	That attachment attunement work and regulation work with them, really working on redoing that attachment development with them. (Interview 2, Page 6, Line 7)
	So some physiological or emotional response is happening with their child and if I can access that, contact that, get connected to that, then sometimes then the parent is able to regulate themselves more. So If I can try and help regulate their arousal, then they are able to do that with their child. (Interview 3, Page 6, Line 77)
	He just knew if you could get people to calm down you could get them to talk to each other, and one way to get them to calm down was to help them feel understood and not negatively judged. (Interview 8, Page 5, Line 69)

Engage Parent and Child Together

Working with the parent and child together was another helpful technique

reported by three out of eight participants. Feedback by the therapist on the parent child

interaction was useful because it helped give the clients a new perspective on how they

relate to each other. One participant mentioned being an active coach to the parent was

helpful in setting expectations and rules on how the parent could engage the child. This

allowed the parent to feel a part of the process while keeping the child regulated.

Table 15. Participants' Responses in regards to Engaging the Parent and Child Together

Theme	Quotations
Engaging Parent and Child Together	*When I'm working with children, I never work with them outside of the context of the family. So the methods I lean towards are always more systemic.* (Interview 1, Page 7, Line 33)
	I do a lot of coaching with the parents about how they are going to step in (to the session). Then I bring the parent into that so the parent can be

	a part of it as well, and they (kids) can see their parent in a different way. (Interview 2, Page 6, Line 34) *We really try and engage them (parent and child) with each other, to give each other feedback on what they're observing and to slow their interactions with each other down so that they can see the interpersonal dynamics they bring into relationships.* (Interview 4, Page 6, Line 12)

Discussion

Sample

The research sample consisted of eight mental health professionals from the Twin Cites metro area. There were six female participants and two male participants. All were clinical social workers except for one LPCC (PsyD. approval). Initial referrals were provided by committee members, and then those participants provided additional interview opportunities.

There were several strengths to this sample. First, most of the participants were well seasoned therapists. All but one of the participants had over twenty years of experience providing psychotherapy to children and families. Next, most of the therapists used a systemic approach to working with families, so they were familiar with how parental trauma impacts the child's system; they had a wide perspective of the problem. Finally, the participants were able to share many cases that involved several types of parental complex PTSD: Childhood sexual abuse, domestic violence, and refugee/war trauma. The researcher felt the sample was of high quality and provided reliable data. However, there were limitations and biases present.

The sample used in this research project was not representative of a wide range of mental health professionals. All participants were licensed independent clinical social workers except for one licensed professional clinical counselor. As such, the practice and models used by the therapists tended to fall into system perspectives and family therapy models, areas that define social work practice. Other professionals may not have worked through the systemic lens and may have provided other alternative theoretic perspectives on working with children who have parents with PTSD symptoms.

Most of these therapists worked with younger child clients and used case examples to reflect this particularly vulnerable population. Older child clients such as adolescents were not reported on. The older children tend to have greater resiliency with family stressors. They are not as dependent on parents for regulation and have already reached a certain level of developmental autonomy, including higher brain development and function. Thus the impact of parental PTSD may be to a lesser extent on adolescents.

Themes

Many themes were generated from the researcher's questions. The interview structure was designed to focus on parental trauma first so that participants could share data connected from families they believed had parents with post traumatic stress symptoms. The middle section of the interview focused on the impact of the parent's PTSD symptoms on the child, parent-child relationship, child sibling and peer relationships. The last section of the interview structure focused on treatment of the child.

Observations of Child with a Parent who has PTSD

Acting Out Behaviors

It was no surprise that a parent's PTSD symptoms impacted the child in negative ways. The first theme that was identified by three out of eight participants was acting out. The participants talked at length about how their clients acted out in ways that included impulsivity, lying, manipulation, disruptive behaviors and violence. These acting out behaviors were well supported in the literature for working with children from families with high stress, economic issues and histories of abuse (Parsons, 1990 and Cosgrove, 1995). Harkness (1993) Researched children from parents identified with

PTSD and found that often times, these troubling behaviors were the first signs of problems in the family system.

Taking on the Symptoms of the Parent

One of the main themes generated from the participants' responses was that the children were observed taking on the PTSD symptoms of their parent. This finding is supported by previous research on intergenerational trauma with families who have survived war and immigration (Raalte et al, 2007). There is also data linking the abuse of a parent and behavior issues of children in the family. Schechter et al (2007) looked at the transmission of domestic abuse trauma of mothers onto their children. The children from these mothers were found to have higher rates of dysregulation, aggression, danger and distress, and avoidance and withdrawal from their caregivers. Many problems seen in the parent are mimicked in the child.

