Posttraumatic Growth Following Adversity in Children Experiencing Divorce: An Integrative Framework

A Clinical Dissertation

Presented to the Faculty of
The California School of Professional Psychology
San Francisco Campus
Alliant International University

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By
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December 2013

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An Integrative Framework

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in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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Abstract

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The purpose of this study was to gain a better understanding of the ways in which children grow from trauma, also known at Posttraumatic Growth. Six semi-structured interviews were conducted of child therapists who believed they had treated a case in which the child had a growth reaction following a parental divorce. Specifically, interviews sought to elicit information about how the child evidenced growth, to what the therapist attributed the growth, and what therapists can do to support a growth reaction. A thematic analysis of the interviews was conducted. Results indicate that children evidence a post-divorce reduction in symptoms alongside an increase in academic, social, and emotional engagement, as well as an increase in their engagement with therapy, indicative of PTG. Participants attribute this growth to a combination of factors, including the therapist attempting to work with the parents, the child gaining protection from the divorce, the role of adult-others outside the family (coach or church leader), adequate time for cognitive processing, and a complex relationship between the child's endowed and learned capacity for growth. Furthermore, results indicate that therapists can do a great deal to support a PTG reaction in children. Creating safety and trust, and offering support, validation, hope, and optimism appear to be antecedents to a growth

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reaction. Results also show that a therapist's genuine enjoyment of the child has powerful implications for growth following parental divorce. This research contributes to expanding the lens on PTG in children by incorporating the relationship between growth and therapeutic stance. Limitations of this study and directions for future research are also explored.

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Dedication

For Jack, whose courage, vitality, and openness helps me grow everyday.

"Don't let someone dim your light,

simply because it's shining in their eyes."

-unknown

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Acknowledgements

Thank you to the talented collective of people who helped bring this project to life. To Dr. Alan Swope, thank you for encouraging me to think more critically about ideas that are important to me, and for your guidance throughout this long journey. To my committee members, Dr. Al Meza and Dr. Claudia Trinklein-Engman, thank you for your encouraging words and participation in this project.

Thank you to my supervisor, Dr. Carol Drucker, for being my cheerleader and supporter through all of life's events that made it difficult to complete this project. Your words of wisdom and unwavering belief in me have had an enormous impact on my achievements.

Thank you to my family, whose support made it ultimately possible to complete this project. Thank you, John, for your strength and patience, and thank you Jack and Emily for constantly reminding me of my capacity for love…and growth.

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CHAPTER I

Introduction

Within the last two decades there has been increased research and clinical attention placed on the traumatic events suffered by children and the significant psychological reactions such events create (Cryder, Kilmer, Tedeschi, & Calhoun, 2006; Milam, Ritt-Olson, & Unger, 2004; Rubonis & Bickman, 1991; Salter & Stallard, 2004; Tedeschi & Calhoun, 1998). This includes, but is not limited to, depression, anxiety and posttraumatic stress disorder (Salter & Stallard, 2004). This important research has led to increased clinical attention being paid to the psychological sequelae of witnessing or experiencing an event that one perceives as highly distressing. Research in this area also highlights that some children are especially susceptible to trauma, and that in some cases this trauma can be long-lasting and lead to impaired functioning in social, interpersonal, and school settings (Ai & Park, 2005). However, while it has been cited that exposure to major life crises increases the risk of the development of psychiatric disorders (e.g., Rubonis & Bickman, 1991), these reports are outnumbered by those of positive growth experiences (Tedeschi & Calhoun, 2004).

Trauma is certainly widespread and some researchers report that it is commonly experienced (Herman, 1997). It appears to affect people from all backgrounds, in myriad ways. Death of a loved one, divorce, natural disaster, displacement, sexual assault, and physical abuse are all possible traumatic events. In this manner, trauma can be conceptualized as any devastating event which shatters one's assumptions of the world and one's place within it. Survivors of traumatic experiences are thus forced to redefine their place in a new reality (Janoff-Bulman, 1992). Researchers contend that the extent to

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which survivors can accomplish this determines negative versus positive outcomes (Tedeschi & Calhoun, 2004).

It seems clear that not everyone who experiences a trauma develops posttraumatic stress disorder. Despite decades of research, questions linger as to why some people develop a debilitating aftermath when others who experienced the same trauma do not. What characteristics help people to overcome, bounce back, or even flourish after a traumatic event? Are there ways for therapists to help clients achieve these positive results or are the processes uniquely contained within the individual? If research has shown that adults and children alike are capable of experiencing growth as a result of struggling with traumatic experience (i.e., Tedeschi & Calhoun, 2004) why isn't this the subject of greater empirical inquiry?

These questions have remained largely unanswered perhaps due to psychology's considerably narrow focus on pathology and symptoms (Ai & Park, 2005). According to Ai and Park the research, theory, and practice of the past century have failed to investigate any positive aspects of mental health, except in the absence of pathological symptoms. To this end, it seems positivity has become equated with the absence of negative symptoms. If one is not suffering from depression, one must be happy. However, as human beings we know this to be untrue. Furthermore, constructs such as hope, optimism, fulfillment and wellness are under-researched, leading to a dearth of studies that offer meaningful, positively-framed additions to the field. To some researchers (Huebner & Gilman, 2003) this focus on pathological distress is quite surprising, given that, "…psychology's historical goal [is] making the lives of individuals more fulfilling and productive" (p. 99).

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Indeed, it seems undisputed that the field of psychology has long been dominated by the medical model. This emphasis has led to extensive research in the areas of disease and subsequent psychopathology. While it is undeniable that this has been of immense value to the field (without it we would have no classification system such as the DSM-V), a pathogenic focus has led researchers and practitioners toward interpreting the negative meanings of "abnormal" symptoms. Clients are classified based on what they lack; for example, rational thinking, enjoyment, impulse control, or adjustment. Consequently, this has led professionals away from focusing on the positive characteristics that make life meaningful (Seligman & Csikszentmihalyi, 2000).

With a renewed focus on what Sheldon and King (2001) term "the average person," psychology can get back to studying the effective functioning of the human being. While a focus on pathology is important in certain capacities (for diagnosis and a common professional language), an orientation towards positive psychology urges psychologists to "…adopt a more open and appreciative perspective regarding human potentials, motives, and capacities." (Sheldon & King, 2001, p. 216). This is not at the exclusion of human suffering; this perspective is an alternative to the victimology that has been upheld as a psychological tradition (Seligman & Csikszentmihalyi, 2000).

One of the ways to break the mold of pathogenic terminology is to consider that some people grow, indeed flourish, from trauma (Keyes, 2007). In the last decade, as interest has shifted to a growing emphasis on positive psychology, there has been developing literature on the positive psychological changes that can follow the experience of traumatic events (Woodward & Joseph, 2003). Resiliency has been identified as an asset that many children and adults have that enables recovery from

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trauma. Resilience has been the source of vast empirical and philosophical inquiry; a simple keyword search into the PsychInfo database results in 2,348 related articles (retrieved March 11, 2009). Growth as a result from trauma is a slightly different construct. The idea is differentiated from *resilience* by a recovery from trauma that exceeds a prior level of functioning (Park et al., 1996; Tedeschi & Calhoun, 1996). It is not simply a return to pretrauma baseline, but a change in life perspective that is qualitatively richer than prior to the trauma.

Many terms have been identified that express this growth: *posttraumatic growth* (Tedeschi & Calhoun, 1996), *stress-related growth* (Park et al., 1996), *flourishing* (Keyes, 2007; Ryff & Singer, 1998), *positive by-products* (McMillen, Howard, Nower, & Chung, 2001), *discovery of meaning* (Bower et al., 1998), *positive emotions* (Folkman & Moskowitz, 2000), and *thriving* (O'Leary & Ickovics, 1995). Other terms that view positive changes as coping mechanisms include *transformational coping* (Aldwin, 1994) and *positive reinterpretation* (Sheier, Weintraub, & Carver, 1986). It is unclear within the research how these constructs are differentiated from one another; they are all very similar. However they differ, each is indisputably rooted in a positive, salutogenic framework that views trauma as an opportunity for growth.

While little is known about the process through which such growth occurs, the evidence is overwhelming that certain individuals facing highly traumatic experiences produce significant positive changes in their life. Because children are at a particularly dynamic point in their development (Huebner et al. 2004), using a positivist approach might enable them to better process highly challenging life circumstances. Focusing on developing strengths and positive responses to adversity might ultimately lead to growth.

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Indeed, while it remains important to uncover the developmental pathways to psychopathology, our clients would clearly benefit from our understanding of the avenues to psychological well-being as well (Larson, 2000).

It is apparent that the use of positive psychology, and its subset of posttraumatic growth, has been well documented in adult populations (see Seligman, Steen, Park, & Peterson, 2005; Tedeschi & Calhoun, 2004). Less research has been done to prove that posttraumatic growth exists for children, but what little exists shows positive results (Milam et al., 2004). With knowledge of the avenues to psychological well-being and research showing that children do experience posttraumatic growth, perhaps a logical recognition is that children grow from trauma, indeed move on, with a greater frequency and fervor than is currently known. That growth is a process, rather than a static outcome, makes its conceptualization in children more difficult.

To this end, I will attempt to demonstrate that posttraumatic growth indeed occurs for children, particularly when embedded within a framework of positive psychology and the experience of positive affect. With an ample review of the literature I hope to show that while the concept of posttraumatic growth is valid for children, perhaps its terminology is insufficient for capturing the true essence of a child's moving on from trauma. To accomplish this, I will compare and synthesize current research in the fields of positive psychology, posttraumatic growth, and child psychosocial development in an effort to analyze critically the components necessary for properly discussing, recognizing, and encouraging growth from adversity in children. Furthermore, I will analyze six clinical cases from child therapists in an attempt to show that growth does, indeed, occur in children experiencing family transition (divorce). Using thematic analysis to highlight

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important themes and evidence of growth, I hope to create concrete suggestions for working with children and adolescents experiencing family transition, aimed also at the prevention of future adverse reactions to trauma. Perhaps this would prevent lasting or future psychopathology. It is my opinion that the literature is insufficient in its attention to these important issues.

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CHAPTER II

Background

Within the last 20 years there has been a surge of research in the areas of interpersonal violence, natural disasters, war, serious accidents, physical abuse and other highly challenging life circumstances, which has broadened our understanding of the relationship between trauma and recovery (Ai & Park, 2005). This research has raised many questions regarding resilience and survival, the largest and most important of which could be why some people develop posttraumatic stress disorder as a result of struggling with challenging circumstances, while others who have experienced the same trauma do not. What characteristics support growth and can these traits be taught or are they intrinsic and unique to the individual?

Posttraumatic Growth

Many researchers have sought the answer to this question, including Tedeschi and Calhoun (1996) who proposed the idea of *posttraumatic growth* (PTG). The term refers to "…the positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). PTG is characterized by transformative life changes that go beyond illusion and are not considered coping mechanisms. Instead, researchers see PTG as a movement beyond one's pretrauma level of functioning. This qualitative change in functioning results from what Tedeschi and Calhoun, the premier authors on PTG and developers of the Post Traumatic Growth Inventory, called "…the shattering of fundamental schemas" (p. 4) that occurs concomitantly with trauma. Because life crises often challenge a person's assumptive world, survivors are forced to redefine their place in a new reality (Janoff-

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Bulman, 1992). Researchers contend that the extent to which survivors achieve this can determine posttraumatic growth. To be sure, though growth is often experienced and viewed as a positive shift in life, the events themselves are highly distressing and not viewed as desirable (Tedeschi & Calhoun, 2004).

Posttraumatic growth is differentiated from *resilience* by a recovery that exceeds a prior level of functioning. In this manner a person actually uses the traumatic experience to build and grow, whereas resilience might be considered a protective cushion. This has proven to be a controversial definition, as it appears to posit that PTG is superior to resilience. In their paper, Westphal and Bonanno (2007) argued that resilience lies at the root of PTG, and that if a survivor is resilient there is little need or opportunity for PTG. Few, if any, studies have been able to quantify the difference between the two constructs, which has lead, in recent years, to a surge in empirical examinations.

Despite the semantic controversies between PTG and resilience, recent investigations have provided evidence for the positive effects of PTG in a wide array of traumas experienced by adults. For example, PTG has been documented in prisoners of war (Erbes, et al., 2005), victims of religious persecution (Ting & Watson, 2007), victims of biological warfare (Cheng et. al, 2006), victims of intimate partner violence (Cobb et al., 2006), victims of head injury (Powell, Ekin-Wood, & Collin, 2007), victims of illness such as cancer (Cordova, Cunningham, Carlson, & Andrykowski, 2001), and many others. It seems the effects of posttraumatic growth are documented among many adult populations.

Posttraumatic growth is assessed using the Post Traumatic Growth Inventory, a 21-item scale written by Tedeschi and Calhoun (1996). It measures 5 areas of growth,

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including: "…greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one's life; and spiritual development" (Tedeschi & Calhoun, 2004, p. 6). The scale was developed in order to quantify observable growth, and numerous cross-sectional investigations of correlations indicate that it does so. However some researchers have criticized the measures' inability to take into account subjective responses to open-ended questions, which could arguably indicate more about a survivor's gained insight and wisdom. Similarly, it has been suggested that some research subjects may emphasize the silver linings of their struggle with trauma because they believe they should do so (Peterson et al., 2008). Lastly, there is some speculation in the literature regarding the accuracy with which survivors remember the aftermath of their traumatic event, and the PTGI is criticized for being unable to account for this. It is clear that there is a strong need for longitudinal studies which focus on the posttraumatic reaction or growth itself, and eliminate other factors that are susceptible to empirical contamination.

Factors That Enable PTG

Although it is clear that stress and crisis can provide a catalyst for growth, as yet it remains unclear which processes enable PTG to occur. According to O'Leary and Ickovicks (1995), most models that address resilience and adaptation to trauma do not easily accommodate for PTG due to the multidimensionality of the construct. Whereas resilience and adaptation might be a measurable *outcome*, posttraumatic growth is a *process of thriving and moving on* and thus harder to conceptualize. For example, research by Park et al. (1996) and Tedeschi and Calhoun (1996) indicated that the more

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severe the trauma, the greater the reported PTG. This poses a challenge for researchers who seek to understand the factors that mediate the trauma and reported PTG.

Tedeschi and Calhoun (2004) cited three factors that have proven important to the process of posttraumatic growth in adults. First, personality characteristics of extraversion, openness to experience, activity, and openness to feelings are all modestly correlated to PTG. Perhaps people with these qualities are better able to find positive benefits, and thus able to process negative emotions more effectively. Second, the ability to manage the distressing emotions could be a determinant of PTG. Because trauma can result in the shattering of preexisting schemata, a disengagement from previous assumptions is forced upon the survivor. An ability to keep the cognitive process active may enhance posttraumatic growth (Park, Cohen, & Murch, 1996). Third, Tedeschi and Calhoun cited the importance of support and disclosure following the trauma. Authoring new narratives about one's life "…forces survivors to confront questions of meaning and how it can be reconstructed" (p. 9). Developing a post-trauma narrative requires a significant amount of reflection, insight, and exploration. Rumination is a cognitive process that has been identified by Martin and Tesser (1996) as a conscious, instrumental, event-related process of linking past, present, and future events. While rumination is often viewed as self-punitive talk in modern parlance, this term is effective for posttraumatic growth, and Tedeschi and Calhoun agreed that "…deliberate cognitive processing is crucial to growth outcomes" (2004, p. 11).

Listening for PTG in Psychotherapy

Tedeschi and Calhoun (2004) offered a variety of suggestions for listening for themes of posttraumatic growth when working with clients. Foremost is learning from the

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client, and using their understanding, knowledge, and terminology regarding the trauma. Tedeschi and Calhoun recommended that the clinician highlight themes of growth for the client, but not label things explicitly as PTG. Finally, it is important to emphasize that growth (or meaning) has come about as a result of the *struggle with* adverse circumstances, and not with the circumstances themselves.

Below is a sample transcript given in Tedeschi and Calhoun (2006, p. 304). Evident domains of PTG include spiritual development, improved relationships, and greater personal strength.

