

THE RELATIONSHIP BETWEEN TRAUMA SYMPTOMS AND THE
QUALITY OF THE PARENT-CHILD RELATIONSHIP
IN ADOPTIVE FAMILIES

by

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Abstract

Children who are adopted often experience early-life trauma, resulting in dysregulation and trauma-related emotional and behavioral problems. When these children are brought into adoptive homes, these trauma-related symptoms could negatively affect the attachment relationship by adversely impacting the parent's perspective on the parent-child relationship. The current study examined the relationship between trauma symptoms in children who were adopted and the quality of the parent-child relationship within these families. Participants included adoptive families who were participating in a therapeutic camp intervention. We analyzed secondary data gathered at a baseline (i.e., prior to the intervention) from a larger study to assess the relationship between trauma-related symptoms and quality of the parent-child relationship. Trauma symptoms of the adopted child, including anxiety, depression, anger, and post-traumatic stress arousal, were significantly correlated with parenting communication, confidence, and frustration. Specifically, the more trauma symptoms an adopted child exhibited, the poorer the quality of the parent-child relationship. Understanding this relationship and the bidirectional effects of trauma on adopted children and adoptive parents could result in better therapeutic interventions for families with adopted children, leading to better outcomes for both adopted children and adoptive parents.

The Relationship Between Trauma Symptoms and the Quality of the
Parent-Child Relationship in Adoptive Families

Attachment, which is the emotional bond between a caregiver and an infant, is the foundation for the healthy development of a child. This attachment is based off of early life experiences and the type of caregiving we receive. Children who were adopted often experience early-life trauma, and this trauma impacts a child's attachment style and overall development. These children often have dysregulation (Schore & Schore, 2008) and emotional and behavioral problems (Juffer & Van IJzendoorn 2005). This dysregulation and emotional and behavioral problems can often times affect the adoptive parents. Family systems theory states that each member of a system is in balance with the other members of that system (Brazelton, 1999). This is true of family systems. The emotional and behavioral problems of adopted children become the responsibility of parents and impacts the parent's overall functioning (Kraft et al., 1985; Bowen, 1972). The purpose of the current study is to determine if there is a relationship between trauma symptoms and the parent-child relationship in families with adopted children through a secondary analysis of data collected from a therapeutic intervention for families with adopted children.

Attachment

Bowlby (1969/1982) described attachment as a unique relationship that is the foundation for the healthy development of the child. This healthy development is dependent on the responsiveness, consistency, and sensitivity of the caregiver (Bowlby, 1969). This early attachment experience creates internal working models, which are life-long templates that guide perceptions and responses in existing and future relationships (Bowlby, 1969). A child's expectation of how a caregiver will respond in meeting their needs is a template for other relationships in which you are dependent on another person to get support and to feel safe.

Attachment classifications. Early attachment styles can be classified as secure, insecure, and disorganized. Children who have had their needs met consistently and sensitively develop secure attachment styles that lead to healthy development, including positive social-emotional competence, cognitive functioning, physical health, and mental health (Ranson & Urichuk, 2008). The insecure classification has two subtypes: insecure resistant (the relationship is expressed as dependence) and insecure avoidant (the relationship is expressed as reluctance and mixed emotions). Disorganized attachment styles are often the result of the parent being the source of the child's fear as well as the child's source of safety. Children with insecure and disorganized attachment styles are at-risk for more negative outcomes regarding their development in all of the previous areas (Ranson & Urichuk, 2008).

Consequences of attachment. Attachment styles predict later self-reliance, emotion regulation, social competence, later relationship satisfaction and life satisfaction (Sroufe, 2005). Sroufe (2005) found that children who develop secure attachment styles become more independent, whereas children who develop insecure attachment styles are less independent. Emotion regulation (the process of monitoring, evaluating, and moderating emotional responses) is developed based on the type of caregiving a child receives (Cassidy, 2008), and children with different attachment styles regulate their emotions differently in order to get their needs met (Main et al., 1985). Secure children are able to show more positive affect in order to build and sustain interactions (Sroufe, 2005), feel comfortable expressing negative emotions (Cassidy, 2008), and use less maladaptive coping strategies (Sroufe, 2005). Insecure children are unable to upregulate their positive emotions, are better able to manage negative emotions (Moutsiana et al., 2014), and use more frustration behaviors, aggression, or give up when experiencing social problems (Sroufe, 2005).

Internal working models are mental representations of the self and of others that function to help people predict and understand their environment and feel safe (Pietromonaco & Barrett, 2000). Children with secure attachment styles have more positive expectations regarding the nature and quality of relationships (Sroufe, 2005), and this is due to the internal working model established in early infancy. These children have a desire to form close relationships as well as show social and emotional capacities to encourage social competence due to their internal working models (Sroufe, 2005). Children with insecure attachment styles show less social and emotional capacities, have less reciprocated friendships, and are more often isolated (Sroufe, 2005). These attachment styles and social competences in early life affect later adult attachment styles as a result of the stable internal working models that are extremely resistant to change (Schoenmaker et al. 2015). In general, secure attachment classifications develop into secure-autonomous adult classification in which the person openly values attachment and has healthy, stable relationships. Insecure avoidant classifications develop into dismissing adult classifications in which the person minimizes the importance of relationships, avoids intimate social contact, and has pessimistic views of relationships. Insecure resistant attachment classifications develop into preoccupied adult attachment classifications in which the person has an obsessive preoccupation with responsiveness, falls in love easily, is overly jealous, and asserts his or her own feelings without the consideration of the partner's (Li & Chan, 2012).

