

University of St. Thomas, Minnesota

UST Research Online

Social Work Master's Clinical Research Papers

School of Social Work

2014

The Role of Resilience in Adolescents with Complex Trauma: A Look at Therapists' Perspectives

Abby O. Schwebke

University of St. Thomas, Minnesota

Follow this and additional works at: https://ir.stthomas.edu/ssw_mstrp



Part of the [Clinical and Medical Social Work Commons](#), and the [Social Work Commons](#)

Recommended Citation

Schwebke, Abby O., "The Role of Resilience in Adolescents with Complex Trauma: A Look at Therapists' Perspectives" (2014). *Social Work Master's Clinical Research Papers*. 383.

https://ir.stthomas.edu/ssw_mstrp/383

This Clinical research paper is brought to you for free and open access by the School of Social Work at UST Research Online. It has been accepted for inclusion in Social Work Master's Clinical Research Papers by an authorized administrator of UST Research Online. For more information, please contact asle4660@stthomas.edu.

The Role of Resilience in Adolescents with Complex Trauma: A Look at
Therapists' Perspectives

By

Abby O. Schwebke, B.S.

MSW Clinical Research Paper

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

Committee Members
Colin Hollidge, Ph. D (Chair)
Tiffany Johnson (MSW, LGSW)
Britta Svhiel (MA, LADC)

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

ABSTRACT

The purpose of this research study was to look at what resilience factors therapists view to be important in their work with adolescents who have experienced complex trauma. This study used a qualitative research design, in the form of semi-structured interviews to collect data. The main findings of this study showed that 100% of the participants perceive healthy attachments to be a leading resilience factor in complex trauma. Additionally, according to the participants in this study, unhealthy coping skills (promiscuity, chemical use, self-harm and dissociation) were discussed as survival techniques. Finally, the use of resilience in therapy was addressed with incongruent findings. Participants differed in their view of client readiness to process their complex trauma. The findings of this study can be used to help therapists gain a better understanding of what resilience factors are common in clients who have experienced complex trauma, which will assist them in their work together.

TABLE OF CONTENTS

Introduction..... 1

Literature Review.....4

Conceptual Framework.....19

Methods.....22

Findings.....25

Discussion.....30

References.....37

Appendix A.....42

Appendix B.....44

INTRODUCTION

Traumatic events have frequently been raised as a concern for many individuals. There is now more information about the numbers of children and adolescents who have experienced trauma. According to Briggs et al. (2013), a cumulative of studies have shown that approximately 25% to 61% of children and adolescents have had at least one incident of potential traumatic exposure. Traumatic events included in these studies are not limited to the following; child physical and sexual abuse, violence in families and communities, natural disasters and terrorism, accidental or violent death of a loved one, refugee and war experiences, impaired caregiving, and life-threatening injury and illness (Briggs et al, 2013).

Often, complex trauma is diagnosed as Posttraumatic Stress Disorder, which includes single episodes of trauma. Therefore, determining the prevalence of complex trauma for adolescents is difficult to ascertain. Complex PTSD is defined by Lawson & Quinn (2013) as “exposure to severe stressors that most often begin in childhood or adolescence, occur repeatedly over time, and are perpetrated within the caregiving system or by other adults who typically are expected to be the source of security, protection and stability” (p. 498). Fairbank (2008) provides an overview of studies that have been completed looking at prevalence of multiple traumas. In the National Survey of Adolescents they found 17.4% experienced serious physical assault, 8.1% experienced sexual assault and 39.4% were a witness to one or more incidents of interpersonal violence. Furthermore, in a study conducted by Abram and colleagues (2004, 2007), they found that 84% of juveniles in a detention center, ages 10-18, had reported “multiple exposures to trauma, with a majority exposed to six or more” (Fairbank, 2008, p. 3).

While it can be difficult to find a specific definition of complex trauma and the statistics of how many adolescents have experienced this type of trauma, there continues to be evidence that it is a concern within this age group. Fairbank (2008) references the *Developmental Victimization Study*, which was conducted by Finkelhor, Ormrod, Turner, and Hambly in 2005. This study had a sample of individuals from 2-17 years of age with a participation of 2,030 children and adolescents. The study looked at several different forms of victimization; assaults (sexual and nonsexual), dating violence, hate crimes, property thefts and criminal victimization. In this study, Finkelhor et al. found that approximately 70% of their participants experienced multiple traumatizations, with an average of three different exposures to victimization (Fairbank, 2008).

Posttraumatic Stress Disorder is similar to other mental health diagnoses in that there are risks for the failure to treat it. Lang, Ford, & Fitzgerald (2010) reported that, “Children exposed to psychological trauma, particularly chronic traumatic stressors, are at increased risk for multiple problems, including internalizing and externalizing disorders, academic problems, impaired relationships, and health problems” (p. 102). The developmental changes during a young person’s life are difficult no matter what a person has experienced, this shows that those who have experienced trauma are at risks for even more disruptions in their functioning. Similarly, Lawson et al. (2013), agree stating that there are lifelong consequences to untreated trauma, such as addiction, self-injury, issues with attention and consciousness, depression and anxiety, and identity concerns.

The risk factors involved with untreated complex trauma are important to be aware of, as it sets a stage for an individual’s ability to function after experiencing complex trauma. An ability to adjust or recover from change or a negative experience

defines resilience (Webster Dictionary). Resilience in a mental health aspect is a concept that begins to address factors that assist in functioning despite experiencing traumatic events. “Studies in the area of trauma have revealed that many human beings are quite resilient when faced with a traumatic event and do not experience any further aversive effects as a result of the already-aversive experience” (Black et al., 2012, p. 192). While research shows the ability for individuals to show resilience in aversive events, this does not speak to what factors must be present in order to have this resilient response to complex trauma.

Research focuses mainly on the types of therapies that are most effective in the treatment of PTSD. There is a lack of information on looking at resilience factors, specifically in complex trauma. There has been much research done on resilience in general regarding aversive events, however, that is a daunting accumulation of definitions. Therefore, the purpose of this study will be to look at what therapists believe is the role of resilience in adolescents who have experienced complex trauma.

LITERATURE REVIEW

Complex trauma will be defined and compared to Posttraumatic Stress Disorder (PTSD). The developmental factors for adolescents and the way in which complex trauma interferes with that development will be addressed. Furthermore, relational aspects and dissociative factors will be explained relating to adolescents who experience complex trauma. The second portion of the literature review will focus on resiliency; what it is, how it is developed, and describe protective factors and interventions.

Complex Trauma

The occurrence of maltreatment and abuse is most commonly found in early childhood. Liberman (2011) reported that death caused by abuse or neglect occurred in approximately 75% of children under four years old. Furthermore, 21.9 out of 1000 children were victims of maltreatment. According to the U.S. Department of Health and Human Services (2010), in 81.3 % of maltreatment cases the parent was the perpetrator and in 13.4 % it was a nonparent (U.S. Department of Health and Human Services, 2011).

Complex trauma is defined as repeated exposure to maltreatment in the form of emotional, physical or sexual abuse, and neglect experienced for an extended period of time, typically by a trusted adult or others who are viewed as safe to the victim. These events are frequently viewed as terrifying, shocking and potentially a threat to safety or integrity (Lawson & Quinn, 2013; Lawson et al., 2013 & Black et al., 2012). One of the main factors that separates complex trauma from a single episode of trauma is the repeated exposure and timeframe that is involved. Furthermore, the diagnosis of complex trauma is not concrete, due to the different types of symptoms from DSM-V disorders

that an individual may experience. There is not a definitive diagnosis of complex trauma, but more so, a focus of the co-morbid aspects of it (Lawson & Quinn, 2013).