Lack of Regulation from Parent and Child Emotional Regulation Problems

Child emotional regulation problems and lack of regulation from the parent were strong themes to come out of the data in this research project. This was not surprising given that there is a plethora of data that links a child's ability to regulate emotions from the parent's ability to self regulate and attune to the child's needs (Siegel, 1999). What is interesting is that these wide emotional swings may indicate animal defenses associated with trauma and PTSD: fear, flight, freeze. The researcher speculates that this could be another example of children taking on a parent's PTSD symptom via intergenerational transmission.

It was not surprising to hear that the lack of emotional regulation in the child often made it difficult to be able to recognize emotions in others. Lewis, Amini, and

Lannon (2001) talk about how minds develop from the minds of others. There is a

specific neurological function of mirroring neurons in teaching us to learn emotions from

our parents, and then being able to identify and connect emotionally to other humans.

This is a significant developmental issue for children who have a caregiver that is

emotionally dysregulated. Steele and Steele's (2008) research on the child's ability to

read faces at a pre-verbal level and implications for emotion recognition and regulation

support the importance of parent attunement in early development . As difficult as it is

for these children to develop a sense of their emotional self from their parents, it really

speaks to a greater issue of being able to establish a connection to others.

Isolation

Isolation was another theme reported from participants. Children have been

noticed to either not make very many social connections outside of the family, or they

have many friends but those friendships are of a superficial nature. There were many

reasons for isolation reported in the findings. Sometimes these children were

embarrassed or had shame about bringing friends home. Some kept their distance in

order to protect themselves from activating their traumas. The isolation was also a

learned behavior according to some participants. Some of the cases that the participants

reported included families where some parents were so fearful of being triggered outside

the house that the children were taught (usually indirectly) that there was danger outside

of the family. Isolation in children who have parents with PTSD symptoms is not a

unique finding. Sherman (2007) reports that isolation from the community in children

from parents with a mental illness such as PTSD is very common for a variety of reasons:

shame, embarrassment, learned behavior.

Trauma Bond

A surprising theme to emerge from the data was the idea that a parent with PTSD and a child could develop a trauma bond. Participants talked about how really severe PTSD symptoms in parents could create a traumatic experience for the child. This traumatic experience would then lead to PTSD symptoms in the child. Participants spoke of cycles where a parent would be triggered by something that would happen with their child, and out of fear, the child would be triggered into a fight or fear response to match their parent's arousal. Participants talked about children becoming aggressive and violent which would send their parent's into a dissociative or fight response. There was such a constant state of arousal reaction in the relationship that that is what became familiar and normal. This trauma bond overrode any sort of nurturance, security, or love between the parent and child. This was now how they connected.

These trauma cycles are prevalent in abusive relationship literature. Carnes (1997) reports on trauma bonds in abusive relationships were partners exist in violent cycles but remain together because they a have this maladaptive connection to each other. There has also been research showing that children can be involved in reenactments in parents who have PTSD (Kellerman, 2001), but the idea of a new *trauma bond identity* for a parent and child who continually trigger and retrigger each other was something that the researcher did not see in the literature.

This is a significant finding because in some ways it speaks to the power PTSD has to shift the idea of what connection means in the parent-child relationship. That for some of these families, there didn't have to be safety and security to feel apart of

something. Their cycle of trauma was so ingrained that it was a new way for them to attach and stay connected. This was their safe base.

Child Sibling and Peer Relationships

Sibling Violence and Sibling support

There were two contradictory themes that emerged when participants spoke of the sibling relationships in families where parents have PTSD symptoms. Some participants' spoke of violence between siblings, and some participants reported that siblings used each other for support and help. As one participant said, "a parent's PTSD impact on children is not discrete" (Interview 8, Page 4, Line 10).

It's not surprising that siblings would turn on each other or help each other in times of need. A certain level of conflict and support between siblings is developmentally appropriate. However, the situations reported by the participants were so extreme that they went beyond what would be considered normal. Sibling violence was reported in cases were the parent dissociated frequently and therefore could not attend to the child's needs. As a result, some siblings became very competitive for attention, to the point of physically injuring one another. In contrast, some children really gave up on their parents and found they could only rely on one another to get their needs met.