The impact of attachment on self-reliance, emotion regulation, social competence, and later relationships all come together to impact the overall life satisfaction of these individuals. Children who develop secure attachments with their caregivers will later on have greater life satisfaction than those children who develop insecure attachments with their caregivers (Sroufe, 2005).

Trauma and Attachment

Many adopted children have faced early-life experiences that impact development throughout their lives (Colvert et al., 2008). These children often experience complex trauma, which is defined as the “experience of multiple chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal and early-life onset” (van der Kolk, 2005). These adverse traumatic events, including physical and sexual abuse, neglect, and maltreatment beginning in early childhood often occur within the child’s caregiving system (Cook et al., 2005). Complex trauma places children at a high risk for physical problems, psychiatric problems, and other impairments (Cook et al., 2005).

The lack of consistent, responsive, and nurturing caregivers results in adopted children having interpersonal, behavioral, and self-regulation problems (Cook et al., 2005). The lack of a caregiver in the early stages of life can lead to insecure and disorganized attachment styles, which affects their overall development and can have lasting impacts on a child’s physical, cognitive, emotional, and social development. (Bowlby, 1969). During the first few years of life, the primary task is to develop a secure relationship with the primary caregiver. This secure relationship is built on emotional communication between the infant and the caregiver (Schore, 2008). Initially, emotion is regulated by others, namely the primary caregiver, and over the course of development becomes increasingly self-regulated (Schore, 2008). Because children who have experienced complex trauma have disruptions in their attachment, their ability to self-regulate is also disrupted. As a result, they often self-regulate in maladaptive ways as survival strategies that are adapted to their environment (Wilbarger et al., 2010). This maladaptive self-regulation can lead to emotional problems, conduct problems, and interpersonal problems (Forslund et al., 2016). These children

specifically struggle with anxiety, depression, anger, hyperactivity, and peer relationships (Juffer et al., 2011; Sroufe, 2005).

Parenting Vulnerable Children

Because of the stability of negative internal working models and maladaptive self-regulation developed by children who have experienced early trauma (Schoenmaker et al., 2015), these relational struggles persist across the lifespan, even when living in safe environments (Tirella & Miller, 2011). Adopted children often face a shift from environments characterized by abuse, neglect, and maltreatment to environments characterized by nurture, safety, and sensitivity. The adaptations that worked in their early-life environments no longer work in their new environments, and this leads to dysregulation and emotional regulation problems (Brown et al., 2017). This creates a challenge for families who adopt children who have experienced complex trauma. Self-regulation problems of adopted children, as well as the emotional, behavioral, and relational problems that come with it, can influence other members of the adoptive family according to family systems theory (Tirella & Miller, 2011).

Family systems. The early-life trauma that adopted children have experienced not only affects the individual, but it affects the entire family system. Family systems theory posits that families are an emotionally connected unit, and the change in one person's functioning impacts the functioning of the other members in the family (Kerr, 1991). The negative or positive functioning of one member in the family will have a reciprocal affect in the functioning of entire family unit (Bowen, 1972). This implies that the emotional and behavioral problems of adopted children will in turn impact the emotional and behavioral functioning of the parents in the family system.

The parents of adopted children have elected to be the psychological trustees of the adopted child (Kraft et al., 1985). The maladaptive regulation of adopted children who have experienced complex trauma that is manifested through emotional and behavioral problems becomes the responsibility of the parents and can negatively impact their own emotional and behavioral functioning within the family system (Kraft et al., 1985; Bowen, 1972). Furthermore, creating a secure attachment relationship with the adopted child is dependent on the parents (Subhani et al., 2014). The early-life trauma and insecure or disorganized attachment of adopted children make creating secure attachment difficult. These difficulties for the parents are presented in various psychological ways: isolation (feelings that no one understands what they are going through), frustration, resentment toward the child, or even questioning of their own parenting abilities (Child Welfare Information Gateway, 2015).