Complex Trauma compared to PTSD

In the DSM-V (2013), PTSD is identified by a list of symptoms that an individual must display to meet criteria for a diagnosis. A brief overview of the symptoms includes: re-experience of the trauma, avoidance, increased arousal, and intrusive thoughts (DSM-V). The DSM-V (2013) briefly explains the difference in presentation of PTSD for individuals. It states that PTSD may be displayed by re-experiences, or emotional or behavior symptoms for some. Others may experience more negative thinking or a lack of enjoyment or dissatisfaction in their life. Still others may notice more of an emphasis on arousal or reactive-externalizing or some may experience more dissociative symptoms. These may appear separately for individuals who have PTSD, or they may be seen in a combination of the different symptoms (DSM-V, 2013). Black, Woodworth, Tremblay and Carpenter (2012) state that the difference between a PTSD diagnosis and complex trauma is: “Complex trauma shares many symptoms with PTSD but is a distinct construct characterized by developmental difficulties such as structural dissociation, somatic dysregulation, and disorganized attachment patterns” (p. 193).

According to Courtois (2004), researchers and clinicians disagreed whether PTSD was a fitting diagnosis for individuals who had experienced repeated traumas. These disagreements helped to form the term complex trauma, due to the varying symptoms or responses extensive trauma displays in individuals. Courtois (2004) explains some of the differences as being age and length of time the traumas were experienced, what the relationship was to the perpetrator, and perceived threat of the trauma. These distinctions

differentiate a single episode of trauma to repeated traumatic experiences. An individual who has experienced multiple traumas does not necessarily have a diagnosis of Posttraumatic Stress Disorder (PTSD).

Terr (2003) explains that mental health professionals more often see complex trauma displayed in diagnoses other than PTSD. It may display itself as conduct disorders, attention deficit disorders, depression or dissociative disorders. Posttraumatic Stress Disorder is a diagnosable disorder, whereas complex trauma focuses on specific characteristics of trauma. While they share some similarities, the distinction of PTSD may not always be the outcome of complex trauma.

Developmental Factors in Adolescents

Adolescence is a time when different aspects of an individual's personality are beginning to develop. *Developing Adolescents* (2002) discusses five different aspects of development; physical, cognitive, emotional, social and behavioral (APA, 2002). While all these areas could potentially be affected by trauma, the focus of this study was on emotional and cognitive development. *Developing Adolescents* (2002) discusses one main feature that begins to take place during adolescence that is, identity formation. They state that there are two main parts to identity formation, which include, self-concept and self-esteem. Part of being able to start exploring these areas for an adolescent is feeling secure to explore what they are unfamiliar with (APA, 2002). Furthermore, Lawson and Quinn (2013) state that adolescents are developing their sense of identity in context with their relationship with themselves, peers and adults. Formation of an identity is only one of the developmental aspects that is taking place during adolescence. Complex trauma can interfere with the development of identity, and therefore the personality of an

adolescent. There have been some studies that address the different ways in which complex trauma interferes with personality development in the following cases.

Miller and Resick (2007) studied 171 women involved in a trial therapy for PTSD. This qualitative study consisted of two days of interviews and scales completed by the participants. The participants of this study were placed into two subgroups of dealing with stress: externalizing and internalizing. Participants in the externalizing group described themselves as “prone to act impulsively with little regard for the consequences of their actions, as well as easily upset, chronically nervous, stressed, and worried” (p. 66). Internalizers described themselves as “unenthusiastic, uninspired, easily fatigued, lacking interests, and like externalizers, prone to experiencing frequent and intense negative emotions” (p. 66). The results of this study found that externalizers showed significant outcomes for features of Antisocial, Histrionic, Narcissistic and Borderline personality disorders, while internalizers showed more features of Avoidant and Schizoid personality disorders.

In a second study conducted by Brown, Kallivayalil, Mendelsohn and Harvey (2012), 20 women participated in a qualitative study using interviews as the form of measurement. The focuses of this study were to address characteristics of early recovery treatment for complex PTSD, determine factors for resiliency and to address concepts important for clinicians to be aware of. The results of this study found that due to early abuse, victims’ development of self-concept and boundaries were inhibited. Furthermore, participants of this study had a negative sense of self, as displayed in isolation from self and others, as well as feelings of hate towards self. Finally, through interviews this study found a pattern of difficulties dealing with emotion regulation. This was explained by

participants as having experienced overwhelming emotions, or on the contrary, a lack of emotions.

Additionally, an aspect of the self that is affected by complex trauma is a child who forms an identification with the aggressor. According to Prior (1996), identification with the aggressor is used as a form to deal with feelings of vulnerability. It is used as a way to cope with feelings of weakness or as a way to prevent revictimization. It is a struggle between needing to feel powerful and in control and also experiencing thoughts that they deserve the same consequences they hoped for their perpetrator. There is the belief that when he identifies with the aggressor that he deserves the same punishments that his aggressor received (Prior, 1996).

Along with identification with the aggressor, self-blame also affects an individual's self-concept. For many children who have been abused or neglected, they believe that they are the cause of the abusive treatment they received. Coming from the concept of self-blame, children begin to believe that they are responsible for and that they caused the rejection, aggression or abandonment they experienced. Furthermore, the belief that they are worthless and guilty is enhanced when the child provokes this rejection from adults (Prior, 1996). Prior (1996) states that children reinforce their belief of self-blame by evoking rejection from adult figures as a form of avoiding being abandoned or victimized again. This action further signifies their view of themselves as "bad".

Dissociation for individuals who have experienced complex PTSD can be viewed on a continuum. One end of the spectrum helps to understand dissociation as a defense,

and on the other end of the spectrum is Dissociative Identity Disorder.

Dissociation can be explained as “a deficit of the integrative functions of memory, consciousness, and identity and is often related to traumatic experiences and traumatic memories” (Liotti, 2004, p. 473). Dissociation can be viewed on two degrees, one where a persons mental state inhibits their awareness of what is going on around them or when a persons thought, behavior or activity is forgotten (Liotti, 2004). Addressing issues of dissociation as a defense is described by Blizzard (1994) as a beneficial trait that children use to maintain attachments that are crucial in mental and physical survival. This allows for a victim to create specific personalities that help to cope with the trauma, as well as to perform important functioning in life. Furthermore, some memories of the traumas can be related to specific personalities that are used to dissociate to more benign memories (Blizzard, 1994).

In a study by Nilsson, Holmqvist and Jonson (2011), 462 adolescent participants filled out questionnaires to determine the association of dissociative symptoms based on attachment. This study focused on two main dimensions of attachment, anxiety and avoidance. The results of this study showed that adolescents who reported more interpersonal traumas had a higher prevalence of clinical dissociation. The study also suggests that participants who experience traumatic responses and dissociation may be explained by attachment. The main finding of this study showed that participants who reported avoidant or anxious attachment styles, reported more dissociative symptoms. (Nilsson, Holmqvist & Jonson, 2011). The connection between dissociation and attachment is further discussed in Pearlman and Courtois (2005) by stating that dissociation is most often activated when there is an emotional connection from the past

trauma that is re-experienced, through the relational attachment. This is experienced most frequently when a victim re-experiences emotions they felt while the trauma was taking place (Pearlman & Courtois, 2005).

