NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Understanding the Impact of Trauma on Family Life From the Viewpoint of Female Caregivers Living in Urban Poverty

Laurel J. Kiser, **Winona Nurse**, **Alicia Lucksted**, and **Kathryn S. Collins**
University of Maryland School of Medicine (LJK), University of Maryland Baltimore School of Medicine (WN, AL), University of Maryland School of Social Work (KSC)

Abstract

Children and their families living in poor, inner-city neighborhoods are at high risk for experiencing multiple traumas. This article describes findings from a qualitative study designed to explore the impact of chronic traumas on family life through the voices of primarily African American caregivers coping with urban poverty. Structured interviews are conducted with 16 caregivers of children ages 6 to 9 years who had been exposed to multiple traumas and had symptoms of posttraumatic stress disorder. Caregivers explain changing daily routines to accommodate child distress and promoting positive family processes such as increased protectiveness. They also describe various roles that religion/spirituality play in their coping with trauma, including finding comfort in the faith that God controls what happens in their lives. These themes are discussed with regard to theory and practical applications for assisting traumatized families.

Keywords

children; posttraumatic stress disorder; poverty; violence; trauma; family ritual; spirituality

Children and their families living in poor urban neighborhoods contend with high risks of experiencing severe stressors and multiple traumas. Additionally, the context of urban poverty is loaded with potentially dangerous circumstances that heighten individuals' vulnerability to traumatic stress disorders after exposure (Briere & Spinazzola, 2005; Levendosky & Graham-Bermann, 1998; Whittlesey et al., 1999). Numerous models and much empirical data have been generated to explain the impact of this socioeconomic context on children, their parents, and their families. This article describes a qualitative study designed to explore the impact of chronic traumas on family life, through the voices of caregivers coping with urban poverty.

Various family risk-protection models have in common a series of mediating factors and processes through which urban poverty is seen as influencing individual and family well-being. First, 70% to 100% of residents living in inner-city poverty experience traumas (Dempsey, Overstreet, & Moely, 2000; Macy, Barry, & Noam, 2003). Traumas are defined as events that result in or pose a threat to a person's physical integrity and that cause a reaction of intense fear, horror, or helplessness (American Psychiatric Association [APA], 1994). For children living in inner-city poverty, typical traumas include victimization by or witnessing family and community violence, caretaker instability including active substance use or incarceration, and house fires.

Address correspondence to: Laurel J. Kiser, PhD, Associate Professor of Psychiatry, University of Maryland Baltimore, 737 W. Lombard Street, Room 500, Baltimore, MD 21201; lkiser@psych.umaryland.edu.

Second, exposure to traumatic circumstances causes distress. For children, common reactions include increased monitoring of their environment, anxiety when separated from trusted adults, irritability, aggression, and/or increased need for affection, support, and reassurance. Persistence of such distress or interference with functioning may be labeled posttraumatic stress symptoms, which can progress to posttraumatic stress disorder (PTSD) (APA, 1994) in 23% to 29% of traumatized children. Distress in adults often manifests as flashbacks, avoidance of intense emotions, or lack of emotional control, depression, fear/worry over the safety of other family members, anger, reexamination of life values and worldview, and stress-related illnesses, such as diabetes, heart disease, and substance abuse (Falsetti, Resick, & Davis, 2003; Peebles-Kleiger, & Kleiger, 1994).

Third, trauma-related distress experienced by adults can add burden to their already stressed parenting role. Numerous well-designed studies show that parenting under conditions of high stress is consistently associated with insensitivity, lack of responsiveness, withdrawal, low warmth, reactivity, irritability, negativity, harshness, and punitiveness (Ceballo, & McLoyd, 2002; Evans, Maxwell, & Hart, 1999; Repetti, & Wood, 1997).

Fourth, research indicates that trauma-related distress in the context of urban poverty is often associated with negative changes in family functioning. Many families react to chronic stress, poverty, and violence with chaos, disorganization, and instability (Brody & Flor, 1997; Clark, Barrett, & Kolvin, 2000; Hill & Herman-Stahl, 2002). Externally, uncontrollable situations make it difficult to sustain an organized, stable daily schedule (Ackerman, Kogos, Youngstrom, Schoff, & Izard, 1999; Evans et al., 1999; Figley, 1988; Meyers, Varkey, & Aguirre, 2002). Oftentimes, just getting through the long list of daily tasks is the goal and accomplishing this is long, drawn out, and laborious (Lareau, 2003; Seaton & Taylor, 2003). In addition, parental distress, psychopathology, and substance abuse can mean that parents are unavailable to organize family life. When caregivers cannot carry out their roles or cannot provide protection and control over environments and events that affect family members, relationships may become inconsistent, unstable, and mistrustful (Ackerman et al., 1999).