Current Study

The purpose of the current study is to explore the dynamics that exist within adoptive families. Specifically, this study will explore the relationship between trauma symptoms and the quality of the relationship between the caregiver and the child. My primary research hypothesis is that as trauma symptoms in the child increase, the quality of the parent-child relationship will decrease. There will be a negative correlation between the trauma symptoms of the adopted child (i.e. anxiety, depression, anger, and posttraumatic stress-arousal) as seen through the Trauma Symptom Checklist for Young Children (TSCYC) and attachment, communication, and parenting confidence as seen through the Parent Relationship Questionnaire (PRQ). There will be a positive correlation between trauma symptoms of the adopted child (i.e. anxiety, depression, anger, and posttraumatic stress-arousal) as seen through the TSCYC and parenting frustration as

seen through the PRQ. To explore this further, the secondary research questions include the following:

1. Is there a relationship between the quality of the parent-child relationship perceived by the child (i.e. emotional distance and isolation) as seen through family drawings and trauma symptoms in the child (i.e. anxiety, depression, anger, and posttraumatic stress-arousal) as seen through the TSCYC. I hypothesize a negative correlation between trauma symptoms and the quality of the parent-child relationship perceived by the child (as trauma symptoms increase, the quality of the relationship decreases).
2. Is there a relationship between the quality of the parent-child relationship as perceived by the parent (i.e. attachment, communication, parenting confidence, and frustration) as seen through the PRQ and the quality of the parent-child relationship as perceived by the child (i.e. emotional distance and isolation) as seen through family drawings. I hypothesize a positive correlation between the quality of the parent-child relationship perceived by the parent and the quality of the parent-child relationship perceived by the child (as the quality of the parent-child relationship perceived by the parent increases, the quality of the parent-child relationship perceived by the child also increases).

Methods

Participants

The participants include the families participating in a therapeutic intervention for adoptive families. These families have at least one adopted child. Families may have more than one adopted child, but only one child is considered the “target child” (the child with trauma-related symptoms that camp will focus on). The target child is between the ages of seven and nine by the first day of camp and will have been living in the adoptive family’s home for at least one year by the first day

of camp in order to be included. Further inclusion criteria include: the target child must be legally domestically or internationally adopted; all members of the family living at home are able to participate in both camp weekends for their cohort; the family is willing to be videotaped and photographed during camp weekends; the family is willing to participate in all research activities; both parents are willing to complete online pre-training before attending camp; both parents and all adults living in the home are willing to complete Stewards of Children Training™ (how to prevent, recognize, and react responsibly to child sexual abuse (Darkness to Light® Stewards of Children Training™, n.d.)); and families must be receiving services from a Trust-Based Relational Intervention (TBRI®) practitioner (a professional trained in TBRI® to work with children from hard places (TBRI® Practitioner Training, n.d.) prior to the intervention. The exclusion criteria include: the family has a child with severe emotional/behavioral problems that may pose a threat to caregiver, self, or others; one or more family members living in the family's home is unable or does not want to commit to all aspects of the research protocol; one or more family members living in the family's home is unable or does not want to commit to attending both weekends of camp.

The participants included in the current study consists of forty-seven participants from fifteen families. Of these families, two were single parent families. The total number of parents participating in the study is thirty-one. Of these parents, 45.2% are fathers and 54.8% are mothers. The total number of adopted children participating in the study is seventeen. The average number of children in each family (biological and adopted) is 3.13. The average number of adopted children in each family is 1.26. The majority of the adopted children in the current study are male (63.2% male and 36.8% female), and almost half of the adopted children in the current study are Caucasian (47.4% Caucasian, 21.1% African, 15.8% Hispanic, 10.5% mixed race, and 5.3% Indian). Most (73.7%) of the children were adopted from foster care, and 26.3% of the children

were adopted internationally. Of the children adopted internationally, 50% were adopted from Ethiopia, 25% were adopted from the Democratic Republic of Congo, and 25% were adopted from India.

Procedure

The current study is a secondary analysis of data collected from a therapeutic intervention for adoptive families. The data collection will consist of one time point taken from a larger study. The larger study has multiple data collection periods in order to measure the long-term effectiveness of a therapeutic intervention (see Figure 1). The larger study includes data collection over a one-year time period. The time point included in this study is the data collection period before the families start the therapeutic intervention. For the purpose of this study, we will call this data collection T1. This data collection period is right after the family has been accepted into the program and completed all consents. Immediately following the acceptance and consents, the families are sent the assessments. The larger study also consisted of more assessments and more participants. For this study, I selected the Trauma Symptom Checklist for Young Children (TSCYC) to measure trauma symptoms, the Parent-Relationship Questionnaire (PRQ) to measure the quality of the relationship perceived by the parents, and the family drawings to measure the quality of the relationship perceived by the adopted child. I selected the fall '18, spring '19, and summer '19 cohorts because of the consistency of the administration of the family drawings.

At T1, each family is sent the assessments. The families are mailed the same standard packet of paper, makers, and instructions for each child between the ages of six and ten to complete the family drawing (see Appendix A). The TSCYC and the PRQ is sent to the parents electronically through email. The TSCYC is completed by the parents for each adopted child. The PRQ is completed by both parents individually based on their own relationship with their adopted child.

The parents have two weeks to complete the electronic assessments and the family drawing. Upon completion, the TSCYC and PRQ are sent back electronically, and the family drawings are mailed back.