The opposite end of the spectrum relates to Dissociative Identity Disorder (DID). Dissociative Identity Disorder develops in individuals who have experienced severe trauma in childhood, and are predisposed to dissociation as a defense mechanism (Scropo, 1998). Dissociative Identity Disorder is best understood under the realm of attachment. Children need to depend on a caregiver of some form, and when that caregiver is abusive, it has an affect on the child's attachment. In order to survive, the child needs to maintain an attachment to the adult which is the function of DID (Blizzard, 1994). In DID, the individual develops the ability to split the representations they have of themselves. The purpose of this is to be able to leave the memories of the abuse or neglect with the "bad" parent and "bad" self and create a personality of the "good" parent and "good" self (Blizzard, 1994).

In a study conducted by Scropo, Drob, Weinberger and Eagle (1998), they set out to determine whether there were any clinical features that differentiated participants with a diagnosis of Dissociative Identity Disorder from participants who did not have a DID diagnosis. The sample for this study consisted of 21 adult female psychiatric clients who had a diagnosis of DID and 21 psychiatric clients without a diagnosis of DID. The results of this study found that participants with a DID diagnosis reported much higher frequency of physical and sexual abuse experienced in childhood. Drawing the connection of dissociation as a defense and the development of DID is referenced in Scropo (1998) stating that the formation of different personalities is essentially a

“fantasy-based activity”, and when connected to early exposure to trauma, will potentially present itself as a DID diagnosis.

Complex trauma often takes place within a familial structure, or by a trusted adult. Complex trauma has a negative impact on the formation of healthy relationships. It is likely that complex trauma will have an effect on the way in which individuals interact with others. As Dorahy et al. (2013) states, “Complex PTSD has been described as a relational disorder with its antecedents in relational trauma and its consequences in relational disconnectedness” (p. 72). Dorahy et al. (2013) conducted a study consisting of 65 middle age adults in Northern Ireland. The study examined intimate relationship differences relating to guilt, shame and dissociation. The study used structured interviews, where participants completed six different questionnaires. The results of this study found that dissociation played a role in how complex PTSD relates to relationship difficulties. Fear of relationships, and relationship anxiety and depression specifically were addressed in the findings (Dorahy et al., 2013).

Similarly, Pearlman and Courtois (2005) state that security and stability of relationships can be affected if a person has experienced complex trauma and their ability to make connections with others. Furthermore, instead of forming healthy relationships, individuals may struggle with instability including, “additional abuse, victimization, and loss” (p. 449-450). Dorahy et al. (2013) mention the importance of understanding the relational aspects of complex trauma, which is determined by dissociative symptoms seen in individuals who have experienced ongoing trauma. Furthermore, this relates to adolescence as they discuss attachment and communication by a caregiver. Lack of

primary caregiver availability puts children at risk of dissociation; which in turn may affect adolescents later on when looking at stress in relationships.

In Everstein and Everstein (1989) they bring up the concept of self-blame relating it to an adolescent's developmental stage. Stating that adolescents at this age are prone to be narcissistic and egocentric, and therefore more likely to place the blame for the assault on themselves. Furthermore, this leaves the adolescent believing that they were raped because of who they are, whether they believe they are "bad", or somehow deserved to be raped, leading to beliefs of being worthless (Everstein & Everstein, 1989). A child learns to believe that they draw out rejection and abuse from adult figures based on the self-blame they experience (Prior, 1996). This concept of lack of trust in adult figures is supported by Lawson et al. stating that, "A disruption in the caregiver-child relationship negatively impact a secure attachment and a coherent and stable sense of self, leading to a general distrust of self and others" (Lawson et al., 2013, p. 331).

Resiliency and Trauma

Luthar and Cicchetti (2000) define resilience as "a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma" (p. 857). Fergus and Zimmerman (2005) clarify the term further when they state that resiliency is a process that overcomes the negative effects of risk exposure, helping the child to cope successfully with the traumatic experience. They also conclude that resiliency is an important trait in "avoiding the negative trajectories associated with risks." (Fergus and Zimmerman, 2005, p. 399). Lastly, resiliency has also been linked to adaptation and meeting developmental achievements despite threats to development due

to adversity (Masten & Reed, 2002). Despite the plethora of definitions for resiliency, there are common themes about what promotes this in individuals.

It is important to know what determines an individual's ability to be resilient. Wilson and Scarpa (2013) state "Characteristics of the abuse, such as the duration, frequency, severity, and type of abuse, in addition to the survivors' relationship with the perpetrator, have been found to be predictive of survivor heterogeneity" (p. 1). As there are many factors that may help determine whether a person has the capabilities to encompass resilience, Bonanno (2008) encourages people to understand "resilience is more common than often believed, and that there are multiple and sometimes unexpected pathways to resilience" (p. 101). As found in much of the literature, the concept of promotive factors is discussed. The importance of this factor is described in *Adolescent Resilience: A Framework for Understanding Healthy Development in the Face of Risk* (Fergus & Zimmerman, 2005), "A key requirement of resilience is the presence of both risks and promotive factors that either help bring about a positive outcome or reduce or avoid a negative outcome" (p. 399). Promotive factors are described as being either assets or resources. Assets are factors that are part of an individual such as intelligence, coping skills and self-efficacy. Resources are factors that are not a part of the individual; family and social supports, community engagement (Fergus & Zimmerman, 2005). For an individual to show resilience they must first encounter some type of risk or trauma in their lives, and from there, the presence of promotive factors determine what degree of resilience they will experience.

Development of Resilience

Depending on the developmental maturity of an individual, there may be some inclination of their ability to display resiliency. O'Dougherty Wright et al. (2013) reviewed key concepts that are seen in individuals who are unable to move forward from adverse experiences. The article states that an important factor for displaying resilience comes from the abilities of human adaptation, which keeps development on track and helps instigate recovery from negative experiences (O'Dougherty Wright et al., 2013). Suniya Luthar (1991) explains that the ability to be resilient has been viewed as an internal ability. Furthermore, this ability to internalize comes from higher levels of development and that this may be related to higher levels of intelligence. Individuals who struggle to show resilience prove to have more issues regarding functioning later in life. Moreover, those who are unable to encompass this type of resilience are more likely to experience consequences in a variety of human functions.

Promotive Factors

Bonanno (2008) states, "Resilience is typically discussed in terms of protective factors that foster the development of positive outcomes and healthy personality characteristics among children exposed to unfavorable or aversive life circumstances" (p. 102). What is included in these protective factors and how effective they are has been studied further. Luthar (1991) studied 144 ninth-graders living in an inner city. The sample for this study was gathered using varying criteria reference as "gate" levels, and then randomly selecting two classrooms within the five "gate" levels determined. This study used a questionnaire to gather its data. The Life Events Checklist (LEC, Johnson & McCutcheon, 1980) referenced 46 different life events, which were to be answered as desirable or undesirable. The variables addressed in this study were intelligence, social

skills, locus of control, ego development, and positive life events. Findings from this study demonstrate that locus of control and social skills were related to protective factors, while intelligence and positive life events were related to vulnerability (Luthar, 1991).