Finally, some families faced with difficult environments and multiple stressors show resiliency, adaptation, and positive outcomes that may serve as a counterweight to the negative outcomes discussed earlier. In fact, some may argue that certain families experience posttraumatic growth and cope in more productive ways following traumatic events (Calhoun & Tedeschi, 1998). Operationalizing resiliency in families who are coping with chronic and ongoing adversities is not simple and must be considered contextually as well as with a developmental lens. For example, family structure is often seen as a primary resource of resilience because of the stabilizing impact of constructive routines with established roles and behavioral expectations that may have developed in the family throughout the years (Fiese & Wamboldt, 2000; Resnick et al., 1997; Seaton & Taylor, 2003; Shapiro, 1994). Yet the circumstances of the trauma (i.e., intrafamilial violence) and the developmental stage/phase of the family, caretakers, and children should be considered when assessing capacity for resilience (Salloum & Rynearson, 2006). It cannot be assumed that resiliency for families can be measured in symptom checklists or that positive adaptation is the opposite of severe sympotomatology (Saakvitne, Tennen, & Affleck, 1998). Knight (2007) suggests that merely surviving traumatic events or stressful environments may offer families opportunities to "evaluate their priorities, enhance or create a sense of spirituality, and prompt them to live their lives in more fulfilling ways" (p. 23).

Families showing resiliency make deliberate accommodations to cope with the unpredictable, dangerous contexts of urban poverty (Burton & Jarrett, 2000). They structure their routines to accomplish daily tasks safely and stress frequent communication when not

together. They adopt relatively strict rules and limits to maintain control of what they can control (Gaudin, Polansky, Kilpatrick, & Shilton, 1996). They also pull together under difficult circumstances, support each other, and believe that they can overcome challenges (Greeff & Human, 2004; Lauterbach, Koch, & Porter, 2007; M. A. McCubbin & McCubbin, 1993; Patterson, 2002). Families adapting well to significant stressors and traumas often rely on a collective value and belief system that helps them in the creation of their understanding regarding what is important to the family and what explanations they use to justify both positive and negative events that affect them (Evans, Boustead, & Owens, 2008; Haight, 1998).

In summary, family risk-protection models and related research findings demonstrate that the traumatic context of urban poverty has pervasive and systemic effects that can erode parent and family functioning and compound the direct consequences of urban poverty on children, although some families are more resilient than others. This is significant as it is widely accepted that parental support and family functioning are powerful mediators between trauma and its impact on children (Banyard, Rozelle, & Englund, 2001; Kliewer, Murrelle, Mejia, Torresde, & Angold, 2001; Pfefferbaum, 1997; Whittlesey et al., 1999).

Based on this evidence, working to preserve or strengthen family processes is now seen as one potential way to limit the impact of stress or trauma on children. However, existing evidence does not detail the dynamics of dealing with multiple, often ongoing, traumas, nor what specific aspects of family life are most vulnerable to traumatic stress. Therefore, this study was designed to interview a sample of caregivers living in low-income, urban neighborhoods and caring for children who have been traumatized about the ways they carry out their families' daily activities and traditions as well as relationships between the experience of chronic traumatic stress and family life.

We framed our discussion of family processes around the concepts of family rituals and routines. In a family context, ritual encompasses celebrations, such as the way a family observes holidays; traditions, such as the particular way a family marks birthdays; and patterned routines. Patterned routines or daily rituals (greetings and good-byes, dinnertime, bedtime, and leisure activity) involve the way family members organize and carry out the tasks of daily living and provide structure and regularity to family life while stipulating the behaviors expected from family members (Bernheimer & Weisner, 2007; Spagnola & Fiese, 2007). Using this framework, we were able to easily engage with caregivers about family celebrations and traditions, the organization of daily family life, planning and follow-through, roles and participation in family activity, family relationships, and the practice of religion along with the formation of shared beliefs.