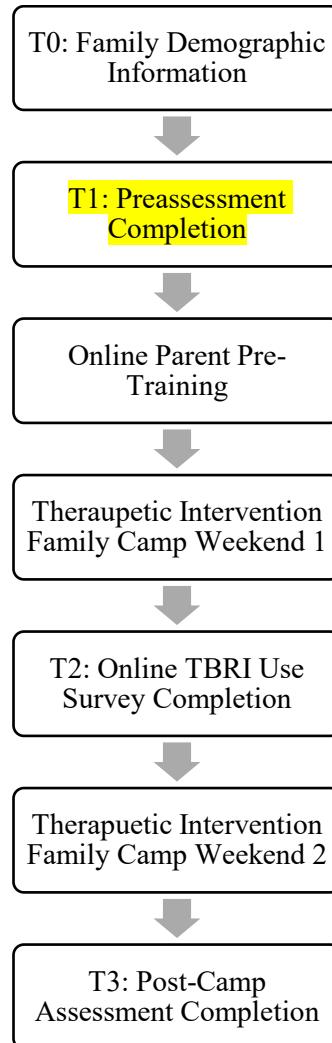


Figure 1. Therapeutic intervention timeline of events.

Measures

Family Drawings. Family drawings represent a child's internal working model of attachment. It is thought that the nonverbal nature of family drawings allows children to express unconscious emotions or emotions that they are unable or feel uncomfortable communicating

(Fury et al., 1997). Children's family drawings have been shown to be a strong measure for looking into a child's representation of attachment relationships (Fury et al., 1997), as well as a valid approach to seeing emotional disturbances in attachment relationships in post-institutionalized children (Howard et al., 2017). The family drawings are scored on Quantitative Markers, Clinical Markers, and Global Markers by a trained family drawing coder (Fury et al., 1997) (see Appendix B). The coder was trained by a previously trained coder in a group setting to ensure reliability. For the current study, emotional distance and isolation (loneliness reflected in disguised expressions of anger, neutral or negative affect, and distance between the caregiver and child) is of particular interest.

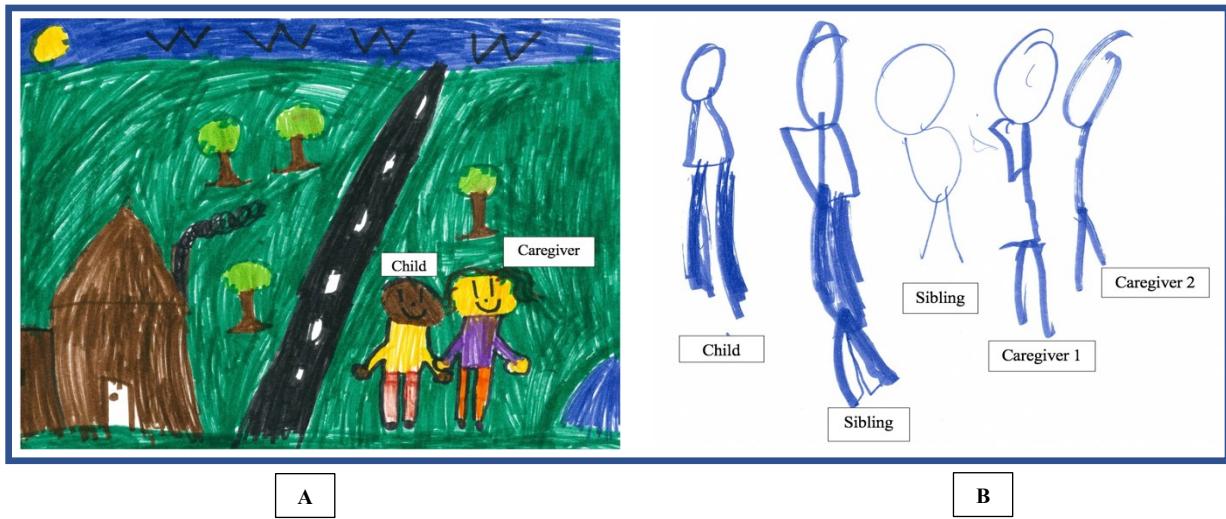


Figure 2. Examples of emotional distance and isolation represented in family drawings. Drawing A reflects low emotional distance and isolation. Drawing B reflects high emotional distance and isolation.

Trauma Symptom Checklist for Young Children (TSCYC). The TSCYC has shown to be a reliable measure of trauma-symptoms in children (Briere, 2001). The TSCYC is a 90-item

questionnaire that contains eight clinical scales: anxiety, depression, anger, posttraumatic stress-intrusion, posttraumatic stress-avoidance, posttraumatic stress-arousal, dissociation, and sexual concerns. The parents use a 4-point scale (1: not at all; 2: sometimes; 3: often; and 4: very often) to rate the observed frequency of each symptom. For the purpose of this study, the following subscales are of particular interest: anxiety (reflects the amount of worry and fear a child displays), depression (identifies the frequency of sadness, crying, and symptoms of depression), anger (reflects the amount of angry and aggressive behaviors observed in the child), and posttraumatic stress-arousal (indicates the level of hyper-arousal child displays and may reflect attention and concentration problems).