Social support, as a protective factor, has been mentioned by many studies (Luthar, 1991; Haskett et al., 2006; Fergus & Zimmerman, 2005). Wilson & Scarpa (2012) define social support as, “lived by, cared for, or valued by another individual, and functioning as part of an interpersonal network” (p. 1). In the study conducted by Wilson & Scarpa (2013), 265 women college students ages 18-26 participated in a study to examine how social support is perceived based on the form of abuse. Participants of this study had to have experienced physical or sexual abuse prior to 14 years of age. In this study, Wilson & Scarpa (2013) found social support to be an important promotive factor, however, only within relationships between family and friends, and from the view of the trauma survivor.

Role of Resiliency in Mental Health

Differentiating resilience in mental health and resilience in the broad spectrum is not an easy task. One way that Davydoy et al. (2010) view resilience in mental health is by referring to it as an ability to return to a level of “mental, emotional and cognitive activity” after experiencing some form of adversity (p. 484). Furthermore, Davydoy et al. (2010) state that the prevalence of people who are able to return to “pre-exposed levels” of functioning to be roughly 15% of individuals, seeing it more frequently in older women and most commonly with individuals who have high levels of social support (p. 484). When one researches resilience, most of the literature delves into the mental health of the individual. What we are looking at when we look at resilience is in what ways are

individuals capable of maintaining a regular level of functioning when faced with some kind of life change. Agreeably, Miller-Lewis et al. state that one of the important factors of understanding outcomes for resilience is learning what is considered to be “unexpected” functioning in individuals (Miller-Lewis et al., 2013).

Nilsson, Holmqvist & Jonson (2011) conducted a study of 462 adolescents in middle school and high school ages ranging from 15 to 20 in two separate cities in Sweden. This study used three forms of self-report questions asking about history of trauma, and two questionnaires that focus on attachments. By researching survivors of trauma, it was found that those who do not display resilience often show signs of mental health and dissociative symptoms compared to counterparts who have not experienced a trauma. This study also found that participants who reported avoidant or anxious attachment styles also reported increased traumatic experiences and higher levels of dissociation (Nilsson, Holmqvist & Jonson, 2011).

Interventions

It isn't a question of what role does resilience play in mental health, but rather how it is addressed. According to Lee et al. (2013), one of the first steps to determining interventions that will be successful is first “Examining the factors and processes underlying psychological resilience” to help determine risk of a mental health diagnosis (p. 327). O'Dougherty Wright, Masten, and Narayan (2013) state that, “Intervening to alter the life course of a child potentially at risk for psychopathology or other problems, whether by reducing risk or adversity exposure, boosting resources, nurturing relationships, or mobilizing other protective systems, can be viewed as a protective process” (p. 28). According to Fergus and Zimmerman (2005), interventions for building

resilience need to be more focused on assets and resource development, as opposed to the more common approach of trying to make the risks more bearable.

One re-occurring theme for resilience interventions is determining the involvement of a support system for the adolescent. According to Fergus and Zimmerman (2005), they report that the Iowa Strengthening Families (ISF) program places its focus on “building positive relationships as a way to prevent negative outcomes,” and involving family members in the process to promote positive development and resiliency (p. 412). Haskett, Nears, Ward and McPherson (2006) referenced previous studies that examined factors to determine their role in resilient functioning. Factors that were discussed in the article included: individual attributes, family environment, and peer/community relationships. Haskett et al. (2006) referenced many studies in their article to show the importance of social support in resiliency. In a summary of the studies they examined, they concluded that children who have reciprocal friendships were found to show resiliency and have higher self-esteem.

Lieberman et al. (2011) discusses the Child-Parent Psychotherapy (CPP) intervention. CPP is an intervention that is to be implemented during preschool ages. In this intervention, Lieberman et al. (2011) emphasizes the role of attachment in instilling resilience for trauma victims. CPP incorporates trauma and attachment by stating that the view of a parent as competent and safe is interfered with when trauma is involved. There is the focus in CPP that the child is dependent on the parent to provide safety and protection and when trauma occurs this view of their caregiver is affected. Therefore, the goal of this intervention is to become more comfortable talking about the trauma, learning to manage traumatic stress and rebuild trust in relationships. The outcomes of

this intervention have been studied at two different universities. It has been found that when CPP was implemented there were improvements seen in the relationship quality between parent and child, cognitive functioning of the child, security in the attachment and mother and child mental health symptoms (Lieberman et al., 2011).

CONCEPTUAL FRAMEWORK

When conducting previous research on the topic of complex trauma and resilience, it is clear that there are specific theories researchers use to compliment their findings. Based on the research that has been found, the theories that will be used to help conduct this research will be attachment theory and systems theory.

Attachment Theory

In looking at complex trauma, there are many parallels drawn in the research to attachment theory. John Bowlby created attachment theory initially, with his work on the connection between child and mother and “its disruption through separation, deprivation, and bereavement” (Bretherton, 1992, p. 45). Another important name to be mentioned when discussing attachment theory is Mary Ainsworth. She is known for contributing to attachment theory by including testing of Bowlby’s ideas. She also helped to introduce the concept of secure attachment to the mother (Bretherton, 1992). Attachment theory can be summarized as “Attachment behaviours is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world” (Bowlby, 1998, p. 27).

Based on the work originally conducted by John Bowlby and Mary Ainsworth, four main attachment types were assigned. Mary Ainsworth conducted a study looking at children’s reactions when a parent leaves, and when they return, which provided information about the type of attachment they display. This was summed up as either a secure form of attachment or one of the two insecure forms of attachment (Bowlby, 1998). Secure attachment can be viewed as “source of emotional health, giving a child the confidence that someone will be there for him and thus the capacity to form satisfying relationships

with others” (Karen, 1994, p. 6). While insecure attachment was viewed as “lowered self-esteem, impaired relationships, inability to seek help or to seek it in an effective way, and distorted character development” (Karen, 1994, p. 6). Feelings of security are developed when a child believes that their caregiver will be responsive and available to them. This allows for the child to value the relationship with the caregiver (Bowlby, 1998). The three patterns of attachment: secure, ambivalent and avoidant are considered to be organized attachments, and those who do not have an organized attachment are considered disorganized (Liotti, 2004).

Based on the type of attachment an individual has to their attachment figure, certain reactions are common. Based on Bowlby he states, “if it goes well, there is joy and a sense of security. If it is threatened, there is jealousy, anxiety and anger. If it is broken, there is grief and depression” (Bowlby, 1998, p. 4). Common in complex trauma is this disorganized pattern of attachment. As hypothesized by Liotti (2004), there is a connection between increased vulnerabilities and dissociative disorders based on disorganized attachments. Whenever stress related to a traumatic event is experienced, an individual’s attachment is affected. The idea behind this is that when an individual has an insecure attachment, and their response to something that causes stress is often times more painful (Liotti, 2004).

Systems Theory

Complex trauma is not a single system diagnosis. Many different aspects of the individual’s family and environment are affected by the trauma. Therefore, using a systems perspective to better understand complex trauma is essential. The view of human behavior being an accumulation of interactions between individuals and the social

systems is completed when using systems perspective (Hutchinson, 2008). The beginning of a systems perspective began in the 1940s and 1950s when several different professionals started to look at “interactions within and among systems” (Hutchinson, 2008, p. 43). Social workers became interested in this perspective around the 1960s, as they wanted to start focusing more on the environment. They were initially attracted to functionalist sociology, where order and stability are found to take place in social systems (Hutchinson, 2008).