Method

Sample

Structured interviews were conducted with 16 parents and/or guardians (caregivers) of children ages 6 to 9 years as part of a larger study (Kiser, Medoff, & Black, 2007) assessing the impact of violence and trauma on family processes. The larger project was a cross-sectional study of 100 children aimed at exploring relationships between exposure, childhood traumatic stress, and family functioning. Families were recruited from community programs and service agencies, such as afterschool programs, community/recreation centers, and a pediatric outpatient clinic. All of the children and their caregivers were living in poor, inner-city communities in a mid-Atlantic city. As violent crime statistics involving children rank this city among the highest in the nation, these communities represent poor urban neighborhoods with high risk for exposure to severe stressors and traumas. This was essentially a nonreferred sample, although the recruitment materials indicated that the study

focused on trauma so some caregivers may have participated because of concerns about their children's exposures to traumatic events.

For this study, we used purposive sampling (a method by which participants who are best able to provide full descriptions of the research questions are engaged) to recruit caregivers from the larger study sample. Caregivers were offered an interview if their child had been exposed to more than one trauma meeting *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; APA, 1994) Criterion A as measured on the Traumatic Events Screening Inventory for Children–Brief Form and Parent Report (Ribbe, 1996) and met partial or full symptom criterion for posttraumatic stress disorder (PTSD) (APA, 1994) as measured on the Schedule for Affective Disorders and Schizophrenia for School Age Children–Present (Kaufman et al., 1997). Partial criteria for PTSD were defined as at least one symptom of re-experiencing, two symptoms of persistent avoidance, and one symptom of increased arousal accompanied with functional impairment (Mirza, Bhadrinath, Goodyer, & Gilmour, 1998). A master's prepared social worker conducted all assessments and determined if the child meet full or partial criteria based on the criteria outlined.

Twenty-eight of the 100 children met these requirements. The caregivers of these children were invited to participate in the interviews. Sixteen caregivers were available and agreeable to being interviewed. Following initial analysis of these interviews, the research team determined that additional interviews were unnecessary as new themes were no longer emerging. Table 1 provides demographic characteristics of the full sample of 100, the 28 who were eligible for interviews, and the 16 who participated in this study.

Of the 16 caregivers who were interviewed, 9 had children who met full and 7 who met partial diagnostic criteria for PTSD. As we were interested in the impact of multiple and chronic traumas on family life, we did not categorize families by type of trauma experienced, duration of trauma, or length of time since the trauma occurred. None of the caregivers interviewed were dealing with acute traumas; they were asked to recall family responses to events that occurred over the course of their child's lifetime.

Measures

A structured interview guide was adapted from the Family Ritual Interview (Wolin & Jacobs, 1989) and the Ecocultural Family Interview (Weisner, Bernheimer, & Coots, 1997). These interviews cover family rituals (traditions and celebrations) and organization of daily routines. Rituals were discussed in terms of a general description, roles, deliberateness, meaning, continuity, and disruption. Discussion of the organization of daily routines involving children covered the following topics: purpose for the activity, people involved, meaningfulness, continuity, and disruption. A previous study using a similar interview guide demonstrated its suitability with a sample of African American caregivers and their families who were surviving poverty (Kiser, Bennett, Heston, & Paavola, 2005). For purposes of this study, caregivers were asked specific questions regarding how identified trauma(s) had affected their rituals, daily routines, family relationships, meaning of trauma and spiritual beliefs, and sense of the future.

Procedures

The structured interview methodology used in this study provided a systematic way to garner rich yet focused information about how trauma and violence affect family rituals and routines—data not easily captured through quantitative means. Qualitative inquiry does not seek to predict, control, or test hypotheses; rather, it is used to unlayer phenomena that can only be understood through the words or stories of the participants.

Data collection—Prior to embarking on this study, approval was given by the University Institutional Review Board. Each caregiver attended one interview session that took 45 to 90 min; participants were compensated $20. All interviews were conducted over a 2-month period by a master's-level research clinician. The interviewer did not deviate from the structured interview guide except to gain further understanding or clarification of participant answers, although she summarized main points made by the participant before transitioning to a new topic of the interview.

With the consent of the participants, each interview was audiotaped and later transcribed by a professional trained in confidentiality and Health Insurance Portability and Accountability Act regulations. During transcription, all identifying details (names, specific locations, etc.) were replaced with anonymous placeholders that preserved as much context as possible (e.g., "older sister" replacing the sister's name).