C: I do have many regrets, but at least the cancer gave me enough time to change.
T: So that you could use your hindsight now.
C: Yeah, I got a chance to do things better. I sure had it backwards. My customers were my family.
T: And your family got shortchanged.
C: I have straightened that out, though.
T: And your customers also cared about you. These were not merely business relationships.
C: Right. But still, I wasn't investing my time wisely. I might never have seen how much my family loves me if it weren't for having to deal with this cancer. stood by me.
T: And she got a better Fred in the bargain.
C: Amazing. In the pain, fear, money problems, and plain nastiness of this disease, we had a better time than ever.
T: Because you were at your best.
C: I was. I do feel good about how I've handled this. Proud of myself, more than I've ever been. I just hope I can keep it together through this part. I'm getting pretty scared at times.
T: So, how are you getting through this part?
C: That's where God comes in. Man, I need Him now. I can feel pretty stupid while feeling proud. How many times do you hear to put God first, family second, then yourself? I had it the wrong way around. Now it's God and family. I had to live it to get that. I wish it didn't have to come to me like this. Well, I just try to do this part better.
T: This part is important.
C: Yeah, well. It's the only part I got left. It's real important. So I'm focused now.

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Posttraumatic Growth in Children

Evidence strongly suggests that posttraumatic growth exists for adults. It appears that those adults who report PTG have adequate support, cognitive strength and flexibility, and perhaps a more grounded spiritual affiliation. However, there is an obvious absence of PTG research in children. Furthermore, studies are likely to conclude that at least a moderate amount of cognitive maturity is needed to report PTG across the growth domains. Generally, a correlation exists between age and perceived growth, suggesting that older children report more growth than younger ones (Polatinsky & Esprey, 2000). Interestingly, a study by Milam et al. (2004) found that PTG was most highly correlated with optimism, a construct separate and distinct from anything outlined by the original creators of PTG. This finding suggests that PTG is greater than the absence of negative psychological symptoms and that children who have a positive approach to highly distressing circumstances may fare better following trauma. However, because optimism is not a term used in the framework of PTG, even children who are optimistic aren't necessarily associated with experiencing growth as defined by this model.

Empirical Research on PTG in Children

In their study of child survivors of a road traffic accident, Salter and Stallard (2004) found that forty-two percent of participants (aged 7-18) reported at least some posttraumatic growth. This study also measured posttraumatic stress disorder in its participants and found that nearly forty percent of those who reported PTG also reported some symptoms of PTSD (Salter & Stallard, 2004). This suggests two things. Firstly, it highlights the importance of immediate and skilled intervention. Secondly, it further

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proves that the experience of positive and negative affects is not mutually exclusive; one does not mean the absence of the other and they often occur in parallel.

Cryder, Kilmer, Tedeschi, and Calhoun (2006) did an exploratory study of posttraumatic growth in children, ages 6-18, who had experienced a natural disaster. Results indicated that some participants did experience posttraumatic growth, finding a positive correlation with children's competency beliefs. Competency beliefs are children's perceptions of their ability to handle problems, akin to coping strategies. The study also revealed that children with a supportive social environment tended to have higher competency beliefs, leading to greater reported PTG.

A study done by Barakat, Alderfer, and Kazak (2006) found that a majority of cancer survivors ages 11-17 self-reported at least some PTG one year post-treatment. As age of diagnosis increased, so too did perceived benefits. The researchers recommended that greater empirical attention be paid to the area of posttraumatic growth in children to further understand the developmental correlates leading to growth following adversity (Barakat, Alderfer, & Kazak, 2006).

These three articles constitute the entirety of empirical research on posttraumatic growth in children. Though the movement towards understanding the correlates of PTG in children started strong, interest has waned in this area. Because the results are promising and could lead to more answers, one might think this would be a promising field of study.

It has been suggested that the maturation needed to process, ruminate, seek social support and create new meaning in life might simply be too far out of reach for the young, developing mind (Barakat, Alderfer, & Kazak, 2006; Cryder at al, 2006; Salter &

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Stallard, 2004). However, because these empirical investigations have supported that children *do* experience posttraumatic growth, perhaps the model's descriptive terminology is too sophisticated for a child's experience. If this is the case, then perhaps children's growth following adversity is being underrepresented and improperly conceptualized simply due to a framework that is insufficient in its understanding of child psychosocial development.

I now turn to the scholarly literature on childhood emotional development to shed more light on the general ways by which children develop, process, and learn to regulate their emotional experience. I argue that it is possible, indeed, for children to process their emotional experience related to trauma and growth, but that they require a great deal of structure and support to do so, more so than adults.

Children and Emotions

Emotions and cognition. Schultz, Izard, and Bear (2004) showed that children's emotions are inextricably linked with cognitions and behaviors. In their study on emotionality and emotion processing, these researchers found that emotion, cognition, and behavior are interdependent, each affecting the others. Such interreliance offers strong implications for children who have experienced a traumatic event; a child who feels sad would be expected to experience depressive thoughts, and, based on these findings, would also be reasonably predicted to exhibit aggressive or acting out behaviors. Another important finding of this study was that a child's expression of emotionality can actually predict patterns of emotion attribution. In this study, happier children were more likely to attribute their experiences as positive, and anger-prone children were more likely to attribute experiences as negative (Schultz, Izard, & Bear,

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2004). Indeed, it seems that cultivating a positive outlook in children is an important part of emotional development. This was corroborated by Isen (2000), who found that a child's positive mood can help to facilitate information processing and decision-making. However, it is undisputed that children don't always have a positive frame of mind. As such, they must learn to manage their emotionality.

Emotion regulation. Emotion regulation refers to the self-monitoring and modification of emotions and emotionally-related behaviors (Southam-Gerow & Kendall, 2002). This generally occurs concomitantly with the development of emotion understanding, loosely defined as knowledge of the indication of, reason for, and ways to regulate emotion (Southam-Gerow & Kendall, 2002). A great deal of research has been conducted on children's self-regulation and effortful control of emotions (for a review, see Spinrad, Eisenberg & Gaertner, 2007). Strategies of self-regulation can be seen as early as infancy (for example, sucking on the thumb) and continue to evolve with increasing complexity as cognitive and social development strengthens. Of key importance is that young children require help with structuring their affect, especially in emotionally overwhelming situations (Landy, 2002; Scharfe, 2000).

Dysregulation of one's emotions, or a difficulty understanding and managing affect, has been found to lead to psychopathology in children (Southam-Gerow & Kendall, 2002). Due to the interconnectedness of emotions, cognitions, and behaviors, a difficulty soothing oneself after upset would likely lead to an overwhelm state where regulation is made even more difficult. A pattern of this response style could leave a child grossly unarmed for his/her adult life. Preliminary research by these researchers also

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suggested that children who have difficulty understanding the emotions of others are also at risk for psychopathology (sadness, withdrawal, acting out, or aggressiveness).

Emotional competence. Research indicates that knowledge and understanding of both one's own, and others' emotions predicts social, academic and behavioral outcomes, including peer acceptance, social skills, and fewer aggression problems. (Eisenberg et al., 2001; Mostow, Izard, Fine, & Trentacosta, 2002; Trentacosta, Izard, Mostow, & Fine, 2006). It has even been suggested that emotional competence is essential to child development, and that poor emotion knowledge and understanding is likely to lead to increased stress and distraction for children (Saarni, 1999).

Trentacosta et al. (2006) suggested that a child with adequate emotional competence is protected from some adverse emotional effects of trauma. Attending to feeling states and being able to think about how feelings might be affecting cognitions and behavior helps to ward off confusing negative emotion following trauma. Furthermore, these researchers also suggested that the skills associated with emotional competence (capacity for empathy, emotional knowledge, adaptive management of emotions) act as a valuable prevention tool.

Research in the area of child and adolescent emotionality has revealed that children are, indeed, capable of experiencing, processing, and thinking about their complex emotions. This is evident from infancy and continues to develop throughout the lifespan. In order to understand how children experience their emotions following trauma and demonstrate positive change, a closer look at research highlighting the concrete markers of positive change is helpful. A thorough review of this literature serves a double purpose: first, to learn more about how children can be positively changed by adversity,

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and second to help form a model by which to evaluate cases of children who have experienced a traumatic event.

How Is Growth Evidenced?

Cognitive and behavioral indicators of positive change in children. Children show evidence of positive change in many ways related to cognition. For instance, positive growth can be seen when a child's way of thinking demonstrates positive attributions of past events, and positive expectancies of future events (Huebner, Suldo, & Valois, 2005). This is characterized by an overall sense of hope, or an orientation towards optimism (Snyder, 2005). Furthermore, a child's ability to demonstrate perspective-taking has been linked with positive growth and change. In this manner, a child is able create enough cognitive distance to be able to see different scenarios more clearly for herself (Barber, 2005). Akin to this is positive self-talk, which has been pointed out by Wolters, Pintrich, and Karabenick (2005) as an important marker of positive change in the area of self-regulation. According to these researchers, this kind of positive inner monologue relates to motivation and engagement in many areas of a child's life (academics, athletics, family connection, and so on). Children who become more cognitively invested in their lives also show evidence of positive growth and change (Fredricks, Blumenfelt, Friedel, & Paris, 2005). This is most commonly seen in a school environment where being thoughtful and willing to engage in the mastery of new skills is typically related to overall success. Similarly, a child who demonstrates goal-directed thinking and who can evaluate both *what* the goal is and *how* to attain it, certainly indicates positive change (Snyder, 2005).

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Behavioral evidence of positive growth and change can be commonly seen at school. Here, a strong maker for change is an enduring attachment to the child's school, including teachers and other adult personnel (McNeely, 2005). Likewise, new or continuing participation in activities, both during and after school, can reflect positive change. Joining a club, team, or group should not be overlooked as an important behavioral transformation (Hofferth & Curtin, 2005). Groups such as these help a child gain a sense of community, and thereby enhance one's sense of identity. Identity formation and support—including all variations of one's identity (ethnic, social, familial, racial)—was hailed by Umana-Taylor (2005) as one of the most significant aspects of childhood. An enduring and evolving identity, or sense of self, undoubtedly reflects an area of positive growth and change. Positive behavior changes in the home, such as a stronger engagement between child and caregiver, greater engagement in commitment and responsibility to the family, and overall closeness and attachment to caregiver are perhaps the foremost indicators of positive behavior changes in the home (Hofferth & Curtin, 2005).

Social and emotional indicators of positive change in children. Children who display certain social traits give evidence that positive change has occurred. Children who maintain a sense of social belonging, or develop a new group of supportive peers have demonstrated positive growth (McNeely, 2005). Similarly, demonstrating empathy and concern for others, and communicating with peers are linked with positive outcomes (Barber, 2005). Altruism, positive self-esteem, and a resistance to peer-pressure have also been found to be indicators of positive change (Benson, Scales, Sesma Jr., & Roehlkepartain, 2005). Finally, an attachment or positive engagement with an adult

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outside the family generally indicates a positive step (Benson et al., 2005). This could take the form of a mentor, pastor, coach, family friend, or even teacher.

The array of emotional indicators of positive change is broad. Perhaps one of the more obvious markers of change is a child's feeling of resilience and inclination to fight current and future adversities (Benson et al., 2005). This appears to be related to perspective-taking, positive attributions, and hope, and is considered to be an important indicator of a child's posttraumatic well-being. Related to this is a child's acceptance of, and reduction in uncertainty, as well as an overall positive life satisfaction (Huebner, Suldo, & Valois, 2005; NcNeely, 2005). A display of pride and self-assertiveness are also markers that have shown positive emotional change (Epps, Park, Huston, & Ripke, 2005). Coupled with a greater internal locus of control, these children can often feel more in control than they did previously. Finally, the child who learns to ask for help, whether in school, at home, or in therapy, shows clear evidence of positive growth (Wolters, Pintrich, & Karabenick, 2005).

Academic indicators of positive change in children. Many of the ways in which children demonstrate positive growth and change can be seen in the school setting. Overall school success, underscored by sustained focus and increased concentration, appears to be a strong indicator of positive change (Epps, Park, Huston, & Ripke, 2005). According to these authors, a child's ability to stick with one activity and persevere through a difficult learning task shows a high level of attention and awareness. Anderman, Urdan, and Roeser (2005) stated that when a child's approach to classroom learning is based on mastery, wherein the child becomes more curious, determined, and motivated to learn, positive change has occurred. Finally, a close attachment to school

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personnel, including teachers or administrators, has been shown to be a protective factor for children, which indicates positive growth (NcNeely, 2005).

Children have been found to flourish and grow from their traumatic life experiences in a range of ways. Whether large or small, observable or unseen, evidence exists which supports that children grow. With psychology's predominant focus on pathology therapists are rarely taught the skills needed to look for positive growth. Furthermore, oftentimes our work with children is insufficiently informed by our work with adults. While there may be continuity in the psychological *meaning* of something, the behaviors of adults and children differ throughout the lifespan and across developmental stages. For example, though both a child and adult might understand the meaning of "bravery," the way a child shows bravery will differ significantly from an adult. In this way, positive change among children must be assessed thoughtfully and carefully.

Positive Psychology and the Experience of Positive Affect

A look at the positive psychology movement might offer a more multidimensional, unique perspective about trauma and recovery in childhood and adolescence. This orientation places emphasis on positive emotions and fostering the factors that allow an individual to flourish (Seligman & Csikszentmihalyi, 2000). Proponents of positive psychology do not differentiate it from other modalities, per se; they claim it is nothing more than the study of strength and human virtues (Sheldon & King, 2001). Indeed, some view positive psychology as the original mission of traditional psychology, aimed at helping others to live their best life (Ai & Park, 2005).

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Original authors of *Positive Psychology* suggest that psychologists "…know very little about how normal people flourish under more benign conditions" (Seligman & Csikszentmihalyi, 2000, p. 5). They posit that the century-old, nearly exclusive focus on pathology and symptoms has led researchers away from a focus on hope, optimism, interpersonal skill, wisdom, and tolerance, among others. Indeed, a vast amount of research is conducted in the areas of diagnosis and treatment of pathologies; a simple PsychINFO keyword search on the term *psychopathology* yielded far more results (13,400) than did a search on the terms *strength* (5186) and *virtue* (606) combined (retrieved March 11, 2009).

It also appears that the disease model of functioning neglects a positive bias (Sheldon & King, 2001). These authors pointed out, for example, that psychologists are quick to look for narcissism in a kind act, rather than altruism. This suggests that some psychologists are so affected by this negative bias that it could conceivably prevent them from recognizing other, perhaps more important, human strengths and outcomes. How might this bias affect children and adolescents? How could a positive psychology orientation help children process, and perhaps grow from, highly challenging life circumstances?

Positive psychology includes three domains: positive subjective experiences, positive individual traits, and institutions that promote them (Seligman & Csikszentmihalyi, 2000). The characteristics that comprise these areas of functioning are thought to offer a protective buffer against developing negative psychopathologies (Huebner & Gilman, 2003). Thus, one could view positive psychology as a preventative form of psychology that serves to protect, indeed, arm a person with the cognitive skills

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to ward off negative effects of traumatic experiences. Therefore, it appears that the benefit of utilizing a positive psychology approach with children is twofold: provide therapy in the moment, while at the same time promoting higher levels of self-esteem, self-efficacy, and altruistic behavior to help mitigate future difficulties.

Researchers have shown that the use of positive psychology is a very effective approach for children and adolescents. Scholars such as Huebner and Gilman (2003) call for a more rounded approach to working with children in the schools, stating that school-based psychologists who employ problem-focused therapies are likely to face less successful outcomes (Huebner & Gilman, 2003). Considering that the field's predominant focus is on the remediation of negative symptoms, this could mean that children are being underserved in therapy. With a focus on the positive, children can not only recover from their traumas, but build enduring life skills as well.

Other scholars claim that school-based positive therapy has the potential to be a vehicle for positive human development, as well as to offer protective, preventive, and lasting change (Clonan, Chafouleas, McDougal, & Riley-Tillman, 2004). This is an important addition to psychology's developing understanding of how children react to trauma and should undoubtedly fuel future models. Likewise, while it seems relevant to know the factors that contribute to psychopathology, so too is it important to know the factors and qualities that lead to psychological well-being.