According to a systems perspective, in order to maintain stability, there must be structure within roles. Roles are defined as “usual behaviors or persons occupying a particular social position” (Hutchinson, 2008, p. 44). Additionally, using systems perspective one must be cautious of boundaries, meaning who is in a system and who is not (Hutchinson, 2008). Being aware of the roles within systems and the boundaries that have been formed can help provide information about how the system functions. Specifically looking at boundaries is helpful to a social worker as it can provide insight into who are potential supports for the client.

The use of a systems perspective in social work is typically more useful when looking at all aspects of an individual's situation and what different components are playing a part in their functioning. Systems perspective looks at a system and how every part of a system is affected by the other. A summary of this perspective is, “Each part of the system serves an essential function in maintaining the system, and the functions of the various parts are coordinated to produce a well-functioning whole” (Hutchinson, 2008, p. 44).

METHODS

Research Design

There have been numerous studies done on the effects of trauma on children and adults. However, little has been done to look specifically at the role of resilience in the recovery of adolescents who have experienced complex trauma. This study used an exploratory design, accompanied by interviews using a qualitative method. This study used semi-structured interviews to examine what therapists view to be the role of resilience in the recovery of adolescents who suffer from complex trauma. The question that was answered in this study was, what do therapists view as the role of resilience in the recovery of adolescents who suffer from complex trauma.

Sample

This study used a non-probability purposive sampling design. The sample for this study consisted of licensed mental health therapists. Participants needed to have at least two years of experience working with adolescents, aged 13-18 who have experienced complex trauma. For this study, complex trauma was defined as having experienced some form of repeated sexual, physical, emotional abuse, or neglect with the presence of intrusion of thoughts, avoidance and hyperarousal.

Demographics

Four participants took place in this study. Two of the participants were male and two participants were female. Two participants were licensed clinical social workers, one participant was a marriage and family therapist and licensed alcohol and drug counselor, and one participant was a licensed psychologist. Experience in working with adolescence

ranged from 5 years to 16 years. Three of the participants worked at private practices and one participant worked at a residential treatment facility.

Protection of Human Subjects

In order to participate in the study interviewees were required to sign a consent form (see appendix A) that explained the purpose and enforced confidentiality for the study. Names of therapists and agencies and/or practices they work at were not used in this study. There were no foreseen risks for the participants of this study.

The interviews conducted during this research were voice recorded using the researcher's phone. The recorded interviews were immediately transferred onto the researcher's computer, and then deleted from the phone. This computer was locked using a password that was only accessible by the researcher. Once interviews had been transcribed and the research had been completed, interviews were deleted from the computer.

Measurement

The method used for this study was a semi-structured questionnaire. The questionnaire consisted of seven questions (see appendix B). The questions focused on complex trauma and resilience. Interview questions focused more directly on resilience and how it is defined and displayed in clients through behaviors and actions. Participants were asked what resilience factors were most important for individuals who have survived complex trauma.

Data Collection

The researcher sent out three e-mails to professionals that fit the criteria to ask them to participate in the study, and asked them to forward the study to other

professionals that would fit the criteria. An e-mail was sent to these therapists to provide information and to determine interest in participating in the study.

Therapists interested in participating in the study after receiving my e-mail were informed to e-mail me. This connection allowed for the therapists to ask additional questions about the study or expectations for participation. If a therapist was interested in participating in this study, they determined a place and time that worked within their schedule to be interviewed. A timeframe of approximately 45 minutes was set up to conduct the interviews. Before the interview began, the participant was provided with a consent form that they read and signed if they agreed to the stipulations of the study.

Data Analysis

Interviews for this study were voice recorded, transcribed and then coded. The coding of the interviews was used to pull out common themes or patterns across different participants.

Grounded theory was used to complete the data analysis for this research. This form of qualitative research was formed to help construct theory about areas of interest. The benefit of using this theory is that it allows for concepts to be determined as the researcher gathers data (Trochim, 2006).

FINDINGS

Three main themes were found in the results of the interviews conducted. The themes that will be discussed that were factors to resilience are healthy attachments and the use of coping skills. The use of resilience in therapy will be discussed and how participants viewed client readiness and the purpose of trust in therapy.

Healthy Attachments

Participants of the study were asked what factors they think promote resilience. All four participants discussed the importance of healthy attachments. Ideally, healthy attachments with caregivers, specifically parents, are desired. All participants felt that important parental characteristics stemmed from the ability to validate, support and be emotionally attuned to their traumatized child. One participant stated that having the protective factor of family helps adolescents to feel safe, secure and supported when they are dealing with distress related to their complex trauma. One participant stressed the importance of family members being supportive of the client, even if they were a part of the trauma.

“I would say the first thing is if they have a supportive and reasonably healthy family. Because the problem lies in the fact that if the family blames them or if they can’t put aside their own issues when it comes to that or if they can’t take responsibility because a lot of times they were part of the perpetration that there is no resolution for the girl if the family isn’t supportive”

One participant stated that the most important resiliency factor is for adolescents to have parents who believe their experience, and are there to provide emotional and logistical support. As one subject states, these attachments are most beneficial when they are created early on in life: *“Being in a family that is emotionally validating and emotionally attuned to the child”* helps to create that healthy attachment.

This study focused on complex trauma where the perpetrator is a parent or caregiver. In addition to paternal or caregiver relationships, other forms of healthy relationships with adults were discussed. Two out of four of the participants reported other caregivers such as teachers, mentors, spiritual leaders, or extended family members play a role in resilience. One participant stated, *“Some kind of extended family member, if there is an aunt or uncle they are close with. A teacher, mentor, spiritual leader is huge.”* The ability for an adolescent to have a healthy attachment with an extended family member, or build a healthy relationship with another supportive person in their life, was seen by two participants to provide adolescents with resilience. One participant focused on finding healthy attachments in the therapy process. This participant reported that a therapist can be that healthy attachment that helps to drive out unhealthy coping skills.

Coping Skills

Three participants discussed the use of unhealthy coping skills when asked about aspects of development that may promote or hinder resilience. Two participants stated that self-harming behaviors are used as a way to avoid their feelings or regulate. The unhealthy coping skills discussed were sexual promiscuity, self-injurious behaviors, and chemical use. One participant discussed unhealthy coping skills in relation to clients feeling powerless.

“...I think those are clients that probably have more of a tendency to get stuck in unhealthy management of emotions. Eating disorders, cutting, acting out in ways that are more extreme, drug and alcohol use, unhealthy sexuality, because the pain is so great and they are so stuck and they don't know any other way to get through it.”

The other participant who discussed the use of unhealthy coping skills viewed it as a sensory component. The participant stated that as humans we do not like to

experience dysregularity and chaos, and therefore we look for ways to soothe ourselves, and those may be productive or not. Ways that they have seen clients regulate themselves is through sexual promiscuity, drug use and cutting.

The importance of discussing coping skills in this study relates to how it effects a client's ability to survive. One participant stated that each client who comes through their door had survived their complex trauma one way or another. This participant focused on looking at what has got the client through the door stating, *"As you go through history you are able to find client strengths. One of the commonalities of all the trauma people I work with is that they are all still here."* This participant believes the client will determine what factors of their lives allowed them to remain resilient in their experience.