Analysis

Transcripts were analyzed by two doctoral-level researchers and one master's-level research clinician using the constant comparative method (Glaser & Strauss, 1967). Each analyst independently sorted and combed the data asking the general research question, "How do violence and traumatic events impact family life, especially rituals and routines?" Initial codes and later initial themes were developed by each researcher. Research team members periodically compared their results and came to a consensus about the major themes found within the data. For example, if a code or theme was discovered by one researcher and not others, the transcripts were reviewed and discussed until the team came to a consensus regarding the code or theme in question. This method of comparing and recombing the data among three independent researchers until consensus (interrater reliability) is reached was designed to enhance the credibility and trustworthiness of the study (Creswell, 1994; Goetz & LeCompte, 1984). After the establishment of themes, the researchers again independently reviewed the data using the themes as a more focused lens through which to further develop rich descriptions, using participant words verbatim wherever possible to demonstrate each final theme. Finally, a third doctoral-level researcher reviewed these themes and descriptions as a way to improve internal reliability.

Results

All caregivers interviewed were parenting at least one child who had experienced multiple traumas. Their children's traumas included a shooting of a sibling, death of grandparents/ cousins, a mother's illness and hospitalization, death of a pet, house fires, experiencing and witnessing domestic violence, being beaten up at school, being robbed at gunpoint, being hit by a car, experiencing and witnessing physical abuse, and having family members removed from their homes. Oftentimes, but not always, the caregivers directly experienced these events along with their children. We present two groups of themes that emerged from the interviews (summarized in Table 2): changes in family rituals and routines after trauma and meaning-making responses to trauma.

Changes in Rituals and Routines

Thirteen caregivers reported that the type, form, and enactment of their family celebrations and traditions (rituals) were unchanged following the experience of trauma. They reported that their celebrations, traditions, and rituals just continued to be "normal." Two caregivers reported disrupted family rituals, and one caregiver reported enriched family experiences around holidays and other special times after leaving a domestic violence situation. She stated:

> I created new ones (laughter).… Yeah, because now I have another family to enjoy those things. So you know, like Christmas, I'm not just staying home and going to my grandmother's anymore. I'm home letting them open up what they have here. Then I go to my grandmother's and they open up what they have there. Then they go to his mom's and they open up what they have there. So it's like a bigger—one big family now. (Number 5)

In contrast, caregivers did describe considerable impact of trauma on their daily routines.

Description of Family Routines

All of the caregivers interviewed for this study could articulate a daily routine. Caregivers mostly described daily routines structured around parenting responsibilities, such as getting children up in the morning and ready for school, getting children to and from school, meals, homework, and going to bed at night, in simple (as opposed to elaborate) terms. For example:

> Wake up, eat breakfast, wash up, get ready for school, get ready for work, go to school. She go to school, I go to work. Go home, do homework, get a snack, watch TV, eat dinner, take a bath, watch TV, go to bed. (Number 12)

Getting by—that is, accomplishing basic tasks required to make it through the day—was a main theme of their daily routines. Most caregivers reflected on the struggles faced by single mothers living in urban poverty, as illustrated in the following quotes:

> So now, you know, you get yourself in a situation where then you have children and you're just struggling so hard just trying to take care of them, you know, when it really could have been a little different, you know. (Number 8)

> Me raising them by myself. Being the good mom that I am. It's a struggle. It's been a struggle for me. There's nothing going to be easy in life. (Number 10)

In exception to the descriptions of basic morning and evening routines, six caregivers emphasized homework as an important and meaningful daily routine. Caregivers who stressed a homework routine placed a high value on education as a way for their children to live better lives. This value was stated eloquently by one caregiver:

> No, we do the homework first.… You can't just allow them to go try to do it on their own and not supervise because they won't get it done. It'll be nine o'clock at night and somebody be talking about well, I didn't finish this. No, that's not acceptable.… Because it has to be done. It's just I'm not accepting anything else because if—I mean, like I said, they can't make it in this world without it.… So I mean I sit there with them and make sure they're doing their work. They know I'm going to keep checking periodically. (Number 13)

Impact of Trauma on Family Routines

Interview transcripts were studied to understand these caregivers' ideas about the impact of exposure to stressors and traumas on their daily routines. Several themes emerged. These included (a) little stated disruption in the immediate aftermath of the traumatic events, (b) alterations in family routines to deal with child distress following the traumas, and (c) positive changes in family routines.

Little Reported Disruption in the Immediate Aftermath of Events

Although at least one member of all of these families had experienced multiple traumas, caregivers did not talk very much or at all about disruptions in routines immediately following traumas. In the case of ongoing traumas, such as family violence, adaptations in

daily routines were obvious, but caregivers did not report upheavals in their daily family life immediately after even major discrete traumas like house fires, a child being removed or sent out of the home, serious illnesses, and so on.