Psychological well-being is often studied in a student population by looking at the construct of subjective well-being. Subjective well-being is concerned with how and why people experience their lives in positive ways and it is comprised of distinct emotional and cognitive components (Gilman & Huebner, 2003). The emotional component

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consists of the frequency with which positive and negative affects are experienced (i.e., happiness, joy and sadness), while the cognitive component refers to overall life satisfaction. Gilman and Huebner (2003) noted that one of the most crucial contributors to childhood life satisfaction is daily positive experience. More importantly, it appears that a cumulative effect of these daily experiences appears to be uniquely related to children, and is more significantly related to overall life satisfaction than other, more discrete, important life events (such as birthdays or graduations) (Gilman & Huebner, 2003). This has significant implications for our young clients recovering from trauma. The authors also showed that certain personal characteristics, such as self-esteem and extraversion, influence life satisfaction. If positive emotions are a direct contributor to subjective well-being, it follows that therapeutic approaches for children should focus on its enhancement.

Though a preponderance of research in this area is conducted on children in the schools, positive-based therapeutic approaches are not limited to that population. Instead, these approaches can, and should, be used across a variety of settings. This might include individual private practice, group settings, and programs with a home visit component.

Helping children explore their subjective experience of trauma has been shown to lead to increased life satisfaction (Huebner, Suldo, Smith, & McKnight, 2004). Perhaps it is in retelling the story of their trauma that children are better able to metabolize its greater meaning. Michael White's (2007) concept of narrative mapping helps clients create a clearer meaning of their life's stories. The premise is to give clients a roadmap whereby navigation is facilitated and better understood. White's idea of scaffolding a child's journey through trauma might aid in growth outcomes.

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According to Huebner, Suldo, Smith, and McKnight (2004) "…[improving] children's lives must also focus on developing strengths, facilitating positive responses to adversity, and strengthening the most important institutions in children's lives" (p. 81). Indeed, Miller and Nickerson (2007) argued that psychology in the schools should focus on the six emerging areas of positive psychology: *gratitude, forgiveness, flow, mindfulness, hope,* and *optimism.* A focus on these domains would positively influence one's ability to cope with serious, as well as everyday adversities. These findings suggest that positive school-based therapy might help children facing challenging life circumstances to grow from their struggle with adversity.

The Broaden and Build Theory of Positive Emotions

The relatively new Broaden-and-Build theory of positive emotions is an exciting new idea that offers further evidence of the importance of positive affect. Authored by Fredrickson (2001), this theory posits that the experience of positive emotions actually broadens a person's inventory of thought-action reactions, thereby building up that person's enduring physical, social, intellectual, and psychological resources. Fredrickson suggested that positive emotions and the broadening effect they have on a person's subjective experience might be a fundamental human attribute that contributes to flourishing.

Complementary analysis of the broaden-and-build theory by Fitzpatrick and Stalikas (2008) suggested that not only are positive emotions *indicators* of change, but they can be *generators* of change as well. They pointed to a cumulative "upward spiral" in which the experience of positive emotions and their broadening effect feed one another, thus generating desired change (p. 137). While Fredrickson (2001) and

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Fitzpatrick and Stalikas emphasized that positive emotions are indisputably influential, they do not negate the importance of negative affect. It seems that negative emotions serve to narrow the focus to know what is of most dire need, whereas positive emotions widen the array of possible reactions.

The idea of broadening is not new, per se. Fitzpatrick and Stalikas (2008) pointed out that the concept already exists within all theoretical orientations, though each therapeutic modality has its own term for the change-event that creates emotion. Psychodynamic patients gain insight, behavioral clients explore their behavioral responses, cognitive-behavioral clients are asked to change their dysfunctional beliefs, constructivist clients create new meanings, and so on. Thus, it appears that broadening is a generic, common factor that can be used with all theoretical orientations, including a positive approach with children.

Benefits of Positive Emotions

Research shows that the experience of positive emotions has many benefits. Firstly, positive emotions alter people's bodily systems. They have an undoing effect in which physiological states are more quickly eased following the cardiac affects of negative emotions, such as anxiety or fear (Fredrickson & Tugade, 2003). Similarly, Fredrickson and Losad (2005) cited that the experience of positive affect can also increase immune functioning. Secondly, the experience of positive affect has been empirically linked to brain development and how long people live (Barish, 2004). Finally, positive emotions alter people's mindsets by increasing one's preferences for variety, broadening acceptable patterns of behavior, and increasing intuition and creativity (Fredrickson & Branigan, 2005).

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Tugade and Fredrickson (2004) have shown how the use of positive emotions can help people bounce back from negative emotional experiences. In their article, the authors revealed that resilient people are mobilized during tough times by the use of humor, optimistic thinking, relaxation, and other positive approaches. The use of these types of positive appraisals is thought to be in a causal, circular relationship with positive emotions wherein one triggers the other. Perhaps most importantly, the authors suggest that the use of positive affect in this manner can lead to greater overall emotion regulation during future adverse situations. This broadening effect leads to an enduring stash of coping resources, and appears to be the keystone to adaptive posttraumatic reactions. Indeed, Fredrickson averred that "…positive emotions are worth cultivating" (2001, p. 218).

Positive versus Negative

The experience of "good" negative emotions can, paradoxically, also facilitate successful outcomes following adversity (Graham et al., 2008). According to these researchers, a willingness to express negative emotions such as sadness and fear can, under the appropriate circumstances, bring two people closer together and develop the pair's intimacy. This has implications in a therapeutic relationship, wherein one's level of disclosure depends directly upon one's level of comfort and connection with the therapist.

According to Graham et al., the expression of negative emotion can actually help people build larger social networks and elicit help during times of need from others within the network. The theoretical framework used by these researchers is not dissimilar from Fredrickson's (2001) broaden and build theory, yet is distinguished by the impact of

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the emotional *expression*, as opposed to the emotional experience. In this case one has to wonder, if the expression of appropriate negative emotions is so good for us and our relationships, then why are we calling it "negative" at all?

This raises the issue of the terms *positive* and *negative* in and of themselves. In psychology, the absence of one does not necessarily mean the other, yet they are frequently used as such. This could create confusing messages for children, who generally are taught to avoid associations with the negative. Furthermore, as children's emotional and cognitive capacities grow, they learn that there are situations in which a person can have mixed feelings (such as feeling sad about divorcing parents, but happy there won't be fighting anymore) (Izard, 2009). This normal developmental process could further confound a child's understanding of what positive and negative really mean.

As Graham et al. (2008) suggested, emotions aren't good or bad, per se, it's what we do with them that counts. A focus on psychopathology locates the experience of negative emotion as a distinct life condition. Perhaps so-called "negative" emotions should be reframed for children as our body signaling us to use them as tools to broaden; for telling us that a challenge is ahead.

It should be noted here that, for children, growth does not exclusively imply forward motion. For some children, growing and moving on from trauma might simply mean being stable until symptoms or danger subsides. This could be any duration of time; days, weeks, or months. In this manner, or in the case of severe reactions to trauma, the fact that a child does not regress should be considered a positive step. While the child may not be growing or thriving as we think of it, the child has not worsened. As such, there is a call for the redefinition of *positive*, as well.

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Clinical Implications

Research has shown that the experience of positive affect is predictive of a range of behavioral, social, and health variables (Joseph & Linley, 2007). Likewise, it appears unequivocal that the value of early positive experiences can facilitate later positive psychological outcomes. It is widely thought that these enduring experiences help to buffer against trauma, and even contribute to growth following adversity (Calhoun & Tedeschi, 2007).

Several researchers have suggested guidelines for working with trauma and positive emotions in therapy. Common to them all is the notion that, although growth can be seen as a universal *tendency*, it is not a universal *experience* (Calhoun & Tedeschi, 2007). Highly traumatic events can be quite distressing, and research overwhelmingly indicates that not everyone finds benefits from their adversities. However it should be noted that simply because one experiences distress, growth is not ruled out. Distress and growth can coexist in distinctly different ways. For example, a war veteran may remember deployment as upsetting and destructive, yet also as providing lessons for living and companionship (Morland, Butler, & Leskin, 2007).

Distress, in many forms, is often the primary symptom and must be worked through in order to ensure that avoidant coping strategies are not embedded within the person's repertoire. Active coping strategies, such as benefit finding and making meaning of the event, usually predict successful adaptation (Morland, Butler, & Leskin, 2007). Children, too, can often show signs of distress (acting out in school, aggression, social withdrawal) while at the same time showing signs of moving on (keeping grades up,

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confiding in caregivers). Active coping, or simply not regressing, should be noticed and positively framed.

Making meaning and finding benefits is best achieved through what Joseph and Linley (2007) term *accommodation*. This is a process wherein a person's existing models of the world evolve to make room for trauma-related information. This is differentiated from *assimilation*, wherein information about the traumatic event is incorporated into a person's existing models of the world. While assimilation causes the person to return to a pretrauma level of functioning, accommodation that occurs in a positive direction ultimately leads to growth (events can also be negatively accommodated, leading to psychopathology). Joseph and Linley (2007) coined these terms for adults and currently there has been no research to conclude whether a child's limited cognitive maturity would allow for a similar process.

Transforming to a new post-trauma life, then, hinges on a person's engagement with the process of adjusting. Successful adjustment calls for grappling with the existential challenges of life, and increasing one's autonomy, personal growth, environmental mastery, and self-acceptance (Joseph & Linley, 2007). Perhaps it is through grappling with trauma that children can enhance their psychological well-being and experience greater positive affect.

A positive psychological perspective such as this one is needed in order to offer young clients opportunities not only for growth following adversity, but for early positive experiences that research has shown can help defend them against future adversity. An illness ideology, which locates maladjustment within an individual rather than his/her interaction with the environment, suggests that problems are biological in nature and

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beyond a client's control. Helping young clients recognize their strengths and competencies in overcoming adversity can increase motivation, self-efficacy, and overall psychological well-being (Tedeschi & Kilmer, 2005). Likewise, young clients are more likely to feel positively about therapy if they feel their therapist gathers a well-rounded, holistic view of them.

Integrating the broaden-and-build theory of positive emotions within the larger framework of the positive psychology movement could offer a more comprehensive way of working with children who are dealing with challenging life circumstances. While the model for posttraumatic growth is essential for working with adults, the criticisms within the PTG literature suggest that the model is insufficient for measuring perceived growth in that population. Moreover, the PTG model does not offer a systematic framework for encouraging, teaching, and enhancing constructs linked to greater outcomes, such as hope, optimism, psychological well being, and self-efficacy. The broaden-and-build theory not only offers such direction, but also reminds us that positive emotions aren't just indicative of change, but they can catalyze the process by which change and growth occurs. This makes psychology a more inherently positive process in and of itself, and might serve to widen the current predominant focus on the pathological.

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CHAPTER III

Method

Overview

As research indicates, children do experience posttraumatic growth. However, despite unequivocal empirical findings, children are under researched when it comes to understanding the antecedents and consequences of growth following adversity. After reviewing the literature, it became apparent that further inquiry was necessary in order to generate a better understanding of this complex topic. As such, this study sought to explore the processes by which children experience posttraumatic following parental divorce.

Six semi-structured interviews of child therapists were conducted in order to gain an in-depth understanding of a child's growth reaction, including what role the therapist plays in a growth reaction. Each participant believed that his/her child patient had experienced a growth reaction following a parental divorce. This approach was intended to produce a comprehensive and richly detailed investigation of the subject matter. Interviews were conducted throughout the Bay Area in the participants' private practice offices. The interview consisted of open-ended questions derived from a review of the literature and my own ideas and questions about posttraumatic growth in children.

Participants

Five participants were interviewed for this study. Four were female and one was male. One female participant gave two interviews, one for each of two different patients, for a total of six interviews. The sample size is appropriate for a qualitative study, as it allowed for a thorough analysis of participant interviews. All participants had worked

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with the case within the last 15 years, and one was currently seeing the child. Children were between the ages of 5-14, whose parents had divorced or were in the process of divorcing.

Procedure

Recruitment of participants. Participants were found through networking in the community, particularly at my internship site where I posted a flyer (see Appendix A for recruitment flyer). This flyer was also used for dissemination through an online newsletter. The flyer provided a brief overview of the study and its objectives, as well as the nature and requirements of desired participation.

Contact was made with prospective participants. During this phone call, a more thorough explanation of the study was given, and eligibility for inclusion was determined (see Appendix B for telephone transcript). Participants who met the criteria were then given information about risks and benefits of participation, required time commitment, and told that the interview would be recorded. Once the participants stated their interest, they were asked about a convenient time and location for the interview, and every effort was made to accommodate this.

Interview procedure. The interviews took place in the private practice offices of the participants. The consent form was provided prior to beginning the interview (see Appendix C for consent form). Each participant was asked to carefully read the form. I then discussed informed consent, the limits of confidentiality, and offered to answer any questions. Participants then signed the form and the interview began.

I aimed to create an inviting environment to ensure that participants could openly respond to interview questions. Interviews, which contained mostly open-ended

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questions, lasted from 25-55 minutes. Due to the nature of semi-structured interviews, I was afforded an ample amount of dialogue with the participants to ensure I received the clearest answer possible. Upon conclusion of the interview, participants were thanked and reminded to call if they had any lingering questions or negative feelings about the process.

Materials

The interviews were conducted using a protocol designed by the researcher (Appendix E for interview). The interview utilized themes that emerged from the literature review, as well as questions reflecting my own research questions about PTG in children. My aim was that the interview questions be non-judgmental, clear, and research-based where appropriate. The interview consisted of five parts.

Part I contained demographic information, such as type and scope of practice, length of time as a therapist, theoretical orientation, and type of degree.

In Part II, I aimed to understand what, if any, prior knowledge of PTG was had by participants. Questions included "Have you ever heard of Posttraumatic Growth?" "If yes, can you tell me what you know of it?" and "Have you ever heard of posttraumatic growth in children?" This section also asked participants to postulate about how they might know a child was having a growth reaction, by asking "Based on your clinical knowledge of children, how would you know that your child client was functioning better after a divorce? What behaviors or statements would indicate a positive change?" These questions helped to evaluate the foundation of the participants' knowledge.

In Part III, I asked participants to discuss a particular case they treated, in which they believed the child had a growth reaction following parental divorce. I aimed to

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discover how growth was evidenced, and their reflective thoughts on how they understand the child's positive outcome. This was evaluated by answers to questions such as, "Please describe the pre-divorce functioning of the child (quality and type of family interaction, peer interaction, academic success or difficulty, participation in activities, cognitive engagement, etc)." This question was asked of the child's post-divorce functioning as well, with the aim of being able to clearly delineate the quality of change. I also asked the participants to reflect on the child's parents with the question, "Please describe the role of the child's parents in the child's pre- and post-divorce symptoms (quality of the parental relationship, quality of the child's relationship to each parent, level of functioning of each parent, etc.)." I aimed to assess how long it took for growth to be evidenced. Questions were "About how long did it take for the child to show signs of a return to pre-divorce functioning?" and "About how long did it take for the child to show signs of a movement beyond their baseline functioning?" and "How would you characterize the trajectory of the child's growth over time?" I asked participants what behaviors or statements the child made that showed a growth reaction. Finally, I asked participants, "To what do you attribute the child's growth reaction?"

In Part IV, I asked the participants to reflect about what interventions they made that might have aided in the growth reaction. These questions were, "What behaviors or statements did you make, if any, that encouraged or enhanced the child's growth reaction?" and "How do you believe your behaviors or statements helped the child?" In this section, I aimed to learn more about the participants' therapeutic stance, with the hope of drawing conclusions about how therapists can impact a child's recovery from trauma.

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Finally, in Part V, I asked theoretical questions about post-traumatic growth in general. This section contained the questions "What areas of growth do you think would accurately describe a child's PTG?" "How do you think a therapist's relationship to his/her client can facilitate a PTG reaction?" and "What type of therapeutic stance might be most helpful in encouraging a child's PTG reaction?"

Data Analysis

The data derived from this study were obtained through in-depth semi-structured interviews. The data were analyzed following a qualitative data analysis plan. Mertens (2005) stated that qualitative researchers "…study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them." (p. 229). This definition seems particularly salient to posttraumatic growth, the meanings of which is most definitely individually experienced.