Expanding on the focus on strengths of clients', one participant discussed the role that Dissociative Identify Disorder (DID) plays in survival and resilience. The participant discusses the use of DID as a coping skill as,

"Their mind will take that and block them off or dissociate that piece so that they can continue going forward every day. So the dissociation is a coping mechanism in and of itself. Often the problem is that later on down the road when you get more stress and agitated...all of a sudden they don't know what to do with it anymore."

Dissociative Identity Disorder as explained by the participant has the ability to be helpful in some circumstances, typically though; it is unhelpful and can be a dangerous coping skill. The participant explained that individuals can dissociate and put themselves in danger, and there are also times when the ability to dissociate is used as a survival technique that allows a client to seek therapy.

Resiliency in Therapy

Participants were asked how they see resilience affect a client's ability to address their trauma in therapy. Participants' answers varied as to what role resilience plays in

therapy and how it is incorporated. One participant stated that she does not see her clients as hesitant to talk about their trauma. Instead the participant stated that she needs to be assured that boundaries are set up to allow for processing to be completed in a safe manner for the client. The participant stated that she sees her clients as “very willing to dive into their pain or their story or their experiences.”

Another participant focused on using clients’ strengths to build on basic tools to make sure clients are able to ground before processing their trauma. The participant explains grounding as making sure the client will not experience a major depressive episode, dissociate or be at risk for suicide at the end of the session. In order to assure these things don’t take place, the participant stated this is where the resilience the client already has, comes into play in the therapeutic process.

Another participant discussed clients that are viewed as more resilient being more willing to work through their trauma. It was stated that, “*When kids have some of those resiliency factors they are just more willing to engage and are able to push themselves through the process.*” Specifically, the resiliency factor of having a validating parent, or the ability of the parents to become validating supports during the process was discussed. The participant stated that as the parent becomes more comfortable validating the client, they notice the anxiety reduces and there is an increase in the engagement in the process.

Three subjects emphasized the importance of the client to trust the therapist and the process. One participant states the motivation to participate in the process is higher in clients who display resiliency factors and are therefore able to have some trust in the process. Similarly, another participant discusses the expectation of trust.

“...we ask them to trust this stranger, this therapist, and spill their guts and work really hard, and they aren’t ready yet. And so often times us clinicians will label it as non-

compliant or uncooperative or avoidant, when really what is happening is they are just so afraid to dive into it.”

Two of the participants (50%) discussed the importance of trust and its central role in building the therapeutic relationship. One participant stated, “There is a willingness when they have a trusting connection to do the work they need to do.” The third participant’s use of trust in therapy focused more directly on the client’s ability to trust the process of working through their trauma. This was explained as, “When kids have some of those resiliency factors they are just more willing to engage and are able to push themselves through the process.” The participant stated that clients she has worked with that have “trouble bouncing back” believe that talking about their trauma will make it worse.

DISCUSSION

The purpose of this study was to gain a better understanding of how professionals view the role of resilience when working with adolescents who have experienced complex trauma. The focus was on what factors promote resilience, whether development affects resilience and how resilience is used in the treatment of complex trauma.

Resilience Factors

All participants of this study reported that a crucial resiliency factor is having a healthy secure attachment with an adult. There are some discrepancies between the findings of this study and what was found in the literature. The literature focused more on attachment and positive relationships being an intervention strategy for complex trauma, looking at the formation of secure attachments after the traumatic events (Fergus & Zimmerman, 2005; Lieberman et al, 2011). The findings of this study suggest that healthy attachments are viewed more successful as protective factors as compared to an intervention. Participants stressed that a major protective factor for adolescents who have complex trauma, is the ability of the child to experience one adult in which they have a healthy attachment. Participants suggested that protective factors build resilience. Participants of this study focused on healthy attachments with teachers, extended family members, mentors or spiritual leaders.

According to the research, the ability to be part of a functioning “interpersonal network” is an important factor for resilience (Wilson & Scarpa, 2012). Participants of this study discussed the formation of attachments as clients work through their trauma, specifically with the therapist. As subjects stated, for adolescents who have not had the opportunity to attach to a healthy and stable adult, there is the opportunity for the

representation of a healthy attachment to be formed with the therapist. However, this was not directly related to resiliency factors prior to entering treatment. Participants stated that having healthy attachments when clients are young play a larger role in their ability to be resilient.

Development Factors

All participants discussed different aspects of adolescent development that affect a client's resiliency. In the literature, developmental factors have been studied in relation to ability to cope, development of self, dissociation and ability to form relationships with others (Miller & Resick, 2007; Brown et al., 2012; Blizzard, 1994; Nilsson et al., 2011; Scropo, 1998; Dorahy, 2013; Pearlman & Courtois, 2005). When asked directly about developmental factors, participants had varied answers as to whether it affected resiliency or not. The perception of developmental affects on resilience ranged from reporting no connection to referencing the changing of the adolescent brain and the impact that has on the ability to be resilient.

Three participants discussed the role that unhealthy coping skills play in resilience. This was discussed in the literature referencing how impulsivity is affected in individuals who experience complex trauma early on in life (Miller & Resick, 2007). The three participants suggest the unhealthy coping skills of promiscuity, self-harm and chemical use can be viewed as ways for clients to escape or regulate their emotions or thoughts. The view of this as a resiliency factor can be a controversial topic, as these behaviors are not always viewed as efficient ways to cope with emotion regulation. The concept of unhealthy coping skills affecting development issues related to impulsivity is then addressed. The belief behind these coping skills is that it is an instant gratification of

the emotions they are experiencing, therefore clients act impulsively to escape or regulate these feelings.

One participant discussed the role that dissociation plays in resilience of clients who have experienced complex trauma. The literature discussed dissociation as a defense that can be related to attachment, and an ability to maintain relationships (Nilsson et al., 2011; Pearlman & Courtois, 2005). Similarly, the participant that discussed dissociation in the study focused on it being a survival technique for clients. The ability to dissociate when memories of the trauma are present can be helpful to individuals, in that it allows them to not re-experience the trauma. This is supported in the literature as dissociation allows for individuals to create personalities that allow them to function and reduce the intensity of the traumatic memory (Blizzard, 1994). On the other end, individuals may dissociate in situations in which they are unaware of where they are and how they got there, additionally adding risk for repeated trauma to occur.

Use of Resilience in Therapy

While researching the literature that has been completed on the topic of complex trauma and resilience, little was found on how resilience is used in therapy. Therefore, a focus of this study was to ask participants how they see resilience being used in therapy. The literature focused more on the use of interventions; involvement of support systems, attachments, and rebuilding trust to address the complex trauma (Fergus & Zimmerman, 2005; Lieberman et al, 2011). The factors that were discussed in the literature were also brought up during the data gathering. Participants discussed the involvement of support systems and attachment in a different context than their use in the therapy process.

The participants of the study focused more on looking at resilience and readiness to participate in therapy. One therapist viewed clients as overly willing to engage and participate. Another participant discussed bringing client's strengths and resilience into therapy and using those as skills to process the trauma. Determining clients' readiness to process their complex trauma was not a concept that has previously been discussed in the literature. The importance of understanding where the client is at with their willingness and readiness to process their trauma is a factor that depends on what kind of protective factors are present and the level of resilience the client has.