Alterations in Family Routines to Deal With Child Distress

Caregivers did describe more gradual impacts on routines, most frequently as responses to children's symptoms and distress attributed to the trauma exposure. Changes in family routines mainly involved taking care of increased fears and problems with school and sleep:

> I didn't leave her with nobody else after that for a long time until she was comfortable being left alone. (Number 6)

> Yeah, I just had to go up to school and get it dealt with. And what I do now is when something traumatic happens I go to school and talk to the teacher and let them know what's going on and if we can work with you to help them to make it through this. (Number 13)

> I had to wake her up in the middle of the night because she was going to the bathroom, peeing in the bed. (Number 7)

Managing or coping with their child's symptoms often involved caregivers changing their own schedules. Such changes were depicted as having both negative and positive sides. On one hand, the extra demands on the caregivers were associated with increased perceived stress and burden, but on the other hand, caregivers said they were more available for their children and paying more attention to them.

Positive Changes in Family Routine

Reduction in overall stress, regularization of routines—Other positive changes in routines were noted. In addition to being more attentive, a few mothers described making wholesale lifestyle changes and attributing these changes to the experience of the trauma or to its resolution. This was most commonly reported in families who had been dealing with family violence and whose daily routines improved dramatically when the perpetrator of the violence was no longer in the home:

> [Our routines are] more consistent…. They're more stable. Mind and body, you know. Because once the mind frame's messed up, your body goes the same way. You know, so yeah, it's more stable. It's steadier and there's no violence…. We have fun (laughter). It's gotten more fun. It's gotten more perky. You know, I know how to take a joke now. (Number 5)

> Well, it's been stressless. I don't have to worry about him no more [abusive partner no longer living in the home]. We're not arguing over the littlest things, so it's been much better. More stable. (Number 9)

> I remember, you know, the older one saying that they were glad that she [daughter who was out of control and violent] was gone because they didn't have to call the police, they didn't have to call me at work…. Oh, boy, I had to leave work sometimes, and she was admitted in (hospital). The police were at my house all the time, you know. They had to chase her around the corner and down the street because she wanted to do what she wanted to do. So there was a lot of tension that was just released, you know. (Number 16)

One caregiver talked about her life-transforming reaction following exposure to community violence:

> Yeah, that [the trauma] got me off the streets. I don't run the streets no more…. I don't hang out like I used to or do the things I used to do. That kind of woke me up. It woke me up because I know that I need to be there for my children. (Number 1)

Findings of positive routine changes were bolstered by the caregivers' descriptions of improvements in family relationships following some traumas. Improved family relationships included becoming more communicative and more protective.

More communicative—Talking more often and openly was one positive change in family relationships that caregivers attributed to the traumatic experiences. Caregivers spoke about this in the following ways:

> It's just that I check with them. I check with the children more, talk to them about how they feel about things. (Number 9)

> That anything, you know, any trials or tribulations that we go through we can always, me and my daughter always going to talk to each other. She's always going to ask questions about—and it means she always know that she can come to mommy and mommy will talk to you (inaudible). (Number 12)

More protective—In addition to changing their daily routines to help their children feel safer, six caregivers told us about family members becoming more protective of each other:

> The boys got closer with her [their sister after she was hit by a car]…. They were really worried about her. No matter how much they argued they was still worried, scared. And her and the younger son, they started to get closer and played together. It was like he was watching over her, protecting her and made sure when they went across the street she was holding his hand and stuff. (Number 6)

> I am more careful about a whole lot now…. I'm way over, from the way my oldest son says, I'm overprotective now. And that's the same thing my fiancé says. He says I'm overprotective of the household, period. (Number 5)

> He understood that mommy almost died, so, it's like they try—they're close to me now. I've got to beat them away sometimes. (Number 13)

Meaning Making and Spirituality

Conceptually, religion and spirituality play an important role in many family rituals and routines and in meaning making when bad things happen. To better understand the role of religion and spirituality in this sample, the structured interview asked questions such as "How important is religion in your family's daily or weekly life?" "Does your religion help you understand what happens to your family?" "What do you think that this experience [the trauma] means to or about your family?" "How do you explain that this happened to your family?" and "Do you feel any differently about your religion or spirituality now?"