The data from the interviews were analyzed thematically. Thematic analysis has been described as, "the search for and identification of common threads that extend throughout an entire interview or set of interviews" (Morse and Field, 1995, p. 139). McCracken's (1988) step-wise approach was helpful in organizing the data to discover themes. McCracken recommends four steps. First is observation, in which the data are reviewed for significance as it pertains to the literature review and research questions. Second is expanded observation, where the researcher continues to observe until implications are fully grasped. The third step is category development, a process of refinement where "patterns and themes should be rising into view" (p. 45). The fourth step is the identification of patterns and themes. Steps involved in identifying and analyzing the present themes followed coding process presented by Hayes (1997) in her

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text on qualitative inquiry. The four steps taken were coding, sorting, local integration, and inclusive integration.

The data analysis began with a transcription of each interview, shortly after the interview occurred. Following the transcription, I coded the responses in each interview. The purpose of coding was to find a connection between the questions and responses. As Hayes (1997) noted, additional coding categories could arise in the process of data analysis, and so I remained open to that possibility.

To aid in data analysis, I used a research-based grid of indicators of positive change that I created following my review of the relevant literature (see Appdenix E for Indicators of Positive Change). This was done to limit bias in data analysis, and help generate a more in-depth look at each case. Evidence in the domains of cognitive, behavioral, social, emotional, and academic growth were assessed on this grid, using several sub-indicators under each domain.

In an attempt to maximize inter-rater reliability, I trained a colleague in the apparent coding categories and asked her to review three transcripts in their entirety. The colleague had recently finished her dissertation using thematic analysis of interviews, as well. Coding categories were modified where necessary to conform to inter-rater reliability standards (Hayes, 1997).

The second step in the process of data analysis was sorting. In this step, responses were divided into categories and sub-categories, where necessary. During the third step, local integration, the categories were summarized and general themes were identified. Inclusive integration was the final step. This process integrated themes and categories with the research questions, and produced the results of this study.

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CHAPTER IV

Results

The focus of this study was to understand the processes by which a child experiences posttraumatic growth following a family transition (divorce). Six in-depth, semi-structured interviews of child therapists were conducted in an effort to reach this goal. The focus was to gain a better understanding of a child's moving-on from such trauma, with an emphasis on how the child evidenced growth, interventions made by the therapist that may have contributed to the child's growth, and to what the therapist attributed the growth.

The results of the interviews with the participants are presented as follows: (a) the demographic data, (b) participants' knowledge of posttraumatic growth, (c) review of cases, (d) analysis of the themes that emerged from the interviews.

Demographic Data

Five participants, totaling six interviews of six different child cases, volunteered to take part in this study. Four were female and one was male. The interviews took place in the participants' private practice offices throughout the Bay Area.

Degree of participants. Three female participants retained a degree of PhD, and one held a degree of MFT. The male participant held the degree of MD.

Theoretical orientation of participants. Participant One reported a theoretical orientation influenced by Control Mastery and Psychoanalytic theories. Participant Two identified using Control Mastery and Self-Psychology. Participant Three stated that her thinking is Psychodynamic in nature, but her work is mostly Cognitive-Behavioral.

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Participant Four was highly influenced by Control Mastery Theory. Participant Five cited Control Mastery Theory and Object Relations as her primary orientations.

Ethnicity of participants. Three participants identified as White or Caucasian. One participant identified as Russian-Jew, and one identified as Caucasian-Jewish.

Experience working with children and families. All participants reported working with children for at least 30 years. All participants reported a caseload of children and families of approximately 50%, except Participant Three who stated that 100% of her caseload was working with children and families.

Knowledge of Posttraumatic Growth

When the participants were asked if they had ever heard of the concept of Posttraumatic Growth, one participant said no, three participants said no but that they could guess what it meant, and one participant said yes. Each participant was then given a brief description of Posttraumatic Growth, including the five domains of growth outlined by Tedeschi and Calhoun (2004). These include: greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; greater sense of personal strength; recognition of new paths for oneself; and spiritual development. It does not appear that having a prior knowledge of PTG impacted results.

Review of Cases

Demographic information. All cases presented fit the requirements of the study. The children described in two cases were 8 years old, one was 10 years old, two were 12 years old, and one was 13 years old. Participants had treated the case within 10 years of the interview. The child in each case was described as White/Caucasian.

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Context of divorce. In four cases, the child's parents were divorced at the time of therapy. In two of these cases, the child's parents had been separated for several years but finalized the divorce shortly before the child began therapy. In the remaining two cases, the child's parents had not yet divorced, but did so during the treatment. In all cases, the participant noted that one or both parents had some form of mental illness (depression, anxiety, paranoid thinking, anger, and/or issues with alcohol) and that this was a contributing factor to the divorce.

Interview Themes

With the above data as context, I sought to explore the change in the child's level of functioning before, during, and after the divorce. I also sought to explore the therapist's role in the child's recovery and growth, and to what the therapist attributed the child's growth.

The responses were analyzed and then grouped according to theme. Six significant themes emerged from the interview data and are addressed below. The first four themes emerged from specific case information relating to the children presented, while the remaining two themes emerged from participants' more general ideas about therapeutic stance and treatment attitudes. A summary of results is given in Table 1.

It should be noted here that I share the same theoretical orientation as four of the participants: Control Mastery. Throughout the process of data collection and analysis, I realized that which I was attributing to participants was also resonating with my own views of psychotherapy. This could possibly have contributed to a bias in thematic groupings, though this remains unclear. This does not diminish the importance or relevance of any findings, but should simply be made clear to the reader.

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Table 1
Summary of Results

Participant One	Child One Pre-Divorce Functioning	Child One Post-Divorce Functioning	Evidence of PTG
PhD, 35 years experience, Control Mastery/ Psychoanalytic, Russian-Jewish	Stuttering, tics, social withdrawal, poor academic performance	Eye contact, engaged with school, interest in therapy, goal-directed thinking	Self-awareness, self-expression, insight, initiative over well-being
Participant Two	**Child Two Pre-Divorce Functioning**	**Child Two Post-Divorce Functioning**	**Evidence of PTG**
PhD, 33 years experience, Control Mastery/Self-Psychology, Caucasian	Underperforming at school, anxious, fearful, no friends	More lively in school, new group of friends, joined church,	Relaxed, cognitive engagement, sense of social belonging,
	Child Three Pre-Divorce Functioning	**Child Three Post-Divorce Functioning**	**Evidence of PTG**
	Anxious, chaotic, shy, isolated from parents, underperforming at school	Interest and engagement in school, sleepovers, closer relationship with dad	Positive expectancies, general resilience, empowerment
Participant Three	**Child Four Pre-Divorce Functioning**	**Child Four Post-Divorce Functioning**	**Evidence of PTG**
PhD, 30 years experience, Psychodynamic/CBT, Caucasian	Learning difficulties, anxious, poor academic performance	Sense of relief, age-appropriate worries, risk taking, joined soccer team, engaged with therapy	Assertiveness, reflective thinking, self-respect, attachment to teacher
Participant Four	**Child Five pre-Divorce Functioning**	**Child Five Post-Divorce Functioning**	**Evidence of PTG**
MD, 30 years experience, Control Mastery, Caucasian-Jewish	Self-harm, social withdrawal, poor grades, physical symptoms	Engaged with school, new relationships, sleepovers, engaged with therapy, artistic	Demonstrates empathy and altruism, attachment to adult,
Participant Five	**Child Six Pre-Divorce Functioning**	**Child Six Post-Divorce Functioning**	**Evidence of PTG**
MFT, 30 years experience, Control Mastery/Object Relations, Caucasian	Hypervigilant, distracted, anxious, poor grades, hiding, burdened	Engaged with school, better grades, honest, engaged with therapy, closer relationship to mom	Perspective-taking, optimism, goal-directed thinking

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Reduction in symptoms.

Pre-divorce negative functioning. In each case presented, the pre-divorce functioning of the child was described in a negative manner. That is to say, the children were not doing well and they evidenced a great deal of suffering. Words such as *passive*, *anxious*, *problematic functioning*, and *troubled* were used by all of the participants.

In three of the cases, children were either misdiagnosed with, or thought to have, significant impairments in their functioning, necessitating a psychiatric diagnosis. These diagnoses came from previous therapists or school counselors, or both. The child presented in Participant One's case (age 12) was diagnosed as having Asperger's Disorder due to his stuttering, tics, social withdrawal, and "general awkwardness." This diagnosis and constellation of behaviors resulted in him being pulled out of mainstream schooling prior to treatment. This diagnosis was later revoked following the parental divorce, subsequent restructuring of the family, and therapeutic treatment of the child. Participant One says:

> Over the last three years [of treatment], there have been significant improvements in his symptomology [*sic*]. Stuttering is significant reduced, tics, which were once every two minutes, have been reduced to once in every half hour or more, depending on the stress of the kid. He is absolutely not autistic, clearly an anxiety reaction, stress reaction to the trauma in his family.

The teachers of the child presented by Participant Three (age 10) felt the child had "…profound learning disabilities because she was having a really hard time completing assignments." Following the finalization of her parents' divorce and her therapeutic treatment, comprehensive testing revealed that she was actually quite bright and that her

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struggles in the classroom were related to stress in her home life. Participant Three explains:

> Academically, she's had a really great year! No learning disabilities here…she really got it together and started taking a lot more risks, and has started to be able to raise her hand, and be able to make a mistake in class—she *never* had been able to do that before.

Participant Four noted that the child he treated (age 13) was hospitalized for a duration of one month preceding treatment with him on account of her social withdrawal, lack of participation in school, and consistent self-harm. Her behavior was so bad that her parents were considering getting her out of the family home and into a long-term therapeutic facility. When the conflict surrounding the custody of the child subsided and she entered therapy with Participant Four, he says that she "…stopped sounding crazy and anxious very early in the therapy and her grades got much better very quickly."

Participant Five discussed how her patient (age 12) lived in a constant state of hypervigilance before her parents divorced, and the impact this had on her, "She was not doing too well in school, because she was so worried and distracted, and fearful about what was going on at home. She was constantly looking for the other shoe to drop. Vibrating with anxiety."

Immediate impact of divorce is negative. Results indicate that the immediate impact of the divorce on the child is negative. In this study it was common for children to experience fear, anxiety, confusion, and sometimes isolation as a result of the split. All participants spoke of this theme. Participant One explained of the immediate impact on her patient:

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> Very negative. A lot of stress, a lot of trauma. Um, just a lot of loss. He could not actually participate in any activities, could only do computer. Only could be involved in solitary activities for quite some time.

Participant Two, who provided two interviews, stated in her first interview that her patient (8 years old) had confused feelings about what was happening, “She said she was worried, like, who was going to take care of her father if he wasn’t living with them anymore, and I could see guilt and conflict in her about it.” In her second interview, Participant Two said of her patient (also 8 years old), “She looked very, very confused and upset by the whole traumatic situation.” Participant Three explained how her patient appeared to be a “deer in the headlights.” She described how her patient had difficulty identifying her emotions, discussing her emotions, or even remembering when she last felt certain emotions: “There just wasn’t any spontaneity in her.”

It is unclear what duration of time the term *immediate* should indicate. According to the participants, and consistent with the research, one to six months seems to be the shortest amount of time for a child to metabolize the changes and begin the rebuilding process. Participant Five noted that, indeed, for some children, “It could take a whole lifetime to get over [parental divorce].”

Post-divorce reduction in symptoms. Following the immediate negative impact of the divorce, there was a clear trend of a reduction in symptoms. This was evidenced in a number of ways, which will also be described below in the themes that follow. Participants reported that they could clearly identify their patients getting better. Participant Two explained of her first case, “She just *said* that she was feeling better, maybe a month or two later. Once things got solidified and the separation got

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normalized…she could just say that she felt better." Participant One expressed how her patient changed quite remarkably. She recalled, "He started to actually look at me, instead of, he stopped displaying the kind of autistic behavior that he did initially. He was head-banging, sitting, throwing things; before he couldn't even stay in the office with me."

Participant Four said his patient (age 13) "…had a lot of physical complaints, headaches, stomach aches, diarrhea…all of which went away shortly after treatment began." Later in the interview he elaborated:

> Before, life was this very grim, kind of perverse, painful experience, that eventually was really enjoyable for her. She could feel good about herself, she could feel good about her relationships, she could feel love. Before it was this bleakness, and her only response was this crazy anxiety and despair.

Participant Three stated:

> She never had a voice to say how she felt, or to even recognize how she felt, that was incredibly risky…It all kind of came together when [the divorce] was finalized, there was no longer that need for her to somehow make it smooth, and not have a sense of her own identity anymore.

Participant Five noticed her patient's improvement quickly:

> There was a distinct sense of relief. Especially from the omnipotent worry she had been carrying for years. It was a struggle to get the family back on track, but once it was, she was free to finally be a kid again.

Reduction in symptoms could be termed the "return to baseline functioning," as it is called throughout the literature on Post Traumatic Growth, although that idea is

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complicated by the specific context of the divorce, so it is not being used. For example, Participant Two's first interview was of a girl from a physically abusive household. When her parents finally divorced, she evidenced a reduction in symptoms almost immediately because she was out of a very dangerous and damaging environment. Because the abusive environment was all she had ever known, the description of her baseline functioning was made difficult; it is hard to say what was her true functioning and what was a by-product of the abuse. To this end, term "return to baseline functioning" may not be accurate in cases where a child has never known anything different. As Participant Five noted of her patient:

> Her functioning had been informed all along by a contentious to very-very contentious marriage the entire time she was growing up. There was really no baseline functioning to begin with, because she was so debilitated by this marriage for her whole life.

Increased engagement evidencing growth. One of the most prevalent ways the children in this study evidenced growth was through an increase in engagement that went beyond the child's level of pre-divorce engagement. Engagement is differentiated in the following sub-themes: engagement with school, social engagement, engagement with therapy, and engagement with self.

Engagement with school. All participants noted that their patients not only performed better academically post-divorce in terms of the quality of their performance as measured by grades, but that they functioned better at school as well. It was clearly noted that the children's performance and functioning was at a level beyond what it had been before the divorce.

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Participant One, whose patient had recently been pulled out of mainstream schooling due to his profile of Asperger's-like symptoms, noted that, in his growth, the child evidenced a "…higher level of competency…to the extent that he could be reenrolled in a mainstream school. And he was actually excited about it and is doing better than ever."

In her first interview, Participant Two stated that her patient had been "underperforming" at school despite her being very bright:

> The teachers weren't complaining but they were saying that she probably wasn't working up to her potential. Later, I heard from the teachers that she was more lively in school. It took her a while to do better, it's true. But they had never seen her engage with school like that.

Participant Three stated of her patient's engagement with school:

> Academically, she's had a really, really good year. She had a phenomenal teacher, but she really got it together and started taking a lot more risks, and starting to be able to raise her hand, and be able to make a mistake in class—she *never* had been able to do that before.

She then linked her patient's growth in school with the impact of the parental divorce:

> As academics became more and more important, and more and more abstract, and she was going to need to ask questions and need to take risks, she couldn't do that because she couldn't do that in her family. 4th grade was abominable because she just had such a difficult time being able to bridge from that concrete world into an abstract world.

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Furthermore, she noted that when her patient learned that she did not, in fact, have a learning disability, she felt relieved:

> I think it also was of very much interest when she came and she told me that she didn't have a learning disability, and she sort of had a half-smile on her face. I think it was like, "Well maybe I am okay?" It turned out that she was certainly able to rise to the occasion!

Participant Two, in her second interview, simply stated that her patient

> …told me how she felt like the teachers really cared about her at her new school, and so she was doing much better academically. She was interested in school and enjoyed being there for the first time.

Participant Four noted that his patient quickly improved her performance, raising her 1.2 GPA to "mostly B's and one A-" in the full semester that followed starting treatment with him. "Teachers were not complaining about her anymore; they weren't worried. She was back working to her potential."

Social engagement. Children in the study also evidenced growth in the social realm, including more and better friendships, joining groups and sports teams, and taking more risks. In her first interview, Participant Two said:

> [Before the divorce] She had very few friends. I don't know if she had *any* friends…I think she wanted to hook into friends, but it was just really hard for her…she felt ostracized and isolated…but I betcha anything that's one of the main things that helped [post-divorce], was that she could finally feel normal. She could be accepted, she could finally fit in. She made a great group of friends. That really showed that she was growing and doing better.