Similar with the literature, two participants discussed trust. In the study, this trust was discussed in relation to the therapist and the therapeutic process, as opposed to rebuilding trust with support systems. The literature looked at attachment; working through the trauma by beginning to rebuild trust in previous relationships (Lieberman, 2011). One participant discussed the process of clients gaining trust in the process through having validation given by caregivers and therapist. Another participant discussed the concept of expecting clients to trust that the therapist is safe and trust that they can share their experience and their thoughts and feelings surrounding their experience.

LIMITATIONS

This study had a small participant response rate. The limited number of participants in this study affects the ability to find common themes across professional's perceptions of resilience. With additional participants there is potential for a stronger understanding of how licensed professionals view resilience.

IMPLICATIONS FOR PRACTICE

This research focused on understanding what resilience factors licensed professionals see in adolescents who have complex trauma. The purpose of this study was to determine what role resilience plays in complex trauma, according to therapists. Many individuals who have complex trauma are able to function, at some level, and display protective factors that help them to survive these experiences. To help clients process through their trauma, it can be helpful for therapists to know what these common factors are and where to look for them. Understanding what factors enhance resiliency can also be useful as an implementation for earlier intervention with clients who have complex trauma. Therefore, addressing issues earlier with the intention that dissociation or unhealthy coping skills are decreased or eliminated.

The main finding of this study showed the importance of having a healthy attachment with an adult and its impact on resiliency. All participants of this study discussed healthy attachments early on in life as being a protective factor for adolescents who have complex trauma. As was found in this study, the ability for a client to have formed an attachment with some adult in their life resonates strongest as a sign of resiliency. This study spoke specifically of building these healthy attachments with parental figures. However, in situations where the perpetrator was a parental figure, participants discussed the role of healthy adults in an adolescent's life.

This is useful for continued work in complex trauma as it helps clinicians be aware of what protective factors to be curious about when working with adolescents. When a client comes into therapy, their outlook on the situation may be negative. Clients can have a difficult time acknowledging their strengths or positive aspects in their life.

This research project suggests that an important part of therapy with adolescent trauma victims is to assist clients in finding what those resiliency factors are that have allowed for the client to manage their ability to function and survive.

Additionally, the role that attachment plays on complex trauma is a major factor in understanding where the strengths and limitations of interpersonal relationships present themselves. In understanding the strengths of relationships in a client's life, it helps to know where support can be sought while the client processes their trauma. Looking to the limitations in attachment allows for therapist to know where there needs to be reconstructing of attachments to assist in the processing of the trauma.

This research suggests that there are different techniques adolescents use to manage complex trauma. Understanding in what ways a client has been affected by complex trauma is useful in therapy. All of the participants discussed different aspects of survival or management of emotions that clients with complex trauma use. This awareness allows for clinicians to understand what tools have been used to help survive: unhealthy coping skills and dissociation were discussed in this study. It also helps clinicians to be aware of where a client may be at emotionally and what their ability is to manage stress.

According to the participants, promiscuity, self-harm and chemical use were forms of unhealthy coping skills that act as a way to escape, regulate or manage thoughts and feelings. According to the findings, due to the intense pain adolescents experience and not knowing how to handle their pain, they turn to things such as cutting, eating disorders etc. It is important to be aware of how clients manage their pain early on. If they are using these unhealthy coping skills and the therapist is aware, they can help work

with the client to learn more productive ways to manage their emotions. Similarly, acknowledging if the client has a tendency to dissociate is of importance to be aware of. While these are all viewed as forms of resilience in this study, they are not ideal forms of managing emotions and can be addressed early on in the therapy process.

An area that has had limited research completed on it is how resilience is used in therapy sessions. In this study, participants were asked how they see resilience being used by their clients during the therapy process. Participants of this study had varying thoughts about how resilience is used in therapy. One concept that was brought up by three of the participants was the use of trust in therapy. Looking at the client's ability to build trust with the therapist was discussed by two of the participants and the third participant shared about the ability of the client to trust the therapeutic process. Continued research of trust in therapy could be beneficial in understanding what role it plays in the client's ability to process their complex trauma. Previous research has looked at protective factors that promote resilience in individuals who have complex trauma. Moving forward, continued research that looks at the specific role and place for resiliency in therapy sessions will benefit both clients who have experienced complex trauma and professionals who work with this population. This will help to determine in what ways resilience can be used in therapy to allow for more successful treatment.

References

- American Psychiatric Association. (2002). *Developing Adolescents: A Reference for Professionals*.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-V*.
- Black, Woodworth, Tremblay & Carpenter. (2012). A Review of Trauma-Informed Treatment for Adolescents. *Canadian Psychology*, 53(3), 192-203. DOI: 10.1037/a0028441
- Blizzard, R. & Bluhm, A. (1994). Attachment to the Abuser: Integrating Object Relations and Trauma Theories in Treatment of Abuse Survivors. *Psychotherapy*, 31, 383-390.
- Bonanno, G. A. (2008). Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events? *Psychological Trauma: Theory, Research, Practice, and Policy*. S:1. 101-113.
- Bowlby, J. (1998). *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Basic Books.
- Bretherton, I. (1992). Origins of Attachment Theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*. 28, 759-775.
- Briggs, E., Fairbank, J., Greeson, J., Layne, C., Steinberg, A., Amaya-Jackson, L., Ostrowski, S., Gerrity, E., Elmore, D., Belcher, H., & Pynoos, R. (2013). Links Between Child and Adolescent Trauma Exposure and Service Use Histories in a National Clinic-Referred Sample. *Psychological Trauma: Theory, Research,*

Practice, and Policy, 5(2), 101-109. DOI: 10.1037/a0027312

- Brown, N. R., Kallivayalil, D., Mendelsohn, M., & Harvey, M. R. (2012). Working the Double Edge: Unbraiding Pathology and Resiliency in the Narratives of Early-Recovery Trauma Survivors. *Psychological Trauma: Trauma, Theory, Research, Practice, and Policy*, 4:1; 102-111. DOI: 10.1037/a0024969
- Corolino, L. (2002). The Neuroscience of Psychotherapy: Building the Brain. Chapter 12: The Impact of Trauma on the Brain. W.W> Norton and Sons. 257-285.
- Courtois, C. A. (2004). Complex Trauma, Complex Reactions: Assessment and Treatment. *Psychotherapy: Theory, Research, Practice, Training*, 41:4, 412-425. DOI: 10.1037/0033-3204.41.4.412
- Davydov, D. M., Stewart, R., Ritchie, K. & Chaudieu, I. (2010). Resilience and Mental Health. *Clinical Psychology Review* 30, 479-495. DOI: 10.1016/j.jad.2012.10.010
- Dorahy, M. J., Corry, M., Shannon, M., Webb, K., McDermott, B., Ryan, M., & Dyer, K. F.W. (2013). Complex Trauma and Intimate Relationships: The Impact of Shame, Guilt and Dissociation. *Journal of Affective Disorders*, 147, 72-79.
- Everstein, D. & Everstein, L. (1989). Sexual Trauma in Children and Adolescents: Dynamics and Treatment. Chapter II Assessment of the Trauma 12-32. New York: The Guildford Press.
- Fairbank, J. A. (2008). The Epidemiology of Trauma and Trauma Related Disorders in Children and Youth. *PTSD Research Quarterly*, 19:1, 1-8.
- Fergus, S. & Zimmerman, M. A. (2005). Adolescent Resilience: A Framework for Understanding Healthy Development in the Face of Risk. *Annual Review of Public Health*, 26, 399-419.