What was interesting was that these volatile relationships were not black and white. Cases that involved the most violent sibling conflict also showed siblings who were incredibly protective of one another. This incongruence in behavior can lead to a very unstable and unpredictable environment. Not only can kids feel like they are walking on egg shells around the parent, but at times they didn't know if their brother or

sister was friend or foe.   There seemed to be a continuous state of hyperarousal with

these kids that made it difficult to ever have a sense of peace and security. Perry et al.

(1995) reported on the neurobiological implications of continuous heightened states of

arousal for kids. The authors report that specific brain structures involved in stress

response change (become physically larger) and become more sensitive as a result of

continuous traumatic events. It is note worthy that in cases where siblings create

unpredictably violent environments, the impact can be equally, and sometimes more

harmful then the original problem with the parent. The writer speculates that these

contradictory themes may come from cases were young children are in such need for

basic attention, their cognitive reasoning is limited due to a constant trauma response

from the family environment.

Sibling Role Confusion

Another prominent theme that came out of the data was how sibling roles change.

The theme of parentified child, problem child, and disciplinarian were all roll identities

participants reported. This finding is not unique as it has been described at length in the

literature. Jurkovic (1997) reports that the parentified child is often found in families

were the parents are unable or unwilling to full fill the protector and nurturer role. The

author describes how these caretaker children will care for not only the parent, but their

siblings as well. As part of this role, they also can be identified as the disciplinarians-

keeping their younger brothers and sisters in line. Often these child-parents create order

via intimidation and violence leading to further chaos in the family system. Jurkovic

(1997) goes on to say how this developmentally inappropriate role creates all sorts of

behavior issues in the parentified child: life long anxiety, anger issues, and problematic

adult relationships. Harkness (1993) also reported on similar findings to the roles that children take on. He found that children can often take on the roles of rescuer and the identified problem child. The findings in this research project support the existing literature.

Superficial Peer Relationships

Three out of eight participants reported superficial peer relationships. This theme was related to the isolation theme found, but slightly differed because children were shown to connect, but not in meaningful ways. Participants reported that sometimes children feel embarrassed and anxious by their parent's behaviors and often avoid deep relationships to protect themselves. Some children do have relationships with friends, but these friendships are very one-sides; they do not share their experiences and stories. This finding was supported by Persons (1990) research on children from veterans. Many children from families who have trauma histories (parental PTSD) do not do well in social situations and find it hard to make meaningful emotional connections to others. As found in the isolation theme, parents themselves do not model how to connect outside of the family.

Helpful Therapeutic Techniques for Child and Parents

Psychoeducation

Psychoeducation was the first theme to be reported as a helpful technique when working with child clients. Four out of eight participants felt that giving their clients information about the nature of trauma and PTSD and how they impacted the family was very helpful. Many of children are often scared and confused about their parent's strange behavior. Some children believe they are to blame for the stress in the family, and often

take on feelings that they are unlovable. Psychoeducation was shown to reduce feelings

of guilt and shame, and it led to a more normalizing experience for the children. Silva et

al. (2003) confirmed the usefulness of psychoeducation with young clients who have had

traumatic experiences. Their findings were associated with children who actually had

PTSD, not just the parents. However, they felt the technique was a useful cognitive

intervention to help children make senses of their experiences around trauma and PTSD.

Developing Regulation in Session

Developing regulation was the second theme to emerge for helping children

clients. Four out of eight participants felt that working on emotional regulation was one

of the first things to do with clients who were experiencing similar symptoms that were

seen in the parent. Participants said that before they could do any meaningful work, they

first had to build trust and security in session. All new therapy clients need to feel safe

with their therapist. Children who have not had a regulated attachment to their caregiver

often vacillate between arousal states so much that just being able to talk about their

problems is not possible. Perry and Szalavitz (2008) confirm this important finding by

saying that before any meaningful change can happen in therapy, the therapist must

ascertain how well the child can regulate him/her self, and how to deal with retriggering

in session and at home.

Engage Parent and Child Together

The last theme to emerge for helpful techniques when working with a child who

has a parent with PTSD symptoms is engaging the parent and child together in therapy.