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She went on to say:

> …She had also gotten really active in the church group that her mother had been a part of, and that helped her feel like she had an extended family, post-divorce. So actually, I don't think she'd ever had a friend over to the house before she got really active in the group. I know she felt like she really belonged there.

Participant Four stated of his patient's progress in her capacity for social engagement:

> She found a new group of friends, and even started going over to others' houses after school. And after some time, what really changed, was she developed a relationship with a boy…who happened to smoke pot. She worked very hard to get him to stop smoking pot. She spent a lot of time at his home and she became very close with his family.

Participant Four saw this at notable because not only did she engage with others in a way that she had never done before (having a boyfriend), but she also demonstrated a newfound capacity for helping others by wanting to help the boyfriend stop smoking pot. She also became close to the boy's family in a manner that proved important and beneficial. This will be further discussed in subsequent themes.

In her second interview, Participant Two stated:

> She had had a good high school experience; um, felt popular and had friends. Did well in school and was active with activities that were school-based. You know, had sleepovers. Her social life had dramatically improved, even from baseline.

Participant Two went on to say that there is great importance to be placed on a child's experiencing of social success, "Even more important than doing well academically, perhaps, is to feel like you are successful socially."

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Participant Three noted that her patient joined a soccer team, and even demanded that her parents come to her games despite their ongoing conflict. Participant Five noted that her patient's social engagement increased in a way that enabled her to be more honest:

> In this [upper class] culture children are prohibited from talking about [the divorce]. So there's a hiding that goes on. These parents have their own way of dealing with a fall from grace. And this was a major fall from grace; the mom was ashamed and humiliated, so my patient was too. But she held it all in, to keep appearances. When it was over and done, they moved away. And she could just live her own life.

She went on:

> So the burden of her feeling like she had to watch out for or monitor her parents was lifted and she was more free [*sic*] to move around, leave the house, go to school, to spend the night over. All the things that she couldn't let herself do before.

Engagement with therapy. In four of the six interviews participants mentioned that the child became more engaged with therapy. It appears that participants viewed such engagement as an indicator of growth. Participant One stated, "He has shifted to coming in on his own, being on time, bringing forth new material for me, telling me what's on his mind, telling me what he wants me to help him with." This type of change was also reported by Participant Three:

> She was really able to use our time better. Instead of covering the basics, or the crisis, we were really talking, problem solving, developing strategies that would

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go together with different feelings…she began to look at stepping outside her comfort zone to be able to take risks, and that it's okay if she doesn't always succeed. That was really phenomenal.

Participant Two in her second interview simply stated:

She just showed a sort of psychological mindedness. The fact that she could begin to talk to me with that kind of wisdom and precocity, emotionality, and that she could describe everything that was going on. That was a real impressive thing.

Participant Four recalled that when the therapy started, his patient was "withdrawn" and "acted kinda crazy." He described her growing engagement with therapy in the following way:

The pictures that she drew started to look less like horrible monsters and more like normal, nice-looking animals who were nice to each other, social, having good times at parties. She loved to show me these drawings and we talked about them a lot. She was able to use our time together in a different way; our relationship was important to her and it showed.

That these children became more engaged in therapy following their parents' divorce may or may not be a direct indication of having a post-traumatic growth reaction. In other words, I am aware that patients become more engaged in therapy in many, if not most, cases as time goes on, regardless of the reason for therapy. Therefore, the increased engagement in therapy evidenced in this study is seen as one indicator, in a cluster of indicators, which suggests there is a growth reaction.

Cognitive/emotional engagement. This sub-theme is meant to encapsulate all the ways in which the children in this study evidenced a greater sense of who they are

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following the parental divorce. This includes evidence of reflective thinking, perspective-taking, goal directedness, internal locus of control, responsibility to self, and more.

Participant Three's case evidenced a great deal of growth in this domain. She showed growth in the areas of assertiveness, reflective thinking, and self-respect:

> She really started getting pissed off, and it was great. It was wonderful. Because she started really talking about how, "I don't deserve this" and "I've done nothing wrong." She was like, "I always thought when I was a little kid that somehow I caused my mom to not want to be with me." But at age 10, it really didn't have anything to do with her, and she was now starting to get really angry. And it was perfect…I remember her saying, "This is the story of my life! They never prioritize me!"

She went on:

> For her to be able to come to a place where she was able to say to her parents, "this needs to be about me, and I haven't caused this, I've done nothing wrong, and I have a right to have you step up to the plate for me" was just phenomenal. Just an incredible ability to gain wisdom in the process. She had such pride in herself.

Participant One's case experienced his own increase in self-awareness, self-expression, and insight in a different way:

> There was a development of a relationship with me that enabled me to help him identify that he wanted to be more flexible. He knew he looked like a weirdo, and he wanted to try and be less of a weirdo. I mean, in essence he was feeling brave!

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> And trusting himself, finally, in our relationship. He was freer to try. He learned that he can tolerate a lot.

Later in the interview she said, “He, for the first time, felt like his family would listen to his needs! So he spoke up and negotiated what he needed from them. He’s taking more ownership and initiative over his well-being. He’s becoming insightful!”

Participant Two explained in her first interview how her patient felt more assured and relaxed in her decision-making:

> She could finally feel a bit more independent. You know, like, “I don’t have to worry about my parents, I can get on with my life” so in that sense the quality of her relationship with herself improved in terms of what we would want a kid to have.

Participant Five noted that her patient had a realistic perspective that enabled her to make the best of her situation. She said:

> I mean, they were just scraping by. But even then, my patient could say how she would rather live in that crappy apartment than be a witness to this marriage falling apart. In that way, she owned it almost like it was her choice. It was quite remarkable.

Participant Two noted in her second interview that her patient also gained a realistic perspective and felt empowered by her emotions about the divorce:

> The girl told me that she felt so sad for her mother, until her mother kidnapped them and didn’t tell the dad where she took them. When the parents were fighting [pre-divorce], she was the mother’s ally and she thought her father was more terrible…. But when mom kidnapped them [post-divorce], she started feeling like

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> it was a bad thing for the mom to do! And then she started to feel resentful that she had to do so much caretaking of her 2-year-old sibling, and was angry with the mom for laying in bed all the time. She felt empowered by her own feelings, which not only was evidence that she was getting better in a concrete way, but this [that she was empowered by her own feelings] actually helped her get *even better*.

Participant Four discussed how his patient's sense of self changed:

> A lot of her energy had been devoted to living out her negative view of herself. As she changed and transformed, her priority shifted from living out negative views to living out more positives views! Exploring relationships, flourishing, seeing there was potential for a positive relationship with her boyfriend and her boyfriend's mother…to me it indicated a different sense of what's going on inside herself and how she views other people.

Role of parents and other adults. The role of parents and other adults was underscored by each of the interviewers, with variations depending on the context of the parental divorce. All participants mentioned working with parents in an attempt to help the child recover from the divorce trauma, although not all cases were successful in doing so for various reasons. In five interviews the participant cited the child's protection from the more dysfunctional parent as being imperative to the child's recovery and ultimate growth. In four cases participants mentioned the importance of other adults in the child's life.

Working with parents. All participants cited the importance of trying to work with parents to mitigate the impact of divorce on the child. When a therapist is able

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to do so, it appears that this is impactful and creates inroads of success for the child. Participant Four explained:

> When you're dealing with kids and parents you are a social engineer, you are trying to help change their environment. You try to get the parents to stop yelling, or to set limits or to stop fighting. You are indirectly helping the child's social reality by helping the parents change. If done well, this can be an enormous help to the child.

Despite this, he further explained that he was unsuccessful in working with his patient's parents:

> I tried to work with the parents to support them to modify their behavior, but that didn't work very well. They backed away. Because of the problems in their relationship they kept avoiding meeting with me…they had problems that they really couldn't address in the context of this therapy. But I tried, and that was important for my patient.

Participant Two, in her second interview, described similar difficulty when trying to work with parents. When describing her patient's father she said:

> I tried to coach him, but he had a bit of a "shove things under the rug" mentality with regards to his ex. I recommended that he validate the experience of [my patient/his daughter] when the mom was behaving in a rageful or blaming way. But he didn't really want to do that.

Participant One described her success in working with the parents and how it was crucial for her patient's growth:

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> The biggest thing that wasn't happening in the family is that, even the dad, who has fabulous intentions, is overwhelmed and doesn't follow through. So I became the auxiliary ego for this family and I documented everything and I went to every school meeting, and I went when they were interviewing different schools to figure out where he should go. And I was in that family as the auxiliary ego teaching them how to ask questions.

She went on:

> They didn't actually know how to talk to this kid; they didn't understand him. He was scary. I mean, he would just be so volatile that they wouldn't know how to contain the volatility. So I just felt like they needed someone to give them permission on how to deal with their kid. And it worked, by and large….Therapists can enable parents to be better parents.

Participant Three explained how she advocated for her patient's wishes when it came to the parents:

> She wanted me to orchestrate a meeting where the four of us would get together. So I essentially mandated to both mom and dad that, "We are going to have a meeting, and your daughter has asked for this to happen, *specifically*." That meeting was so important for her, and her parents just weren't listening to her on her own. It had to happen in my office, so I made sure it did.

Of the importance of working with parents, Participant Five said:

> In my opinion, one of the best things we can do for parents is to give them permission to follow their own good judgment, and not think that there's a way they *should* be doing it instead. Sometimes, parents are even smart enough to

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> admit that they're confused and don't know what to do, and then you can help them with that. But in our culture, where everybody is supposed to already know how to do it and be doing it right, you have to be proactive with parents. Kids deserve it, especially kids of a traumatic divorce.

Protection from the more dysfunctional parent. The word *protection* was used in five of the six interviews to describe an important way in which the child's functioning improved beyond baseline. In each of these cases, it appeared that the more dysfunctional parent was in some way toxic to the child and this impeded the child's functioning. When the child had protection from this "toxicity," the child evidenced improved functioning leading to growth. In two of these cases the child could explicitly infer that it was the protection that was helping them get better, which evidenced perspective and insight indicative of growth.

Participant One explained:

> His symptoms improved dramatically for a number of reasons, but a significant part was that he was protected from his crazier mom. The dad's higher functioning….Significant improvements were seen once dad become much more involved in the case and with the child.

Participant Four said:

> The fact that her father loved her, even with all of his problems, he was very devoted to her, and tried hard to protect her from the mother. And even though he wasn't effective completely, I think she was able to internalize his good wishes for her.

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Participant Two cited in her first interview:

> I think being protected from her crazy father, and the violence and eccentric weird behavior, his rage, was enormously helpful. She wasn't just saying, "Oh I'm recovering from the divorce," she was saying "the fact that I'm protected now from my dad, he's out of the home, it's so peaceful, it's so peaceful. We don't have to worry about daddy getting mad at us. We don't have to worry!"

In her second interview, Participant Two explained:

> The girl said she was just so happy when the dad got her, that…she was rescued from the situation with this crazy mother, but also since she thought he was the more stable, solid, loving one, she was very relieved and really liked living with him. He had protected her. She felt like she had a stable home, meals were on the table every night. Her father put her in a really nice private school. So it seemed like a more normal family, like "Oh finally, a normal family!"

Participant Five said:

> The key factor, especially if you have one parent acting out their craziness, is that the person who is the shepherd of the children most of the time, it's how they handle it. It's always what makes the difference, at least in the short run, of getting through it. This mom knit together a life for this kid, protected her from her crazy dad, and pulled through for her.

Importance of other adults. Positive non-parental adults were cited as important to the children in four of the six cases. These appeared to be meaningful relationships that aided the child in his or her growth. This is consistent with research indicating that the presence of a positive adult-other is a protective factor for children

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(Benson et al., 2005). As Participant Two simply stated: "Some kids are so lost in general that a competent adult that they feel safe with, it's like water to somebody in a desert."

For Participant Three's patient, the teacher proved to be an important figure:

> Her teacher was just phenomenal. I think the teacher believed in her. It was also a male. And I think that was important, again, when you look at it from a transitional view, mom was deadbeat, and the only hope that she had was her dad who was starting to desert her, but she trusted that male image. And [her teacher] was an incredible figure to her. He just kind of embraced her, and took her along with him. He was a stable, competent adult that she could rely on, and she needed that.

Participant Two noted in her first interview that her patient found important adult figures in the church:

> She got very involved in this church community, and she felt that there were some strong, mentally healthy adults, finally, that were not only going to help her, but help her mother too! They were very important people in her life. They gave her meaning outside the tumult of the divorce.

Participant Four explained:

> That she had a supportive relationship with her boyfriend's mother—that might have been the *most important* asset to her getting better. It may have helped her incorporate some of that ability to take care of herself in the face of a very difficult environment, and find good in herself…She had much healthier interactions at his home than her home. I supported her in spending more time at

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> the boyfriend's house, and less time with her father and stepmother. It was helping her get better.

When the father in Participant One's case remarried, the stepmother became an important figure to her patient. She explained:

> The new mom is the secret. She's fabulous. She's the healthiest person in this whole family dynamic. Bringing in her kind of clarity and warmth and not being a nutcase really helped this family. She really helps to stabilize my patient.

The impact of the therapist as an important adult-other was noted, and will be discussed in subsequent themes.

Growth: A variable timeline. In four of the six cases, results indicated that although pockets of growth were seen throughout the first several months of treatment following the immediate negative impact of the divorce, a retrospective recognition of growth didn't occur until around one year post-divorce. This is difficult to quantify, however, and simply based on the participants' impression or remembrance of the child's growth. This is commensurate with literature questioning how and when PTG occurs in children, and how a child's age, development, cognition, and ability to have perspective impacts perceived growth (Polatinksy & Esprey, 2000; Salter & Stallard, 2004). Participant One explained:

> My patient had had a real break in his development [post-divorce]. He was behaving a good three years below his stated age, and now he's much more…he's catching up, he's starting to become the man that he's going to be. That didn't happen overnight!

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Participant Two explained in her first interview:

> I think she was doing better at the end of the first year when she would have been nine [years old]. It was very clear to me that she felt much more at ease and not so scared, so it was clear that she was doing better. But it took a long time for her to feel it was safe enough to gradually stop worrying, that she didn't need to worry.

She went on:

> It's a quality among many divorce cases, where the child is being asked to operate way beyond her years. So she was having to use a bunch of adult functions, which is part of what makes the trauma so terrible. She was having to think and feel, like…it's a complete loss of innocence. That takes time to undo, or at least understand.

Participant Three explained, "I think things were status-quo for quite some time. It was just a total sense of immobilization." Participant Four said:

> Well, therapy went rather typically; she saw me every week, you know, in a supportive therapy. We established a good relationship over time, and I could see what she was working on with her parents and I tried to help her get some perspective in her conflict with them. But I saw her for two years, so this took time.

This theme is further complicated by the two remaining cases in which the participant noted that growth was immediate because violence or extreme toxicity was all the child had known. In these cases the divorce alleviated years of negativity that the child had been steeped in, so the child essentially had nowhere to go but up. In sum, the immediate impact of the divorce was not bad, but instead very good for these children.

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Participant Two said, in her second interview:

> [The immediate impact of the divorce] caused chaos, for sure. But she looked like she had returned to baseline within a month or so of the father bringing her back home. Her functioning went up fairly abruptly. He offered a stability and care she had never had. He took care of her materially, which was important. She was still shaken up, internally, but she was able to fit in and perform well despite that because it just felt so good to have stability.

Participant Five explained:

> There was so much fear, grieving, and processing of the decimation of the marriage before the actual divorce. There was a lot leading up to the parents' split. She had guilt about this, but there was a relief that she could say, "this is actually much better." She didn't think she was supposed to feel that way; kids are told that's not how they're supposed to feel. "I'm not supposed to be happy that my parents are divorced." Maybe happy isn't the right word, but she didn't have to worry about what was going to blow up next, that kind of stuff. So the immediate impact of the divorce did not make things worse for this girl. In fact, in a way the divorce actually improved her functioning right away.