- Haskett, M. E., Nears, K., Ward, C.S., & McPherson, A. V. (2006). Diversity in Adjustment of Maltreated Children: Factors Associated with Resilient Functioning. *Clinical Psychology Review* 26. 796-812.
- Hutchinson, E. D. (2008). *Dimensions of Human Behavior: Person and Environment*. Sage Publications, Inc.
- Karen, R. (1994). *Becoming Attached: First Relationships and How They Shape Our Capacity to Love*. Warner Books.
- Lawson, D. M., & Quinn, J. (2013). Complex Trauma in Children and Adolescents: Evidence-Based Practice in Clinical Settings. *Journal of Clinical Psychology*. 69:5. 497-509. DOI: 10.1002/jclp.21990
- Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating Complex Trauma: Critical Interventions With Adults Who Experienced Ongoing Trauma in Childhood. *Psychotherapy*. 50:3, 331-335. Doi: 10.1037/a0032677
- Lee, J. E. C., Sudom, K.A., & Zamorski, M. A. (2013). Longitudinal Analysis of Psychological Resilience and Mental Health in Canadian Military Personnel Returning from Overseas Deployment. *Journal of Occupational Health Psychology* 18:3, 327-337.
- Lieberman, A. Chu, A., Van Horn, P. & Harris, W. (2011). Trauma in Early Childhood: Empirical Evidence and Clinical Implications. *Development and Psychopathology* 23, 397-410.
- Liotti, G. (2004). Trauma, Dissociation, and Disorganized Attachment: Three Strands of A Single Braid. *Psychopathology, Theory, Research, Practice, Training*. 41, 472-486.

- Luthar, S. S. (1991). Vulnerability and Resilience: A Study of High-Risk Adolescents. *Child Development* 62:3, 600-616.
- Luthar, S. S., & Cicchetti, D. (2000). The Construct of Resilience: Implications for Interventions and Social Policies. *Development and Psychopathology*. 12. 857-885.
- Masten, A. S., & Reed, M.J. (2002) Resilience in Development, In R. Snyder, & S. J. Lopez (Eds.), *Handbook of Positive Psychology* (p. 74-88). NY: Oxford University Press.
- Miller, M. W., & Resick, P. A. (2007). Internalizing and Externalizing Subtypes in Female Assault Survivors: Implications for the Understanding of Complex PTSD. *Behavior Therapy*. 38: 58-71.
- Miller-Lewis, L. R., Searle, A. K., Sawyer, M. G., Baghurst, P. A., & Hedley, D. (2013). Resource Factors for Mental Health Resilience in Early Childhood: An Analysis with Multiple Methodologies. *Child and Adolescent Psychiatry and Mental Health*. 7:6, 1-23.
- Nijenhuis, E. & van der Hart, O. (2011) Dissociation in Trauma: A New Definition and Comparison with Previous Formulations. *Journal of Trauma and Dissociation*, 12:4, 416-445, DOI: 10.1080/15299732.2011.570592
- Nilsson, D, Holmqvist, R & Jonson, M. (2011). Self-reported Attachment Style, Trauma Exposure and Dissociative Symptoms Among Adolescents. *Attachment and Human Development*, 13:6, 579-595. DOI: 10.1080/14616734.2011.609004
- O'Dougherty Wright, M., Masten, A.S., & Narayan, A.J. (2013). Resilience Processes in Development: Four Waves of Research on Positive Adaptation in the Context of

Adversity. Handbook of Resilience in Children. DOI 10.1007/978-1-4614-3661-4_2

Pearlman, L. & Courtois, C. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress*, 18. 449-459.

Prior, S. (1996). Object Relations in Severe Trauma. *Relational Dilemmas*. Pg. 61-77. Jason Arson Inc.

Scroppo, J. C., Drob, S. L., Weinberger, J. L., & Eagle, P. (1998) Identifying Dissociative Identity Disorder: A Self-Report and Projective Study. *Journal of Abnormal Psychology*. 107:2. 272-284. DOI: 0021-843X/98/53.00

Trochim, W. M. K. (2006). *Research Methods Knowledge Base*. Retrieved November 6th, 2013 from <http://www.socialresearchmethods.net/kb/qualapp.php>

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). *Child Maltreatment 2010*.

Wilson, L. C., & Scarpa, A. (2012). Childhood Abuse, Percieved Social Support, and Posttraumatic Stress Symptoms: A Modern Model. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advanced online publication. Doi: 10.1037/a0032635

Appendix A**CONSENT FORM
UNIVERSITY OF ST. THOMAS****The Role of Resilience in Adolescents with Complex Trauma: A Look at
Therapists' Perspectives****541180-1**

I am conducting a study about resilience factors in adolescents who have experienced complex trauma. I invite you to participate in this research. You were selected as a possible participant because you have an expertise on working with adolescents and working through issues of complex trauma. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by graduate student, Abby Schwebke. I am being chaired for this research by Colin Hollidge Ph. D, LICSW from the Graduate School of Social Work, University of St. Catherine/St. Thomas University.

Background Information:

There have been numerous studies done on the effects of trauma on children and adults. However, little has been done to look specifically at the role of resilience in the recovery of adolescents who have experienced complex trauma. Research has appeared to focus mainly on the types of therapies that are most effective in the treatment of PTSD. There shows to be a lack of information on looking at resilience factors, specifically in complex trauma. There has been much research done on resilience in general regarding aversive events, however, that is a daunting accumulation of definitions. Therefore, the purpose of this study will be to look at what therapists believe is the role of resilience in fostering recovery in adolescents who have experienced complex trauma.

Procedures:

If you agree to be in this study, I will ask you a series of questions, which will take approximately 30 minutes. During the interview I will take notes and it will be voice recorded. The interview will be transcribed onto the researchers computer. The notes and tape will be destroyed once the information has been transferred onto the computer.

Risks and Benefits of Being in the Study:

This study has no expected risks or benefits.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I

will create include a tape recording of the interview; notes and a transcript of the interview will be used for coding purposes. The interviews conducted during this research will be voice recorded using the researchers phone. The researcher will be the only individual with access to the phone. Once the interview has been transcribed onto the researchers computer it will be deleted from the phone. The researcher will take notes, as well, during the interview. The notes will be shredded after they have been transferred to the researchers computer. The notes and transcribed interview will be kept on the researchers computer, which will be locked using a password. This computer will be locked using a password, and will only be accessed to by the researcher. Once interviews have been transcribed and the research has been completed interviews will be deleted from the computer. All data will be destroyed on May 19th, 2014

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until May 1st, 2014. Should you decide to withdraw data collected about you will not be used in the paper. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Abby Schwebke. You may ask any questions you have now. If you have questions later, you may contact me at (612) 269-9659. You may also contract the research chair Colin Hollidge at (651) 962-5818. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

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

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I agree to be voice recorded for this interview.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

- What factors promote resilience?
- What type of results do you see with these factors?
- How do adolescent development factors promote resilience?
- How do these factors relate to clients who have complex trauma?
- How does resilience affect a client's ability to address the trauma in therapy?