Parenting Relationship Questionnaire (PRQ). The PRQ has shown to be a reliable measure of the parent's perspective of the quality of the parent-child relationship to assess factors that influence the development of a healthy child (Kamphaus & Reynolds, 2006). The PRQ is a 71-item measure includes scales of attachment, communication, discipline practices, involvement, parenting confidence, satisfaction with school, and relationship frustration (Kamphaus & Reynolds, 2006). Parents indicate how often they do each item with their child on a 4-point Likert scale ('0' *never*, '1' *sometimes*, '2' *often*, and '3' *almost always*). For the purposes of this research study in examining the relationships between the adopted child's trauma symptoms and the parent-child relationship, the following subscales will be examined: attachment (measures how well the parent can assess their child's thoughts and feelings and the parent's ability to comfort the child when distressed), communication (measures the amount of quality communication between parent and child), parenting confidence (measures the parents' level of confidence and comfort in caring for their child), and relational frustration (measures the amount of stress and frustration the parent experiences while parenting).

Results

The Statistical Package for Social Sciences was utilized for the data analysis. The Pearson product-moment correlation coefficient was used to analyze the data. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, or homoscedasticity. A specific procedure was followed to analyze the quality of the parent-child relationship perceived by the parent. Each parent's relationship was correlated with their child individually (the individual parent's PRQ and the TSCYC for their child), analyzing both the mother and the father's relationship with the child. Correlations were considered statistically significant if $p < .05$.

TSCYC and PRQ

The primary research question examined is the relationship between trauma symptoms in the adopted child such as anxiety, depression, anger and post -traumatic stress arousal as measured by the TSCYC and the perceived quality of the parent-child relationship measured by the PRQ. The PRQ is a self-report instrument assessing the parents perceived levels of attachment, communication, parenting confidence, and frustration (see Table 1 for Pearson product-moment coefficients). A negative correlation was predicted between trauma symptoms examined in adopted children and the parent's perceived quality of the parent child relationship. This suggests as trauma symptoms go up, the perceived quality of the parent child relationship would go down. The relationship between perceived parental attachment and measured trauma symptoms were found to be non-significant. This suggests that trauma symptoms in adopted children are not related to the parent's perceived attachment of the child to the parent. Analysis of the relationship between parents perceived communication and adopted children's trauma system was statistically significant in relation to two trauma symptoms: depression, $r(31) = -.376$, $p < .05$; and posttraumatic stress-arousal, $r(31) = -.356$, $p < .05$. The relationships between parental perceived

communication was not significantly correlated with anxiety or anger. This suggests that as depression and posttraumatic stress-arousal increases in the child, the perceived communication between the parent and the child decreases and vice versa (as parental communication decreases, depression and stress increase). However, an increase in the anxiety and anger of the child is not significantly related to the reported communication within the relationship. Parenting confidence was statistically significant in its relationship with all four trauma symptoms: anxiety, $r(31) = -.403$, $p < .05$; depression, $r(31) = -.597$, $p < .01$; anger, $r(31) = -.506$, $p < .01$; posttraumatic stress-arousal, $r(31) = -.365$, $p < .05$. This suggests that as the observed trauma symptoms increase in the child, the parenting confidence decreases, and vice versa (as the parenting confidence decreases, the trauma symptoms increase). Frustration experienced by parents in the parent-child relationship was positively correlated in all four measured trauma symptoms: anxiety, $r(31) = .437$, $p < .05$; depression $r(31) = .360$, $p < .05$; anger, $r(31) = .797$, $p < .01$; posttraumatic stress-arousal, $r(31) = .651$, $p < .01$. This suggests that as the measured trauma symptoms increase in the child, the frustration experienced by the parent also increases, decreasing the quality of the parent-child relationship. These results support the hypothesis that as trauma symptoms of the child increase, the quality of the parent-child relationship will decrease.

Table 1. Pearson Correlations Between Trauma Symptoms and the Parent-Child Relationship Perceived by the Parent ($N = 31$).

Variables	Attachment	Communication	Parenting Confidence	Frustration	Anxiety	Depression	Anger	Posttraumatic Stress-Arousal
Attachment	1.000							
Communication	.741**	1.000						
Parenting Confidence	.413*	.239	1.000					
Frustration	-.352	-.185	-.539**	1.000				
Anxiety	-.318	-.330	-.403*	.437*	1.000			
Depression	-.302	-.376*	-.597**	.360*	.560**	1.000		
Anger	-.254	-.227	-.506**	.797**	.522**	.450*	1.000	
Posttraumatic Stress-Arousal	-.230	-.356*	-.365*	.651**	.630**	.541**	.795**	1.000

Note: Statistical significance: * $p < .05$, ** $p < .01$

TSCYC and Family Drawings

The secondary research question examined is the correlation between trauma symptoms in the child and the quality of the parent-child relationship perceived by the child. Specifically examined was the relationship between emotional distance and isolation as measured by family drawings and anxiety, depression, anger, and posttraumatic stress-arousal as measured by the TSCYC (see Table 2 for the Pearson product-moment correlation coefficients). Emotional distance and isolation of the child evaluated through the family drawings yielded no significant correlations with depression, anger, or posttraumatic stress-arousal. Emotional distance and isolation did, however, reveal a strong significant relationship with anxiety: $r(31) = -.533$, $p < .01$. This suggests that as anxiety experienced by the child increases, the emotional distance and isolation perceived by the child decreases as evidenced by family drawings, and vice versa (as the emotional distance and isolation decreases, the anxiety increases). This negative relationship opposes the hypothesis.