She went on:

> Her functioning had been informed all along by a contentious to very-very contentious marriage the entire time she was growing up. There was really no baseline functioning to begin with, because she was so debilitated by the marriage. The divorce gave my patient a chance to live a whole new life, and that was crucial.

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Therapeutic stance. It is well-documented in the research that the therapeutic alliance between patient and therapist is of utmost importance to the patient's getting better (Weiss, 1993). The environment created by the therapist provides a frame by which therapy can progress and deepen. This is true among and across all therapeutic modalities and theoretical orientations. Results from this study corroborated this finding. In this study, an environment of safety was found to be paramount to helping the child process emotions related to the divorce. Once safety and trust were established, the therapist could move on to validating the child's experience and thus deepen the work. Providing a sense of hope and optimism for the child also emerged as an important theme. Finally, therapists evidenced a genuine enjoyment of the children whom they discussed. It appears that this stance has a positive impact on encouraging posttraumatic growth reactions in children.

Creating safety and trust. In five of the six interviews, participants directly cited safety as an important feature of their work with the child. Participant One described her ideas about safety and trust:

> I worked to understand his unconscious plan and where he needed to go, and then created an environment of safety for him to get there…My stance is that how he feels matters. What he needs matters. That he has a right to be heard. Everybody has some needs, and he gets to have his needs be a part of the mix.

She went on:

> And my own position is, you get to choose your plan. You get to choose. I could name ten things we need to work on, and you order them. I'm your advocate. You tell me what you want me to fight for and I'll do it.

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Participant Five said:

> I have a very real style. I don't sugar coat much. But I do create a safe environment, first and foremost. You have to help the kid feel safe, because they don't feel safe in general. They're worried and hypervigilant. So I wanted this girl to feel she could really be herself with me. Your parents might not be able to hear it, but I can.

Participant Three explained:

> I'm in the trenches with kids, that's my style. I'm not just going to sit there and say "very interesting, we'll talk about this next week." I tend to be more proactive. I don't think kids just unfold the way adults might, they need to be coaxed out sometimes. It creates a feeling of safety, and that's what really deepens the work.

In her first interview, Participant Two said of safety in her case:

> Well, I think everything was really out on the table in a sense, so we could talk more directly than a lot of kids…She felt there was a strong, mentally healthy adult, finally, who was going to protect her and keep her safe, and I was going to help her mother and father too…It took a bit of time to create that safety, but it relieved her a great deal.

Participant Four explained:

> I think having a consistent, supportive, sane adult in her life who didn't traumatize her the way all other adults in her life traumatized her by failing to set limits, setting punitive limits, or being provoked by her, was immensely helpful. It

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made her feel safe. She didn't have to feel bad that she hurt me or ruined my life the way she felt about all the other adults in her life.

Validation and support. This sub-theme was strongly evidenced in all six interviews. It appears to be an important aspect of helping children to have a growth reaction. Beyond validating *feelings*, which is common therapeutic practice, Participants mentioned validating the child's *reality*. Both types of validation are valuable, but the distinction is an important one.

As discussed by Janoff-Bulman (1992), trauma can cause a shattering of one's assumptions about the world and one's place in it. It can thus be assumed that for children, who oftentimes have difficulty processing traumatic events, validating *reality* is a crucial way in which therapists can bridge the gap between a child's experience and a child's understanding of that experience. Linking this back to the child's *feelings* about the experience creates a helpful, and perhaps much needed, learning experience for the child.

In her first interview, Participant Two explained her treatment style:

> I think the key was, let's see, helping her ground herself in reality, validating her reality was super important, which I did over and over, every session….I would help name the parts that were scary to her; things that she couldn't articulate that clearly, but when I could, then she would say "Yeah, that's it."

Later in the interview she said, " [Children] won't be able to separate from a troubled parent unless they can feel that it's based in reality, that they're not exaggerating how bad mother or father is."

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Participant Five reported:

> [I helped her by] affirming her observations of what was going on. By not doubting her need to stay away from her father. By not giving her a lecture about kids needing to spend time with both of their parents. That was probably a big one. Helping her not feel guilty about not wanting to be around him.

Participant Four stated:

> I think what was curative about this therapy was that I allowed and supported this distance between her and the toxic energy, which she was really in the center of before. We got her out of the center…The idea that she could avoid the toxicity, and that it was actually okay for her do so, that was supportive to her. She was only hearing from everyone else that she wasn't okay. It was important that I validate that it was okay—good, in fact—for her to distance herself.

In her second interview, Participant Two had a great deal to say about validation and support:

> [My patient] said to me that she was really worried she was bad, and that she was making the mom unhappy. Especially as she got older and more distance from it [the divorce] she described it very poignantly. She was able to say that she felt like a really, really bad daughter. So I was validating that she was *not* a bad daughter…I felt it was crucial to validate the terrible circumstances she was in, including that her mother was very troubled.

Later in the interview, she said:

> Validating reality often includes validating really difficult circumstances. But you must. And you must validate their feelings of those circumstances. So if the

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> parents are troubled, acknowledging that even if they can't. I wouldn't push it if it makes them uncomfortable, but I would say it a few times. And related to that, asking about or guessing about all the feelings they have about the divorce, and putting things into words if they can't. But I'm validating both [feelings and reality] because it seems so much that kids can't, if parents aren't doing it with them.

Participant three recounted:

> [My patient] was reticent to speak up, so I offered a lot of validation for her not being crazy. She was able, then, to start thinking like, "Well you know, yeah maybe I could ask for something" or "Maybe I could figure out what I need or want." I mean, she felt like she didn't have a right to a voice. But I sensed that she really had a voice inside, so I tried to give that voice permission to become externalized. She loved that concept, and we started working on, "well, when you get tricked into believe that you can't say anything, what would like to say back to that feeling?" That was when she began formulating this idea that "I have a right," "I have to respect myself" and "There's no reason I can't stand up for what I want." I think giving her permission to look at those types of strategies, and validating her feelings about it all, was really helpful.

Participant One took a straightforward approach to validations:

> I just worked to acknowledge how smart he was, and that I was going to be his tool to help him get better. I wanted him to know that I was smart too, and that together we'd figure it out… I take him very seriously and I listen to him very

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> carefully. And I follow through. He may feel like he has to take care of his family, but I try very hard to make it clear that he doesn't have to take care of me.

Hope and optimism. As research indicates, the experience of positive affect has a building effect wherein a person can experience an "upward spiral" of positive emotionality (Fredrickson, 2001; Fitzpatrick & Stalikas, 2008). This has enormous implications for working with children post-trauma. In five of the six interviews, hope and optimism emerged as a theme. Therefore, results of this study indicate that maintaining a sense of hope and optimism for a child following parental divorce is an important therapeutic tool.

In her second interview, Participant Two explained:

> You have to be careful not to say it too quickly, like, "Oh this is going to be better for you," but of course it's something we hope for…Not right after the separation, but it's okay to say something like, "I think things will get better. I think in a few months you'll know the schedules and you'll see where dad's going to be living, and you'll see what things are going to stay the same and what is going to be different. Knowing all that will make it easier for you. You won't be so uncertain about how things are going to go, so that will feel better. Even if you still wish they hadn't gotten divorced, that part will get better." See, I'm creating hope that things will get better. Putting words on things that don't feel good, like uncertainty, can give them a little hope. And telling them *how* things will get better is helpful too—it communicates your hope for the child more clearly, and it's important that they know we have hope for them!

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Participant Five explained:

> We have an opportunity to have a different voice and intervene, and it's imperative that we do. Kids are not responsible for parents. Helping them to understand that they don't have to be unhappy because their parents are unhappy is key. I wanted my patient to know that! I wanted her to live a fuller, happier life and I believed that she could!

Participant One simply said, "I saw the potential in this kid and I held it in a way such that he could see it too. It took time, but I knew it was there and it was important that he see it!" Participant Three poignantly described her thinking about hope and optimism:

> First of all, I think we have to believe that it's a process. And we have to believe that there is potential for growth. Once you have embraced that concept, it's a lot easier to hammer away at helping that child create inroads into positive self-identity; some sense of closure or understanding of what happened, from a developmental perspective.

In her first interview, Participant Two said:

> Believing that things will be better, and telling the kid that things were going to be better, without being Pollyannaish about it, is crucial. Encouraging them not to worry about the parent, and giving them permission to actually focus on themselves. I reassured my patient that we were going to help her get to a better place, a more serene existence.

She went on:

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> I also tried to talk about the good things about her father, so that she could try to, partly, lessen her guilt. But also, she very much needed to be reassured that she could not see him much and he'd still be okay and they'd still love each other. Talking about the good parts gave her hope that they'd both be okay.

Genuine enjoyment of the child. In five of six interviews, Participants reported experiencing a genuine enjoyment of the child they treated. The impact of a therapist's enjoyment of his or her patient was beyond the scope of the literature review for this study, and so this was not an expected theme. However, it is not a surprising finding in and of itself, and adds a welcome dimension to the study. In her second interview, Participant Two recalled what she told her patient:

> [I told her] that she was amazing. And she really was. What she had been able to do against great odds! It's like, "I don't know how you did it. You were up against such horrendous circumstances with everything going on and you pulled yourself up from your bootstraps! You've got such grit and determination and courage." I really admired her.

She went on to explain why enjoyment is important:

> Number one, without question, is enjoying the relationship with the child or teen; helping them see who they really are, and their strengths, and accepting all parts of them. Then putting all of that in a frame so they feel you have an unconditional positive regard for them. That you respect them, that you think they're great, that you want to know specifically about the things they're doing and interested in so they get the feeling that they're really special, and special to *you*.

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Participants One and Five echoed their enjoyment of their patients by simply saying, respectively, "I love him! He's so wonderful!" and "Oh, I just loved her so much!" Similarly, Participant Three said, "Oh just talking about her courage gives me goose bumps!" and "She was so phenomenal. Absolutely phenomenal. She had such good, such grace. She's loveable and I wanted her to feel that." In her first interview, Participant Two said, "I just loved hearing about her successes in the church group and with playing the trumpet." She went on to say:

> And more than that, I think telling her and showing her that I believed in her and really *liked* her and that I was interested in her life outside the divorce was important. She was a whole person! Not just a child of divorce.

The impact of this finding remains unclear. That is, it is unclear whether the child experienced a growth reaction in part because the therapist found enjoyment in him/her, or if the therapist reported, retrospectively, experiencing enjoyment in the child because of the child's evidencing growth. Both seem possible and likely, but there is a clear distinction that needs further attention.

Endowed versus learned capacity for growth. Participants in five interviews discussed their own ideas about growth being either an endowed or learned trait. Participant One said that she believed capacity for learned growth exists via therapy: "I think everyone in the family models around me. And I think we're surrounding him with people who also have a positive attitude, and that helps his odds [of having a growth reaction]." Certainly this helps, or at least doesn't hurt, a child's probability of experiencing growth beyond baseline. But she also said that this concept "…is not so straight forward."

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Other participants corroborated this finding and expressed difficulty in knowing whether capacity for growth is endowed, learned, or a complex combination of both. Participant Three stated:

> I can't help but believe that she had some natural resilience; that there was some cosmic piece in there. She had to have something like that. But yeah, I don't think it was just absolute; not just a serendipitous event here.

Participant Two, in her second interview, offered:

> Well I think some people are born better endowed than others. I think intelligence is correlated with resilience. It's one factor. Psychological mindedness is another factor that people seem to be born with, that helps them grow and do better.

She went on:

> I think nurture can play a big role in it, too, obviously. Parents that are emotionally tuned in can teach their kids a lot about emotions and how to tolerate their own distress and how to think about it, and how to use their brains and minds to think about what's happening to them and others. But I think some people are better endowed at doing this, so it's complicated.

Participant Five cited that "…always at the core, is basic temperament. Whatever her own [*sic*] inborn level of resilience was, and it must have been pretty high. I think [basic temperament] is always number one." Similarly, Participant Four described:

> I think kids in general are fairly resilient if they are relatively healthy, if they don't have major illness, like genetic or even other illnesses. So I don't think it's so much as resilience is genetic, but the lack of resilience could be genetic. It's

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not like kids have a resilient gene, but most, if left to their own devices, will be resilient if they don't have underlying things holding them down.

And so it remains an important, albeit complicated, theme found by this study that growth is attributed to an assorted, perhaps unquantifiable set of learned and endowed factors.

Summary of Results

Six in-depth, semi-structured interviews of child therapists were conducted in an effort to learn more about the processes by which children experience a posttraumatic growth reaction following a parental divorce. Participants had treated a case in which they believed their patient had a growth reaction. One participant gave two interviews, for a total of 5 Participants. Four participants were female and one was male, each with at least 30 years of clinical experience working with children and families. All participants were Caucasian, as were the children in the cases they described.

Six themes emerged from the interview data. Across all cases, participants reported a reduction in symptoms, as measured by comparing the child's pre-divorce functioning, his or her functioning immediately following the divorce, and the child's post-divorce functioning. Pre-divorce symptoms ranged from self-harm and autistic-like behaviors, to social withdrawal and school refusal. Post-divorce, these same symptoms were greatly reduced. In several cases psychiatric diagnoses given (or assumed) prior to the divorce were revoked following the divorce and after beginning treatment with the Participant. All participants described the immediate impact of the divorce in a negative manner.

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Participants noted that, over time, their patients exhibited increased engagement in the areas of school (renewed or newfound interest in attending, better grades), social connections (enduring or new group of friends, joining teams or clubs), therapy (arriving on time, active participation, collaboration), and engagement with the self (taking more risks, feeling brave, evidencing courage).

The role of parents and other adults was an important theme. Some participants reported that working with parents was an important addition to helping the child, although when attempted it was unequivocally difficult to successfully do so. In all cases the participants talked about the child receiving protection from the more dysfunctional (in some cases physically and/or emotionally abusive) parent as a result of the divorce, and how this likely contributed to the child's growth reaction. It was important not only that the child was not exposed to the dysfunctional parent as much, but that the other, more healthy parent made an effort to protect the child.

It was also found that growth takes time to achieve. Although pockets of growth were seen over time, the participants' retrospective recognition of growth didn't occur until around one year post-divorce. This finding was complicated by two cases in which the participant noted that although the immediate impact of the divorce was negative, the pre-divorce functioning was all the child had ever known. That is to say that, following the immediate chaos and disorganization caused by the divorce, the child had nowhere to go but up and did so quite quickly.

The type of therapeutic stance held by each participant shared much in common. All participants highlighted that creating safety and trust acted as a springboard from which deeper processing could occur, and was paramount to helping the child move

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forward. Providing validation of the child's feelings as well as the child's reality was a clear distinction made in several cases, as was supporting the child through his/her shifting understanding of their place in the world. Exuding hope and optimism to the child emerged as a clear finding, evidenced by all but one participant. The finding of much interest was that all but one participant spoke directly to their genuine enjoyment of the child. Feelings of love, respect, and admiration were expressed.

Finally, in five interviews participants spoke of their general ideas about whether a child's capacity for growth is a learned or endowed trait. Although it was directly mentioned by one participant that capacity for growth could be taught through therapy, the clearest finding was that there is a complex combination of both learned and endowed traits that enables children to grow from trauma. From the participants' perspectives, it appeared that psychological mindedness, luck, temperament, and other inborn traits lay the foundation for learned growth to occur.

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CHAPTER V

Discussion

This study contributes to the dearth of research in the area of PTG in children. Previous research has found that children do experience growth reactions following trauma, but the overwhelming outcome is that growth itself is inherently difficult to measure in children (Cryder et al., 2006; Salter & Stallard, 2004). While adults can easily fill out a self-report measure or discuss the traumatic event with higher-order processing traits like retrospection, perspective, and thus perhaps a greater capacity for meaning-making, it is unclear how a child's developing mind impacts the reporting of PTG. The focus of this study was to understand the processes by which a child experiences posttraumatic growth following a family transition, specifically a divorce. Specifically, the research goals were to gain a better understanding of a child's moving-on from such trauma, with an emphasis on how the child evidenced growth, interventions made by the therapist that may have contributed to the child's growth, and to what the therapist attributed the growth. Through the analysis of in-depth, semi-structured interviews of child therapists who treated a case where PTG was evident, this research adds depth to the existing results in the comparatively minute literature on PTG in children.