Three out of the eight participants said that this was key to treatment success. Given the

relational implications discussed in this research project, a systemic approach to helping

children was necessary. No matter how much change and relief that can come from

individual therapy with the child, they always have to return to a broken system. As one

participant pointed out, "what's the point." Harkness (1991) agreed that family therapy

with the parent and child would be a very helpful treatment model for children of parents

with PTSD. However, the therapist must make a careful assessment of whether the

parent is able to participate in therapy, or would a referral for individual therapy be more

appropriate first.

Researcher Reaction

The researcher was surprised that no participant talked about veteran trauma and

how families of soldiers with PTSD impacted their children. The researcher expected,

given the popularity of PTSD diagnosis in this population, that there would be more cases

shared that involved war trauma. Most of the literature found on parental PTSD and the

impact on the child stemmed from data collected from veterans' PTSD cases. Even

though the sample was small, it really suggested that PTSD symptoms are a much bigger

problem outside of the military.

The greatest difficulty the researcher had was not to lead the interview in ways

that would support what the researcher already thought about the impact of parental

PTSD on the child. Attachment theory and the ecological systems theory model were

used as the conceptual framework because the researcher believed these theories were

sound and important for understanding the relational challenges of parental PTSD. When

participants reflected on their perceptions of child-parent relationships, the researcher

noticed that he would be more drawn to responses that were framed through attachment

or a systems perspective because that was what was familiar.

Limitations and Recommendations for Future Research

There were several limitations to this research project. First, given the nature of trauma, many of the parents in the case examples did not have a formal diagnosis of post traumatic stress disorder. Often, parents aren't aware of lingering effects of trauma, especially if they were subjected to early developmental and complex trauma. Participants shared stories and examples where they observed symptoms in the parents, but clear clinical diagnosis was often not possible. It would be valuable to have future research that had more reliable criteria to identify parents who had an actual PTSD diagnosis. Also, it would be helpful to look at the differences between a DSM diagnosis for PTSD tied to a specific traumatic event vs. a complex PTSD diagnosis, and if there were differences in impact on the child.

This research project did not distinguish between the ages of children, and how maturity changes the impact of parental PTSD symptoms. Younger children are at a much greater disadvantage for coping skills compared to older adolescence because of immature brains (more vulnerable to traumatic stress), and limited social connections (for safety and security). A recommendation for future research could include a study on how the age of the child influences their resiliency to parental PTSD. Interviews and or surveys could be conducted with professionals around the specifics child development and exposure to parental PTSD.

The sample for this research project was small and not random. As such, the data can not be generalized to a population of all clinicians working with children who have a parent/parents with PTSD. A recommendation for future research would be to do an online survey where a larger randomized sample of participants could be gathered.

Implication for Social Work

This research project focused on the parent-child relationship and how post traumatic stress of the parent can interfere with that bond. All of the findings in this paper were supported in the existing literature. However, the theme of a parent-child trauma bond and how invasive the trigger/re-trigger cycles could be to the family system was the most important finding of the paper.

Social workers often practice from a systemic perspective, even in individual psychotherapy. So, the idea that parents who are mentally ill impact their child in profound ways is not surprising by any stretch of the imagination. What is important is that future research and policy for families who have trauma histories focus on systemic approaches to care. There are many mental health professionals that do not treat the system. A potential implication may be that there is a tendency to blame the child as the problem and miss an opportunity to address the real issue in the parent's experience. Well trained social workers that provide therapy to children understand that to truly create meaningful change, system interventions are needed. It is the social workers job to spread the word and educate so that money and time are allocated in the most helpful ways.

Another implication for social work is the importance of understanding the trauma bond through an attachment perspective when dealing with these families. It can be easy to forget about the parent's history and experience when treating the child. It can also be difficult to include the parent in treatment especially if the parent has been abusive or neglectful to the child. Sometimes it doesn't make sense why children and parents still stay connected when the relationship is so painful and dysfunctional. Attachment theory has its base in biology and evolution, so it's important to remember

that the parent-child connection is entwined on a cellular level. Implications for treatment may be to find strategies to work with the parent and the child together in a collaborative way to interrupt the activation cycle and create new connection identity.

Conclusion

The purpose of this research project was to investigate the impact of parental PTSD symptoms on the child. The researcher was curious if the existing literature could be substantiated by the experience of a mental health professionals' experience.

The participants of this study brought years of experience and a wealth of knowledge to working with this client population. All had received advanced training in family systems and trauma practice. Although all of the participants were from the Twin Cities metro area, they reported that their caseloads had socio-economic diversity.