Table 2. Pearson Correlations between Trauma Symptoms and the Parent-Child Relationship perceived by the Child ($n=31$).

Variables	Emotional Distance and Isolation	Anxiety	Depression	Anger	Posttraumatic Stress-Arousal
Emotional Distance and Isolation	1.000				
Anxiety	-.533**	1.000			
Depression	-.241	.560**	1.000		
Anger	-.241	.522**	.450*	1.000	
Posttraumatic Stress-Arousal	-.341	.630**	.541**	.795**	1.000

Note: Statistical significance: * $p < .05$, ** $p < .01$

PRQ and Family Drawings

The other secondary research question being examined is the correlation between the parent-child relationship quality perceived by the parent and by the child. Specifically examined is the relationship between emotional distance and isolation in the child and attachment, communication, parenting confidence, and frustration experienced by the parent (see Table 1 for the Pearson product-moment correlation coefficients). The relationship between emotional distance and isolation and parenting confidence was found to be non-significant. This suggests that an increase in the child's perceived emotional distance and isolation does not affect the parent's confidence in parenting the child. Emotional distance and isolation was, however, significantly related to attachment, $r(31) = .401$, $p < .05$; communication, $r(31) = .456$, $p < .05$; and frustration, $r(31) = -.399$, $p < .05$. This suggests that as the emotional distance and isolation of the child increases, the attachment between the parent and the child perceived by the parent and the communication in the relationship perceived by the parent increases. Conversely, as the emotional

distance and isolation of the child increases, the frustration felt by the parent decreases. These results oppose the hypothesis.

Table 3. Pearson Correlations between Parent-Child Relationship Quality Perceived by the Parent and by the Child (*n* = 31).

Variables	Attachment	Communication	Parenting Confidence	Frustration	Emotional Distance and Isolation
Attachment	1.000				
Communication	.741**	1.000			
Parenting Confidence	.413*	.239	1.000		
Frustration	-.352	-.185	-.539**	1.000	
Emotional Distance and Isolation	.401*	.456*	.210	-.399*	1.000

Note: Statistical significance: **p* < .05, ***p* < .01

Discussion

Early-life trauma can negatively impact the attachment style and overall development of a child. Because adopted children have often experienced early-life trauma, it is crucial to understand how their maladaptive attachment styles can impact the dynamics within their adoptive family. In the current study, we examined the relationship between trauma symptoms of adopted children and the quality of the parent-child relationship in adoptive families. Through this secondary analysis, we found significant relationships between trauma symptoms and the quality of the parent-child relationship perceived by both the parent and the child, suggesting that trauma symptoms exhibited by adopted children can bi-directionally affect the quality of the parent-child relationship.

The primary focus of the study was to examine the relationship between trauma symptoms of the adopted child and the quality of the parent-child relationship perceived by the parent. Our findings show a significant negative correlation between parenting communication and anxiety, depression, and posttraumatic stress-arousal, as well as between parenting confidence and anxiety,

depression, anger, and posttraumatic stress-arousal. Specifically, as trauma symptoms exhibited by the child increased, parenting communication and parenting confidence decreased. A significant positive correlation was found between parenting frustration and anxiety, depression, anger, and posttraumatic stress-arousal. Specifically, as trauma symptoms exhibited by the child increased, parenting frustration also increased. These results are consistent with current literature on family systems theory. Family systems theory posits that the functioning of one family member, negative or positive, will have a reciprocal effect of the functioning of other family members (Bowen, 1972). The trauma symptoms of an adopted child that are manifested through emotional and behavioral problems becomes the responsibility of the parents (Kraft et al., 1985; Bowen, 1972), and this felt responsibility by the parents can create frustration and questioning of their own parenting abilities, leading to an overall poorer parent-child relationship quality perceived by the parent.

The secondary explorations in the current study included the relationship between trauma symptoms and the quality of the parent-child relationship perceived by the parent and the relationships between the quality of the parent-child relationship as perceived by the parent and as perceived by the child. Our results showed a significant negative correlation between anxiety and emotional distance and isolation: as the emotional distance and isolation of the child increased, the child's anxiety decreased. Our results also showed a significant relationship between emotional distance and isolation and parenting communication, parenting frustration, and the attachment security of the child perceived by the parent. As the emotional distance and isolation of the child increased, parenting communication and attachment security perceived by the parent increased, while parenting frustration decreased. In summary, as the emotional distance and isolation of the child increased, the child experienced less anxiety and the quality of the parent-child relationship

perceived by the parent increased. Although this is not what we expected to see in our results, these findings are consistent with new, growing literature on the adopted children.