This discussion will explore the ways in which the children in this study evidenced growth, the complex relationship between endowed and learned capacity for growth, how the therapeutic stance of the therapist can positively impact a child's growth reaction, and limitations of the current study with suggestions for future research.

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How Growth is Evidenced

A primary finding of this study was that children showed a dramatic reduction in symptoms, as reported by participants. This finding is consistent with the research and shows agreement with the idea that a highly traumatic event can cause significant impairments in functioning (Herman, 1997). Indeed, several of the children described in this study were given, or almost given, psychiatric diagnoses prior to the dissolution of the marriage. Participants recalled their patients as having negative and worrisome symptoms prior to the divorce, such as isolation, withdrawal, anxiety, depression, learning difficulties, and self-harm behaviors. Yet following the completion of the divorce and the initiation of treatment with the participants, the children showed a decrease in the above symptoms. This finding is not surprising in itself, as it could be reasonably expected that a patient would show even modest improvement as the trauma subsides. It was likely a combination of both the dissolution of the marriage and the initiation of treatment that brought about the reduction in symptoms. The significance of this finding is that it appears that the trouble in the family leading up to the divorce was as traumatic, if not more troublesome, than the divorce event itself. This finding corroborates ideas generated by Salter and Stallard (2004) who showed that nearly forty percent of children who reported PTG following a road traffic accident also showed signs of posttraumatic stress disorder. Understanding that children can experience both positive and negative affects concurrently appears to be an important aspect of PTG.

It seems clear that children are particularly vulnerable to the negative impact of a trauma. Because they lack the high-order processing skills retained by most adults, children need help to understand the impact and effects of the trauma in a different way

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than adults. Narrative mapping, for example, scaffolds children through a safe understanding of what has happened (White, 2007). This type of emotional support was absent in all families presented, and was instead provided by the participants during treatment. In cases where participants were involved early in the divorce process, the child appeared to have a quicker and easier path to growth than when participants were introduced later in the process. Perhaps when such scaffolding is missing, the child is more susceptible to the negative symptoms such as those seen in this study.

It should be mentioned here that PTG literature uses the phrase "return to baseline functioning" to describe one's recovery from the trauma (differentiated from one's growth or movement beyond baseline). The phrase "reduction in symptoms," as it is used herein, could be termed the return to baseline functioning, however that idea is complicated by the individual contexts of the divorces in this study. As such it is not being used. For example, the 8-year-old child described in Participant Two's first interview came from a physically abusive household. When her parents finally divorced, she evidenced a considerable reduction in symptoms almost immediately because she was out of a very dangerous and damaging environment. Because the abusive environment was all she had ever known, the description of her baseline functioning was made difficult; it is hard to say what her true functioning was, and what was a by-product of the abuse. To this end, although PTG uses the term "return to baseline functioning" to describe one's first steps towards recovery from trauma, this may not be accurate in cases where a child has never known anything different.

One hypothesis is that the term reduction in symptoms could more accurately encapsulate what it means for a child to grow from trauma. The term return to baseline

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implies a return to what once was, which is a reasonable standard for quantifiably measuring growth as it is defined by "doing better than before." But perhaps it fails to recognize what the child has accomplished to get back to that place, which undoubtedly required traits like courage and persistence, among others. Reduction in symptoms implies that the child is improving and moving forward—growing—regardless of where his/her baseline was. If we know that children are at a greater disadvantage in the face of trauma, and that some children may not have a baseline to return to, then perhaps we should measure their recoveries from their lowest point of functioning, not solely their baseline functioning. This idea needs greater attention.

A greater sense of engagement was evidenced in several domains throughout this study. This was a predicted finding based on research on indicators of positive change, specifically in the areas of cognition, behavior, social, emotion, and academic performance. Because there isn't a great deal of research on the antecedents or consequences of PTG in children, I was challenged with piecing together research in different areas to create a rubric by which to measure growth in this study.

All children in this study evidenced increased engagement with school, and this has been well documented as indicative of positive change (Epps, Park, Huston, & Ripke, 2005). This was apparent in the areas of enduring attachment to the school and teacher, greater competency, and better overall performance. The findings corroborate those of McNeely (2005), who found that continued participation in school and school-related activities is a strong marker of positive change.

One participant identified risk-taking as an important way in which the child had grown, and this was an unexpected finding not predicted by the literature. In this case, the

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participant saw taking risks as a necessity in the child's schooling; for example, the ability to raise her hand, make a mistake, and grapple with new concepts. Prior to the divorce the child was unable to take these types of risks, and so her academic performance and relationship to the teacher was suffering. As she worked through the divorce in therapy, the participant saw a distinct positive change in the child's ability to take risks, which, in turn, helped dramatically improve the child's academic success.

One hypothesis for this unexpected finding is that the specific context of a child's family must be taken into account when assessing growth. In this case, the unique problems the child was facing in her family system were affecting her in similar ways at school. Prior to the divorce, this child's lack of risk-taking was thought to represent severe learning disabilities. This located the problem within the child. But the participant assessed that the family dysfunction had paralyzed the child's ability to take risks, which placed the problem outside the child and more accurately in the family system. It therefore appears that helping a child move toward a growth reaction requires carefully tailored attention and intervention.

Children in this study displayed evidence of a sense of social belonging through several avenues, including joining a church group and joining a soccer team. On a more concrete level, participants noted their patients began spending the night at friends' houses, and participating in social events outside the home such as parties and school functions. One child became romantically involved with a boyfriend, which the participant saw as a strong indication that his patient was displaying a movement beyond her baseline functioning (for example, increased capacity for emotion, tolerance of connection, altruism). These findings are consistent with the literature, which

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demonstrates that children who maintain an enduring group of friends, develop a new group of supportive peers, or engage in social activities with friends show evidence of positive change and/or higher competency beliefs (McNeely, 2005; Cryder et al., 2006).

Children also showed evidence of growth through their engagement with therapy. This finding was moderately predicted by one study, which found that a child who learns to ask for help in therapy shows clear evidence of positive growth (Wolters, Pintrick, & Karabenick, 2005). However, one alternative hypothesis for this finding is that the theoretical orientation of the participants influenced how the treatment progress was conceptualized. Four of the five participants reported a theoretical orientation partially or fully influenced by Control Mastery Theory, which places a high value on the therapeutic relationship as a barometer for patient progress (Weiss, 1993). As such, it seems possible that these participants would be likely to see a connection between their patients engaging more in therapy and the occurrence of objective, measurable growth outside the therapy.

All children in this study displayed an increase in their cognitive and emotional engagement. This finding was predicted by the research and its importance is worth highlighting. Cognitive/emotional indicators of positive change include internal characteristics of the child, such as positive attributions and expectancies (Huebner, Suldo, & Valois, 2005), optimism (Snyder, 2005), perspective taking (Barber, 2005), general resilience (Benson et al., 2005), pride, and assertiveness (Epps, Park, Huston, & Ripke, 2005) to name a few. For the purposes of this study, this subset of indicators represents an important gauge of how children assimilated information from the trauma; that is, these traits are the hoped-for result of the struggle with the trauma, which

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Tedeschi and Calhoun (2004) cite as the primary contributor to adult PTG. That participants reported this kind of growth in their patients is remarkable and adds to the body of research supporting that children do, indeed, grow from trauma.

How Growth Happens

While it is unequivocal that the children in this study did grow, it is less clear what processes enabled that growth to occur. This is consistent with other findings in the PTG literature, which explain that because PTG is a process of thriving and moving on, it is thus difficult to conceptualize (O'Leary & Ickovicks, 1995). The findings discussed below are specific to PTG and divorce, of which no prior studies exist.

The participants cited working with parents as an important process that may have enabled PTG to occur in the children in this study. This finding was not predicted by the literature and contributes to the growing body of research on PTG. Interestingly, participants reported that working with these parents was extremely difficult, and for the most part they were unsuccessful in engaging the child's parents in the therapy. However, it appears that, regardless of how successful the attempt was, the attempt itself was important to the child and perhaps enabled growth.

In cases where the participant was able to engage the parents in the therapy, growth appeared to be faster and more measurable. Participants reported being able to help the parents understand the child better, make helpful accommodations for the child, and create opportunities for the child to be heard by the parents. It appears that this intervention, when successful, has considerable benefits. First, the parents are included in the therapy. When this is in the best interest of the child, it has widespread positive impact. Second, in the therapist's attempt to help the child in this concrete way, the child

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feels more understood by the therapist, perhaps leading to a deeper, closer therapeutic relationship. If an attempt to engage the parents has a positive impact on the child even when it's unsuccessful, it could easily be assumed that its impact on the child when it *is* successful is of enormous value. Further study is needed to better assess the relationship between the occurrence of PTG in children and parental engagement in therapy.

Unequivocally, when the divorce resulted in the child gaining protection from his/her more dysfunctional parent, growth occurred. Participants used the words "protection" and "toxic" to describe this process. Although this outcome was not predicted, as there is no previous research in this area, it is not a surprising finding. It could be reasonably expected that the removal of a toxic person in a child's life would bring about a reduction in physical symptoms and emotional guilt, both of which evidence considerable growth. However, that a child feels the divorce *protected* them in some way appears to be an important antecedent to PTG in cases of divorce. Further study in this area would be a valuable contribution to the literature.

This study found an important association between the presence of other adults in the children's lives and PTG. This finding was predicted by research on indicators of positive change, showing that an attachment or positive engagement with an adult outside the family is indicative of a positive step (Benson, et al., 2005). Four children in this study evidenced a relationship with an adult-other, which the participant viewed as an important process by which growth occurred. This is differentiated from being evidence of growth, as was discussed above. In this case, it appears that having an enduring adult outside the context of the divorce enabled the child to have a helpful distance from the family's difficulties. One hypothesis for this finding is that this afforded the child a

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healthier and more supportive view of what was going on in his/her family, as would be the case with a church leader. Another hypothesis is that the adult-other acted as a healthy distraction from the divorce, thereby giving the child permission to stop thinking about it and instead engage in age-appropriate activities, as would be the case with a soccer coach. In either case, it appears evident that a child's relationships to an adult-other is a strong contributor to PTG.

There was a rich and complex discussion by the participants about whether a child's capacity for growth is an endowed trait or a learned set of skills. This question did not result in strong findings in either direction, but adds to the body of research suggesting that PTG and resilience are complicated constructs worthy of greater empirical inquiry. It was evident that the participants felt both ways about a child's capacity for growth; that it could be partially endowed through the child's temperament, and that it could be learned under ideal circumstances. Participants mentioned psychological mindedness, openness, resilience, intelligence, and even the luck of the cosmos as endowed qualities. However, it was also noted by one participant that parents who are emotionally tuned-in can teach their children the requisite skills for processing distress, the skills which research shows can not only help children process trauma in the moment, but that can also buffer against future trauma (Huebner & Gilman, 2003). Likewise, although it tentatively appears that growth is combination of both endowed traits and learned skills, further research in this area is needed to elucidate the complexities of this relationship.

A related finding of this study is that growth takes time to achieve. This finding is commensurate with literature questioning how and when PTG occurs in children, and

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how a child's age, development, cognition, and ability to have perspective impacts perceived growth (Polatinksy & Esprey, 2000; Salter & Stallard, 2004). In four interviews participants discussed the child's progress as being most noticeable after about one year post-divorce. In these cases, growth trajectory was described as slow and steady. A complication of this result is that, for two of the children in this study, growth (as measured by reduction in symptoms) happened very quickly due to the fact that the divorce relieved the child of life-long imminent fear or danger. In this case, growth was immediate and of steep trajectory. This adds emphasis to the need for context-specific assessment when measuring the relationship between PTG and divorce. Further research is needed to elucidate the relationship between perceived growth and duration of time since the trauma, and what role the child's age and development have in impacting the occurrence of PTG.

How Therapists Can Support a Growth Reaction

There were commonalities in the therapeutic stance used by participants and this emerged as an important finding in this study. This finding contributes to a gap in the literature with respect to the relationship between therapeutic stance and PTG, as no such studies have been authored. It seems likely that the previous findings in this study were impacted by the participants' therapeutic stance, and as such deserves much attention.

There appears to be a strong relationship between the occurrence of PTG and the participants' creation of safety and trust in the therapeutic relationship. It was directly noted in five interviews that the creation of safety and trust was paramount to helping the child feel comfortable in the therapy. This finding itself is obviously not a new result. Creating safety and trust is taught to undergraduates and first-year graduate students in

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the fields of psychology, social work, school counseling, and other social sciences, and is considered the foundation of therapy. But because no studies have been conducted on the relationship between therapeutic stance and PTG, these results are the first of their kind and call for further empirical attention.

Providing validation and support emerged as important factors that may have enabled PTG to occur in this study. In a study conducted by Park, Cohen, and Murch (1996) results indicated that keeping the cognitive process active following a trauma may help enhance PTG. Indeed, even the authors of PTG themselves have cited the importance of deliberate cognitive and emotional support following the trauma (Tedeschi & Calhoun, 2004). Furthermore, Huebner et al. (2004) found that helping children explore their subjective experiences of trauma leads to increased life satisfaction. These findings were corroborated by this study and add emphasis to the existing literature.

Two types of validation were evidenced in this study: validating *feelings* and validating *reality*. Validating feelings is common therapeutic practice, and although doing so often implies that the therapist has an understanding of a patient's reality, it appears that a clear distinction between the two is important for working with children. As discussed by Janoff-Bulman (1992), trauma can cause a shattering of one's assumptions about the world and one's place in it. It can thus be assumed that for children, who oftentimes have difficulty processing traumatic events, validating reality is a crucial way in which therapists can bridge the gap between a child's experience and a child's understanding of that experience. Linking this back to the child's feelings about the experience creates a helpful, and perhaps much needed, learning experience for the child.

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Participants in this study also discussed the significance of hope and optimism in their relationship with the child. Although no previous studies have examined the relationship between hope and optimism and PTG as it relates to therapeutic stance, these results are not entirely unexpected. Related literature is peppered with the words hope and optimism. For example, the positive psychology movement has identified that cultivating hope and optimism, among other traits, positively influences one's ability to cope with major traumas as well as everyday struggles (Miller & Nickerson, 2007). Likewise, Fredrickson's (2001) broaden-and-build theory of positive emotions cites that the experience of hope, optimism, and other positive emotions broadens one's inventory of reactions to all types of situations. While these studies reflect the significance of hope and optimism within the patient, the present study imparts the significance of these traits within the therapist.

One hypothesis for this finding is that the therapist's optimistic perspective was a novel experience for the child, creating a substantial positive impact for him or her. It is not uncommon for children to feel scared, worried, and low-spirited about the difficulties in a divorcing family, and this was certainly true in the present study. Similarly, it is not uncommon that when embattled parents reassure children that everything will be okay, children often do not believe it. With a strong therapeutic alliance built on safety and trust, perhaps the therapists' assertion that the child's circumstances and feelings will get better was more relieving than the parents' same statement.

It seems likely that a child would benefit from a therapist's hope and optimism during a challenging time. Children need a great deal of help following a traumatic event: processing the trauma, regulating feelings about the trauma, and understanding the

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impact of the trauma are all aided by the therapist. It thus seems entirely expected that children would also need help feeling hopeful, and that the therapist would undertake this task as well. In either case, it is good therapeutic practice to hold positive qualities on behalf of patients who cannot hold them for themselves, and this is particularly true for children. That a therapist maintains and conveys hope and optimism for the recovery and ultimate growth of the child appears to be a worthy contributor to PTG.

In five interviews, participants directly mentioned how much they genuinely liked or admired their patient. This emerged as an interesting finding, suggesting that there may be a relationship between the occurrence of PTG and the therapists' genuine enjoyment of the child. No such studies have examined this relationship, so these results were unexpected. It is unclear what process enabled this result; in other words, whether the child experienced a growth reaction in part because the therapist found enjoyment in them, if the therapist found enjoyment in the child because of the child's growth, or if there is another explanation altogether. One hypothesis could be that, due to the fear of and guilt evidenced by the children in this study about causing the parental struggles, the child may have felt unworthy of being enjoyed. If that were the case, then it would be expected that the therapist's explicit positive regard for the child would have an extensive impact on the child. These hypotheses are beyond the scope of the present study, but could greatly benefit from further empirical examination.