The qualitative design of this research project was a strength. Most existing research on parental trauma and the impact on children were from quantitative designs, emphasizing statistical analysis and short answer survey collection. The researcher felt that more in-depth information was gathered from the clinicians' cases, especially when they used their own words to convey the client's experience. Their stories were provocative and informative in ways quantitative data could not express. The use of a research assistant in independently identifying themes added to the reliability of the qualitative data.

Most of the findings in this project were supported by existing literature. However, the concept of the trauma bond between the parent and child was significant, as it had previously just been reported in domestic abuse relationships. To hear the

experience of a child and parent who were so deeply entrenched in fear and shame, and as a result of something that was out of their control, was remarkable.

On any given day, the news media will cover stories of war, rape, death, poverty, and other abuses of humanity. Few of these stories will go into the detail of the victims' experience. Even fewer will mention the impact on relationships to their children. And hardly any will mention the trauma and PTSD effects on the individual child and their world. Given the pervasive and invasive nature of PTSD, and how it affects the individual and their connection to others, some trauma researchers believe that children exposed to trauma (either directly or indirectly) is the greatest public health challenge we face as a society today (Van der Kolk, 2007)

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Appendix A.

The Impact of Parental PTSD on the Child
St. Catherine's University
RESEARCH INFORMATION AND CONSENT FORM

Introduction
You are invited to participate in a research study investigating parental post-traumatic stress disorder (PTSD) symptoms and its impact on a child . This study is being conducted by Michael Schaeffer, a student in the MSW program at St. Catherine University and supervised by Dr. Michael Chovanec. You were selected as a possible participant in this research because you are a mental health professional who provides psychotherapy to children. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:
The purpose of this study is to look at the impact of parental PTSD symptoms on a child. Approximately eight people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to do the following things: Meet with me for an in-person 60-minute interview and complete a demographic information form. An audio recording of this interview will be made. A transcript will then be made from the audio by a third party. This transcript will be shared with a research assistant for a reliability check, and the data will be presented in a research paper and a school presentation.

Risks and Benefits:
A potential risk of this study is that you may experience vicarious trauma when you share difficult and traumatic stories.

The study has no direct benefits.

Compensation:
There will be no compensation for participating in this research project.

Confidentiality:
Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. Transcript records will be kept in a locked file in my office filing cabinet. I will also keep the electronic copy of the transcript in a password-protected file on my computer. A third party will transcribe the audio for the purpose of analysis. A research assistant will review the transcript of the interview for analysis, but will not know who you are. Both the transcriber and research assistant will sign a confidentiality agreement. I will delete any identifying information from the transcript. Findings from the transcript will be presented and discussed in a research paper as well as a research presentation. The audiotape and transcript will be destroyed by July 1, 2012.

Voluntary nature of the study:
Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to

participate will not affect your current or future relations with St. Catherine University, or the School of Social Work. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected. Your relationship to the University of St. Thomas and St. Catherine's University will not be affected.

Contacts and questions:
If you have any questions, please feel free to contact me. You may ask questions now, or if you have any additional questions later, you can call the faculty advisor, Dr. Michael Chovanec. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Lynne Linder at lelinder@stkate.edu, 651-690-6203.

You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.
_____

I consent to participate in the study and I agree to be audio taped.

_____
Signature of Participant   Date

_____
Signature of Researcher   Date

Appendix B.

<u>Why Are You Crying?: The Impact of Parental Trauma on the Child</u>
<u>Research Instrument Page #1</u>

*Please complete these demographic questions prior to our interview.

<u>Participant Demographics:</u>

Ethnicity: [ ] White [ ] White, non-Hispanic [ ] Hispanic [ ]African-American

                             [ ] Asian- Pacific Islander [ ] Native American [ ] Other

Gender: [ ] Male [ ] Female

Age: [ ] 25-29 [ ] 30-34 [ ] 35-39 [ ] 40-49 [ ] 50-59 [ ] 60+

Yrs. of practice: [ ] 3-5 [ ] 6-9 [ ] 10-14 [ ] 15-19 [ ] 20+

Licensure: [ ] LP [ ] LICSW [ ] LMFT [ ] LPCC

Would you list any specialized training or certifications you have obtained:

Appendix C.

<u>Why Are You Crying?: The Impact of Parental Trauma on the Child</u>
<u>Research Instrument Page #2</u>

*Please review these questions before we meet. If it is helpful, you may make notes under the questions.