Children who were adopted have often experienced complex developmental trauma, also known as relational trauma (Bath, 2015). Often times, this chronic adversity and lack of nurturing support alters the child's brain chemistry leading them to develop dysfunctional coping behaviors (Bremner, 2003; Carrion, 2006). Because of its interpersonal nature, complex trauma can create barriers in a child's ability to develop healthy relationships (Verhulst, 2000). In the past, the child has learned to not trust adults and that close relationships cause pain, making them "uncomfortable" with developing close relationships with trusting adults. Therefore, when adopted children are brought into new family environments that are nurturing and safe, the child's internal scripts of relationships and altered brain chemistry cause their trauma symptoms to intensify (Verhulst, 2000), causing the child's anxiety to increase when there is less emotional distance and isolation. However, utilizing their dysfunctional coping behaviors and staying emotional distant and isolated in this new family, their trauma symptoms and anxiety is reduced, as shown in the results of the current study (Carrion, 2006).

Less emotional distance and isolation within the adoptive family is, for the adopted child, considered a threatening condition. Children with insecure or disorganized attachment styles often behave and give "cues" to the adoptive parent that they do not want or need the caregiver (Dozier et al., 2002), eliciting a complimentary behavior from the caregiver by not responding with nurturance (Stovall & Dozier, 2000). This "miscing" and preoccupation with previously unmet attachment needs compromises their underlying attachment needs and their desire for security and autonomy (Kenrick et al., 2019). This "miscue" from the child makes it unlikely that their caregiver will respond appropriately to the child's distress (Cooper et al., 2005), potentially masking the

trauma symptoms of the child and giving the parent the illusion of better parent-child relationship, as shown in the results of the current study. It is crucial that parents understand and look beyond the miscuing of a child in order to let the child know that it is safe to express attachment needs (Kenrick et al., 2019). Although the child's maladaptive coping behaviors might intensify trauma symptoms, it will allow for the development of a secure attachment and a healthy parent-child relationship.

A few limitations of this study must be considered. The data included in the study are self-reported and subject to bias on the part of the informants. The data was collected at one point in time and therefore directionality (causal relationships) cannot be inferred. There is also controversy over the validity of family drawings (Joiner et al., 1996; Riethmiller & Handler, 1997). However, family drawings are widely used by researchers and clinicians because they can provide access to a child's representational world and they transcend language limitations and cultural barriers (Cherney et al., 2006; Smith & Handler, 2016). Although the validity of family drawings is controversial, we had the data from the larger study, so we wanted to explore what relationships there were, if any. Also, in the two-parent families participating in the study, each parent filled out a PRQ, but only one parent filled out the TSCYC (usually the mother). In the future studies, both parents should fill out the TSCYC from their own perspective, and the TSCYC completed by one parent should be compared with the PRQ completed by that same parent. This would give insight on the unique parent-child relationship quality for each parent rather than the holistic parent-child relationship quality. The study was only for adopted children who were between the ages of 7 and 9 years old and did not differentiate between foster-care adoptions and international adoptions. Future studies should include adopted children from wider range of ages as well as differentiate between foster-care adoptive families and international adoptive families. This would extend the

results to a wider range of children and families as well as determine any unique differences of the impact of trauma symptoms on the parent-child relationship quality in different types of adoptions. Furthermore, the study did not look at race, sibling dynamics, or language differences within adoptive families. In the future, researchers can further explore this topic by looking at adoptions in the context of race, additional familial factors, and environmental stressors to address cultural considerations.

Despite these limitations, the results of the current study and of the literature on the impact of trauma on adopted children and adoptive families make it clear that not only are interventions for adopted children necessary to promote healthy development and long-term outcomes, but also interventions for the entire family system are necessary to positively impact the functioning of the familial unit. Understanding the bidirectional effects of trauma on adopted children and adoptive parents could result in better therapeutic interventions for families with adopted children, leading to better outcomes for both adopted children and adoptive parents. One intervention for adoptive families is the Hope Connection 2.0 Camp created by the Karyn Purvis Institute of Child Development at Texas Christian University. The Hope Connection 2.0 Camp is a trauma-informed, two-weekend family camp for adoptive families that utilizes Trust-Based Relational Intervention (TBRI®). TBRI is a model to help caregivers support the healing of at-risk children whose principles guide caregivers and children in developing healthy ways of interacting to allow both to play a role in the healing process of vulnerable children (Purvis et al., 2013). By utilizing TBRI principles and working holistically with the entire family, The Hope Connection 2.0 Camps aim to foster healing in every member of the familial system. Through the findings of the current study, we have a better understanding of the unique characteristics of adoptive families. This can better

inform those who work with adoptive families of how trauma symptoms can impact the quality of the parent-child relationship so that better therapeutic interventions can be utilized.

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Appendix A

Family Drawing Directions

Materials:

- 12 x 18-inch sheets of white paper
- Markers
- Pencil

Prior to beginning the family drawing, sit across the table from the child and lay out 1 piece of white paper and a pencil in front of the child.

“Today we are going to do some drawings. There is a piece of paper and a pencil in front of you. Will you draw a person on your paper? It can be whoever you want.”

This initial warm-up task is included to promote a relaxed atmosphere and to reassure the child that the drawing task is not a test of ability.

After encouraging the child’s first drawing, put the first drawing aside and place another sheet of white paper plus the markers in front of the child.