The aforementioned findings regarding the relationship between therapeutic stance and PTG suggest that with a calibrated approach, growth outcomes for children are not only possible but can be more prevalent than previously thought. Indeed, most participants had no prior knowledge of PTG, yet treated a case where it occurred. As

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such, this study's hypothesis that growth happens more than we realize is true. However, because no research has been conducted on the relationship between therapeutic stance and PTG, further research is needed to substantiate these findings.

Summary and Conclusion

The constellation of these findings, when taken together, creates a framework for understanding the complicated processes by which children experience a post-traumatic growth reaction following a divorce. Results clearly indicate that children evidence growth in many ways, some objectively measurable (as in concrete reduction in symptoms) and others more susceptible to subjective perception (as in emotional engagement). This finding substantiates results found in the wider literature on PTG and indicators of positive change but adds that perhaps growth becomes more recognizable when the therapist is oriented to the child's progress starting from his or her lowest point, as opposed to his or her baseline functioning.

The participants in this study attributed the growth of their patients to several factors. Attempting to work with the child's parents in a way that is seen as aligning with the child (the success of the attempt did not matter), the child feeling as though the divorce protected him or herself in some way, as well as the important role that other adults in the child's life played were all cited as central to the growth reaction as a whole. These findings are mostly consistent with the literature, but add that growth can be accomplished by more than solely grappling with the trauma, as the authors of PTG (Tedeschi and Calhoun, 1995) suggest is the primary causal process for PTG in adults. Furthermore, results of this study corroborate the findings of others that a child's capacity for growth is a complicated combination of endowed and learned traits. Although it

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appears that a child with more endowed traits may fare better following a trauma, it is clear that therapists can have a substantial impact on the learning process. Adding complexity is the question of how long it takes for growth to be achieved following the trauma. Although results were mixed in this area, it appears that growth occurs slowly with a retrospective account of growth around one year post-divorce. However, if the divorce alleviates imminent danger or fear, it appears that growth is more immediate. The sum of these findings add emphasis to the notion that a child's capacity for growth is context-specific and requires case-by-case, individualized assessment.

Perhaps the most interesting and clinically relevant finding of this study is that therapists can do a great deal to help children experience PTG. Creating safety and trust, though not a novel finding in itself, emerged as a keystone to working with the children in this study. Validation and support, with a distinction between validating the child's feelings separately from his or her reality, were also noteworthy and may impact the occurrence of PTG. There appears to be a relationship between the therapists' orientation towards hope and optimism and PTG. Although it is unclear how, exactly, hope and optimism impact PTG, it is clear that a therapist's belief that the child can and will get better has powerful meaning to the child. Finally, it appears that a therapist's genuine enjoyment of the child is an influential contributor to PTG. This is a complicated idea beyond the scope of this study, but has important clinical implications with regards to positive outcomes.

Because these findings on their own are generally known to be influential in therapy, it is my belief that these results have a building effect wherein the therapeutic relationship is made stronger by the achievement of each previous step.

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Limitations and suggestions for future research. Several limitations should be acknowledged and hopefully addressed in future research. First, it is important to mention the apparent difficulty in delineating the extent to which the child's growth was impacted by the therapy, rather than the result of grappling with the trauma itself. This is a complicated distinction, but one that seems vital to achieving a deeper understanding of PTG in children. Further research is needed to tease out this complication, perhaps utilizing different modalities of therapy (i.e. group therapy or school-based counseling) or other means of data.

Methodological limitations may exist in the current study. Although qualitative studies have a capacity for richly detailed findings, a quantitative inquiry may have resulted in more robust findings. The results of a quantitative study would be of immense value to the existing literature. While the current study's use of semi-structured interviews allowed for a detailed depiction of the child being presented, future research should perhaps include more questions relating to the background of the marriage and context of the divorce. At the onset of the study, my focus was on how the child's symptoms would evidence change and amelioration over time. Although this focus proved significant with respect to the findings, the aggregate of the results implies that an assessment of PTG and divorce requires case-by-case, individualized and context-specific measurement. Additional questioning during the interview would help to elucidate this material and add depth to the existing body of knowledge.

One unanticipated challenge of this study was the recruitment of participants. Responses to the Internet advertisement/flyer were sparse and only one participant was found via this channel. The remaining participants were found with the help of colleagues

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and friends. Although this added a friendly aspect to the interviews, which may have made participants feel more comfortable and willing to talk to me, it may have added an unintended complication to the sample. All but one participant had a theoretical orientation either partially or fully influenced by Control Mastery Theory. This theory places a high value on the therapeutic relationship, and the findings of the present study conferred that a tailored approach to the therapy may result in a greater likelihood of PTG in children following divorce. Although previous research has highlighted that PTG can occur across all theoretical orientations, it is unclear what effect, if any, the participants' theoretical orientation had on the results of the study. Future studies should broaden the sample to include participants with varied theoretical orientations.

Due to the difficulties I experienced with recruitment, the sample of participants in this study was inadequate in its representation across racial and ethnic groups. Indeed, three participants identified as White/Caucasian, one as Caucasian-Jewish, and one as Russian-Jew. This could call into question the interpretability and generalizability of these findings due to underrepresentation of other racial/ethnic groups and overrepresentation of White/Caucasian participants. Furthermore, the children presented in this study were all identified as White/Caucasian. This greatly limits the generalizability of the current findings, and future studies should ensure a wider sample with respect to the race and ethnicity of children to better understand PTG across ethnicities.

Based on these limitations, future studies examining the link between PTG in children and divorce would benefit greatly from a mixed-method approach. A longitudinal design consisting of a larger sample size would be ideal, utilizing various

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methods of data collection and analysis. Gathering data from parents, teachers, therapists, and even the source of the referral for therapy would add great depth of knowledge, as would data collected from the child him/herself. Behavior rating scales and measures of anxiety and depression given at intervals of time would offer helpful quantitative measures of change over time. Additionally, future studies should make the effort to achieve greater detail regarding the context of the marriage and subsequent divorce. Undoubtedly, a second interview solely dedicated to this information would be of immense value. Furthermore, it would be of great interest and proper research design to follow several cases that seemed unlikely to result in PTG to serve as an empirical control group.

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Appendix A

Recruitment Flyer

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HELP NEEDED FROM CHILD THERAPISTS

Are you a child therapist (MFT, PsyD, PhD, MD)?
Do you have a caseload of at least 50% children?
Have you been licensed for at least 5 years?
Have you treated a child of divorce where you believe the child actually *grew* or *flourished* following the immediate negative impact the divorce?

If you answered **YES** to ALL of these questions, please consider being interviewed for a study about post-traumatic growth in children experiencing family transition (divorce).

What it involves:

- Having one confidential interview (phone or in person) lasting approximately 1 hour
- Reflecting on a case you treated where you perceived the child had a growth reaction (more than just a return to baseline functioning) following his/her parents' divorce
- Discussing your knowledge of post-traumatic growth in children

Participation is voluntary and confidential.

If you are interested please contact

Jodi Engstrom, M.A. at (415) 609 – 2813 or e-mail Jodi.L.Engstrom@gmail.com

Your help is greatly appreciated

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Appendix B

Contact Transcript

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Hello. My name is Jodi Engstrom and I am a doctoral student in psychology at the California School of Professional Psychology (CSPP) at Alliant International University. I am working on my dissertation and would like to tell you about my study to see if you are interested in participating. I was wondering if I could have fifteen minutes of your time.

(If no) Is there a better time to contact you?

(After response) Thank you, I'll be sure to call you then.

(If not). Thank you, I appreciate your time.

(If yes) Thank you. My study is involving a child therapist's account of a divorce case, wherein you, the therapist, perceived that the child showed a positive growth reaction following the adversity. In other words, I am interested in hearing about the possible ways in which the child not only returned to his or her baseline functioning, but actually flourished following the divorce. There is much research proving that adults grow from trauma, but less so about children. To be eligible to participate, you need to have a caseload of at least 50% children, and have at least 5 years of licensed professional practice. Does your practice fit these criteria?

(If yes) Wonderful! If you decide to contribute, participation would require one interview, conducted by me, that would last approximately one hour. We can complete the interview either in person or on the phone. If the interview is done in person, we could complete the interview in your office at a time that is convenient to you, or in a private room at Alliant International University (CSPP). If we conduct the interview over the phone, I will mail you the consent form a week prior to our scheduled interview, so

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that you may read and sign it, and so that I may have it back in my possession at the time of the interview.

Is this something you might be interested in? Can you think of a case you'd be willing to talk about?

(If so) Great! Thank you so much. I hope that the study will inform psychotherapists about post-traumatic growth in children, and give better insight as to how therapists might be helpful in enhancing growth following adversity. Let's see if we can schedule a time for an interview.

(If not, I will read the following) I understand, thank you for your time. Might you be able to provide me with contact information for other child therapists who might be interested in participating in my study? Please feel free to give my phone number or email address to other therapists you know who might be interested.

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Appendix C

Informed Consent

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Informed Consent

TITLE OF STUDY: Enhancing Growth Following Adversity in Children Experiencing Family Transition: An Integrative Framework

PRINCIPAL INVESTIGATOR: This research is being conducted by Jodi Engstrom, M.A. Ms. Engstrom is a graduate student in the doctoral program in clinical psychology at Alliant International University, San Francisco, California. The research study is being conducted to fulfill a degree requirement for the academic program in which she is enrolled.

WHAT WILL I BE ASKED TO DO? If I choose to participate in this study, I will be asked to respond to a series of questions related to a case I treated wherein a child experienced divorce. The interview should take approximately one hour to complete.

WHAT IS INFORMED CONSENT? I am being asked to take part in a qualitative research study. Before an informed decision is made whether to participate, the possible risks and benefits associated with this study should be understood. This process is known as informed consent. This consent form will provide me with the information about this study and my rights so that I can make an informed decision.

WHAT ARE THE POSSIBLE RISKS INVOLVED? There is minimal risk in participating in this study. I do not have to answer any questions I do not wish to, and can stop the interview at any time.

WILL I BENEFIT FROM TAKING PART IN THIS STUDY? Participating in this study may help me gain greater understanding of the concept of post-traumatic growth, and thus perhaps impact my future work with children of divorce. My participation will certainly help Ms. Engstrom understand more about post-traumatic growth in children,

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and the ways in which children may growth from an adverse experience. I will also have the option to request to see the final results of the study. If I choose to do this I will leave my contact information at the end of this consent form.

WHO WILL SEE THE INFORMATION THAT I GIVE? Identifying information about me obtained in this study will be kept confidential and will not be released without my written permission unless compelled by law. My identity will not be revealed in any publication of study results. All data will be de-identified and all participant names will be kept separately. Furthermore, Ms. Engstrom will ask me to use a pseudonym or single initial to identify the child client about whom I discuss, thus keeping his/her identity entirely confidential. All records will be stored on Ms. Engstrom's personal computer in a password-protected file, and in a locked filing cabinet in her home. She will be the only one with access to my materials. However, in situations in which there are ethical or legal limits of confidentiality, such as immediate grave danger to myself or to others, and recent child or elder abuse or dependent adult abuse, information must be disclosed.

AUDIOTAPING: Ms. Engstrom is requesting permission to audio tape the interview so that my responses can be transcribed exactly as I say them. Ms. Engstrom will then take these audiotapes and transcribe them. These audiotapes and transcriptions will be stored in a locked cabinet in Ms. Engstrom's home. The transcription will be on her personal computer and password protected. No names will be included in the transcription. Files stored on her computer will be destroyed with secure erase software along with stored audiotapes five years after the completion of the study or publication, whichever comes later.

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WHAT IF I HAVE QUESTIONS? If I have any questions about this study, I can feel free to call Ms. Engstrom at (415) 609-2813. If I would like to talk to someone separate from the research study, I can call the Institutional Review Board (IRB) at 415-955-2151 or e-mail at irb-sf@alliant.edu.

By signing below I agree to participate in the study and to be audiotaped. In addition, I agree that I understand my rights and what is entailed in this study. I will receive a copy of my signed consent for my records.

____ _______________
Signature of person agreeing to take part in the study Date

____ _______________
Printed name of person agreeing to take part in the study Date

____ _______________
Signature of person providing information to participant Date
Ms. Engstrom

____ _______________
Printed name of person providing information to participant Date
Ms. Engstrom

[ ] Yes, I am interested in receiving a summary of the feedback about the results of the study once it is completed. I am including my information below so that I may receive them.

____

____

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Appendix D

Interview Protocol

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I. Background Information

1. How long have you been working with children?
2. How long have you been licensed?
3. What is your degree?
4. What proportion of your caseload is children and families?
5. What is your theoretical orientation?
6. What is your ethnicity?

II. Experience with and knowledge of post-traumatic growth

1. Have you ever heard of post-traumatic growth (PTG)?
2. If yes, can you tell me what you know if it? If no, offer brief description.
   -Greater appreciation of life and changed sense of priorities
   -Warmer, more intimate relationships with others
   -Greater sense of personal strength
   -Recognition of new possibilities or paths for oneself
   -Spiritual development
3. Have you ever heard of, or read about post-traumatic growth in children?
4. Based on your clinical knowledge of children, how would you know that your child client was functioning better after a divorce? What behaviors or statements would indicate a positive change?

III. A case of PTG in a child client

Think of a case you treated where you believe your child client experienced a post-traumatic growth reaction following a family transition (divorce).

1. How old was the child?
2. Please describe the **pre-divorce** functioning of the child (quality and type of family interaction, peer interaction, academic success or difficulty, participation in activities, cognitive engagement, etc)
3. Please describe the **immediate impact** of the divorce on the child? How would you describe the child's reaction (quality and type of family interaction, peer

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interaction, academic success or difficulty, participation in activities, cognitive engagement, etc)

4. Please describe the **post-divorce** functioning of the child (quality and type of family interaction, peer interaction, academic success or difficulty, participation in activities, cognitive engagement, etc)
5. Please describe the role of the child's parents in the child's pre- and post-divorce symptoms (quality of the parental relationship, quality of the child's relationship to each parent, level of functioning of each parent, etc)
6. About how long did it take for the child to show signs of a return to pre-divorce functioning?
7. About how long did it take for the child to show signs of movement *beyond* their baseline functioning, ie a positive growth reaction?
8. What behaviors or statements did the child make that showed a growth reaction?
9. How would you characterize/describe trajectory of the child's growth reaction over time? (i.e. slow, steep, short, quick)
10. To what do you attribute the child's growth reaction?

IV. Therapist Interventions

1. What behaviors or statements, if any, did you make that encouraged or enhanced the child's growth reaction?
2. How do you believe your behaviors or statements helped the child?

V. Theoretical Considerations

1. Adult PTG is characterized by growth in several discrete domains, which are not necessarily applicable to children. What domains (or areas of growth) do you think would accurately describe a child's PTG?
2. How do you think a therapist's relationship to his/her child client can facilitate a PTG reaction?
3. What type of therapeutic stance might be most helpful in encouraging a child's PTG reaction?

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Appendix E

Indicators of Positive Change

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Trait	Not Evidenced	Somewhat Evidenced	Evidenced	Strongly Evidenced
COGNITIVE				
Positive Expectancies				
Positive Attributions				
Optimism				
Perspective-Taking				
Positive Self-Talk				
Goal-Directed Thinking				
Cognitive Engagement				
BEHAVIORAL				
Attachment to Adult				
Enduring Identity				
Evolving Identity				
Engagement with Mother				
Engagement with Father				
Joining a Club/Team				
Commitment to Family				
SOCIAL				
Sense of Social Belonging				
Enduring Group of Friends				
New Group of Friends				
Demonstrates Empathy				
Demonstrates Altruism				
Positive Self-Esteem				
Resistance to Peer Pressure				
Attachment to Adult Other				
EMOTIONAL				
General Resilience				
Desire to Fight Adversity				
Overall Life Satisfaction				
Reduction in Uncertainty				
Pride				
Self-Assertiveness				
Internal Locus of Control				
Asks for Help				
ACADEMIC				
Focus				
Concentration				
Perseverance				
Mastery Approach				
Curiosity				
Motivated				
Attachment to Teacher				
Attachment to School				

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