<u>Interview Questions:</u>

1. When working with child clients, have you observed PTSD symptoms in the parent? If so, briefly describe the types of trauma you have identified with parents, and the PTSD symptoms?

2. Would you share a few cases that involved parental PTSD symptoms and what you have noticed with the child?

3. To what extent does a parent's PTSD symptoms impact the parent/child relationship?

4. How has a parent's PTSD symptoms influenced the child within the family, in the community, and outside the local community (if applicable)?

5. How has a parent's PTSD symptoms affected the child's sibling and peer relationships?

6. How do parents think of their PTSD symptoms affecting their child, and are they themselves involved in treatment?

Why Are You Crying?: The Impact of Parental Trauma on the Child
Research Instrument Page #3

Questions continued:

7. What therapeutic techniques are helpful when working with children and parents affected by parental PTSD symptoms?

8. How do you engage the parent in the treatment process of the child?

9. How do you define success in treatment with your child clients? Are the parents PTSD symptoms taken into consideration when you define success?

10. Is there anything else that you can think of that would be helpful for me to know?

Appendix D.

Transcriber Confidentiality Agreement

St. Catherine University

I Don't Understand You: The Impact of Parental PTSD Symptoms on the Child

I, _____ [name of transcriber], agree to transcribe data for this study. I agree that I will:

1.   Keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., disks, tapes, transcripts, digital files) with anyone other than _____ [name of researcher], the primary investigator of the study;

2.   Keep all research information in any form or format (e.g., disks, tapes, transcripts, digital files) secure while it is in my possession. This includes:
   - Using closed headphones when transcribing audiotaped interviews;
   - Keeping all transcript documents and digitized interviews in computer password-protected files;
   - Closing any transcription programs and documents when temporarily away from the computer;
   - Keeping any transcripts in a secure location such as a locked file cabinet; and permanently deleting any email communication containing the data;

3.   Give all research information in any form or format (e.g., disks, tapes, transcripts, digital files) to the primary investigator when I have completed the research tasks;

4.   Erase or destroy all research information in any form or format that is not returnable to the primary investigator (e.g. information stored on my computer hard drive) upon completion of the research tasks.

_____   _____
Signature of transcriber   Date

_____   _____
Signature of researcher   Date

Appendix E.

Research Assistant Confidentiality Agreement

St. Catherine University

I Don't Understand You: The Impact of Parental PTSD Symptoms on the Child

I, _____ [name of research assistant], agree to review and open code the interview transcripts for this study. I agree that I will:

1.   Keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., disks, tapes, transcripts, digital files) with anyone other than _____ [name of researcher], the primary investigator of the study;

2.   Keep all research information in any form or format (e.g., disks, tapes, transcripts, digital files) secure while it is in my possession. This includes:
   • Using closed headphones when transcribing audiotaped interviews;
   • Keeping all transcript documents and digitized interviews in computer password-protected files;
   • Closing any transcription programs and documents when temporarily away from the computer;
   • Keeping any transcripts in a secure location such as a locked file cabinet; and permanently deleting any email communication containing the data;

3.   Give all research information in any form or format (e.g., disks, tapes, transcripts, digital files) to the primary investigator when I have completed the research tasks;

4.   Erase or destroy all research information in any form or format that is not returnable to the primary investigator (e.g. information stored on my computer hard drive) upon completion of the research tasks.

_____   _____
Signature of research assistant   Date

_____   _____
Signature of researcher   Date

Appendix F.

Email Template

Hello _____,

My name is Michael Schaeffer and I am a graduate student in the social work program at the University of St Thomas and St. Catherine's University. I got your name from _____ at _____.

I am conducting a research project investigating the impact of a parent's PTSD symptoms on their child from a clinician's perspective. _____ thought you might be able to help me. I'm seeking a licensed mental health professional (LP, LICSW, LMFT, LPCC) with at least three years experience working with children (1-18yrs.) I am interested in your experience with children where a parent has PTSD symptoms.

If you are interested in participating in this research project, I would ask for a 60 minutes interview with you. An audio recording will be made from the interview for transcription purposes. I will also have you fill out a demographic information form. The data gathered from our interview will be confidential and kept in a secure location. I would supply you with a list of interview questions and consent form before you commit to meeting with me.

If you have questions or would like to participate, please feel free to contact me via email or phone.

Michael Schaeffer