“That is a great picture! Okay, now on this next sheet of paper, will you draw a picture of your family? You can include anyone in your drawing who is considered family to you.”

No further direction is given, with the intention of making the task as open-ended as possible. If they ask to include pets, extended family, etc., answer as vaguely as possible, “*It is your drawing, you may include whoever you would like.*”

Upon completion of the task:

“I see that you are done with your drawing. Can you identify everyone in your drawing and tell me how they are related to you?”

Label the child’s answers in pencil on the drawing.

Appendix B
Family Drawing Score Sheet

1 = yes/present, 0 = no/not present/absent

*When measuring, round to the nearest 1/10th of a centimeter

*Do reliability, every 5th drawing

Subject: _____
Scorer: _____

Color:		# Color	Notes	
Figures		Total # of colors used for figures		
Background		Total # of colors used for background		
Total number of colors		Total # of colors		
Size: Appropriate size to child:		Appropriate Size		
Of caregiver 1		Child is correct proportion to mother	1/0	
Of caregiver 2		Child is correct proportion to father	1/0	
Layout/Organization:		Portrait	Landscape	
Drawing layout	1/0	1/0		
	<-length->	^width		
Total area of paper sheet	cm	cm		
Total area of family unit frame	cm	cm		
Total area of family and background	cm	cm		
Faces:		Smile	Hair	Eyes
Of caregiver 1	1/0	1/0	1/0	1/0
Of caregiver 2	1/0	1/0	1/0	1/0
Of sibling(s)	Total #/ out of #	Total #/ out of #	Total #/ out of #	Total #/ out of #
Of self	1/0	1/0	1/0	1/0
Features:		Fingers	Hands	Feet
Of caregiver 1	0 = none	1/0	1/0	Total # of colors
				Add Faces & Features

Of caregiver 2	1 = incomplete	1/0	1/0	Total # of colors	Add Faces & Features
Of sibling(s)	Total #/out of #	Total #/out of #	Total #/out of #	Total # of colors	Add Faces & Features of sibling(s)
Of self	2 = complete	1/0	1/0	1/0	Add Faces & Features
<i>False starts:</i> # of times					
<i>Unusual signs, symbols, scenes:</i> Describe					
<i>Presence/Absence:</i>					
Of caregiver 1	1/0				
Of caregiver 2	1/0				
Of sibling(s)		Total # present/Tot al #			
Of self	1/0				
<i>Proximity of Self:</i> (record distance in cm)					
From caregiver 1	cm				
From caregiver 2	cm				
From sibling(s)	cm				

Clinical Markers

Markers:														
Of Caregiver														
1														
HE	SF	F	FH	PS	B	S	D							
Hollow eyes	Solid filled eyes	Floating	Floating head	Phallic symbols	Box around	Smallness of figure	Dissociative/fantasy							
DM/S	LM	E	OM	SOB	PF	RRP	RRS							
Dark markings/scratches	Light markings	Erasures	Omissions	Self on back	Placement of figure away	Role reversal position	Role reversal sexual							
EF	Exaggerated figure													
I	Incomplete figure													
Of Caregiver														
2														
HE	SF	F	FH	PS	B	S	D							
DM/S	LM	E	OM	SOB	PF	RRP	RRS							
EF														
I														
Of Sibling(s)														
HE	SF	F	FH	PS	B	S	D							
DM/S	LM	E	OM	SOB	PF	RRP	RRS							
EF														
SF1.5														
Of Self														
HE	SF	F	FH	PS	B	S	D							
DM/S	LM	E	OM	SOB	PF	RRP	RRS							
EF														
I														

Scorer's Comments:

Global Markers (Bowles, Cross, Milling)
1(low) - 3 (high)

Vitality/Creativity: RS	
Family Pride/Happiness: RS	
Vulnerability:	
Emotional	
Distance/Isolation:	
Tension/Anger:	
Role Reversal:	
Bizarreness/Dissociation:	
Global Pathology:	

RS=reverse score 3=1, 2.5=1.5, 2=2, 1.5=2.5, 1=3 Total:

Vitality/Creativity:

Emotional investment in drawing reflected in embellishment, detail, and creativity

Family Pride/Happiness:

Child's sense of belonging to and happy in the family group

Vulnerability:

Vulnerability and uncertainty reflected in size (or shape) distortions, placement of figures on the page, and exaggeration of body parts

Emotional Distance/ Isolation:

Loneliness reflected in disguised expressions of anger, neutral or negative affect, distance between caregiver(s) and child

Tension/Anger:

Tension or anger inferred from figures that appear constricted, closed, without color or detail, careless in appearance, or scribbles/crossed out (signs of erasure and correction).

Role Reversal:

Suggestions of role reversal inferred from relations of size or roles of drawing figures

Bizarreness/Dissociation:

Underlying disorganization expressed by unusual signs, symbol, fantasy themes, hollow eyes, missing hands, and floating heads or bodies

Global Pathology:

Overall degree of negativity reflected in global organization, completeness of figures, use of color, detail, affect, and background scene

*anchors: 1.no evidence of... 2. moderate evidence of... 3.significant evidence of...