Thirteen of the caregivers said that religion and/or spirituality are important in their lives and their coping with stressors, to varying degrees. Examining the meaning and function of religion and spirituality vis-à-vis life patterns and stressors in the interview transcripts, we discerned several overarching themes and titled them (a) "God determines why things happen as they do," (b) "God as helper," (c) "moral behavior," and (4) "religion/spirituality helps me slow down." Each is detailed below. Note that in these titles and in using the term *God*, we are reflecting the expressions and word choice of the caregivers interviewed.

God Determines Why Things Happen as They Do

This was by far the most common and prominent theme regarding religion and spirituality. Almost every caregiver expressed some variation of the belief that God makes or allows things to happen for important reasons, even if these reasons are unknowable to humans. Therefore, many participants believe that how or whether something happens is ultimately God's doing:

> I know that I've done the best that I can, and I've given them [her children] the foundation for life, and for that reason, you know, I truly believe that everything will work out the way it is supposed to. You know, my life, my death, my children's life and death, you know. Whatever God has planned no man can stop or start, so. (Number 7)

Caregivers seemed to find "God's will" a comforting thought for two reasons: First, it allowed them to see meaning in seemingly arbitrary misfortunes that had befallen themselves or family. That is, even if they could see no reason for something or no good that could come out of it, they were comforted by the belief that God had important reasons. Second, caregivers indicated that belief in God's will allowed them to let go of trying to control or understand things outside their influence, to relinquish to God what they cannot control or understand, and that this lightened their perceived burdens. A few caregivers tempered their description of comfort with comments about being sometimes angry or confused at God when they cannot understand what possible important purpose could be behind a terrible event or problem. However, even this negative perspective still assumes that God is determining why things occur. By relinquishing some of their worry and responsibility to "God's will," caregivers were freed to concentrate their energy on routine daily tasks and surmounting obstacles they could influence.

"God made it not worse"—An important subset of this theme was voiced by many caregivers, especially when talking about specific traumas. The title "God made it not worse" came from their expressing thanks to God for preventing a bad thing from being even worse than it was, such as a child who was shot but did not die:

> [After daughter was hit by car but not seriously injured] it made me get closer and trust in the Lord more because it was only the Lord that saved her. He really saved her because when she hit that ground she jumped right back up [and so wasn't run over by the car]. (Number 6)

> [Does religion help you understand that incident?] Yeah, because I know he [perpetrator] could have killed him [her son, beating victim] and I know … God did that for a reason. God sees things like, "Well, I'm going to do this in a certain way," so that happened, you know. I just look at it like that. (Number 14)

This subtheme was important to caregivers for seeing meaning in negative experiences and also for release from trying to control uncontrollable things. These expressions were also an important embodiment of caregivers' coping with trauma. They often bolstered their spirits by engaging in downward social comparison, such as when one woman said:

> I know it was God that my son is still here [after being shot] because look at all the people that's children … gets shot one time and their children are gone. (Number 1)

Thus, from a resiliency perspective, this subtheme seems to reflect a strategy for thinking positively in the face of difficulty and a self-reminder to not take things for granted, thereby projecting some optimism and hope via the realization that it could have been worse.

God/Religion/Spirituality as Helper

Many caregivers also mentioned God or religion/spirituality as a help or guide. Most often, they described God as a comfort in difficult times, either feeling God's presence as strengthening and comforting because it means one is not struggling alone and/or calling on God for specific guidance, especially though prayer. This was an important part of many participants' daily routines.

> I hope they [her children] also, you know, realize that God is with them, through times like that [hard times] and all the time. And that they can keep going and not, you know, collapse and turn to drugs and alcohol to hide problems. (Number 4)

Some added that the values and teachings of their religious or spiritual beliefs provide the basis for their moral behavior. For example, one caregiver said: "It's when I forget about religion that my anger has the opportunity to overpower me" (Number 5). Others reflected that religious or spiritual beliefs help them take time to think about their words and actions before responding so that they act in more thoughtful ways. One caregiver said it very directly:

> [Religion] helps to not to rush, like I used to sometimes make such a rash decision. And it makes me sometimes now, it lets me actually think which way's better instead of just zooming the first way. (Number 15)

Another expressed the same idea in more concrete terms:

> [I say to my kids] I'll explain to you a little later when maybe I can think about it and pray about it and try to come back with a better answer for them. (Number 3)

Discussion

Family risk-protection models demonstrate the importance of family functioning for dealing with exposure to traumatic events. This qualitative study surfaced important themes and raised further questions about how families cope when bad things happen to them. We discuss these themes in the context of family routines and resilience theories and where appropriate suggest potential strategies for intervention.

Family Routines and Trauma

Routine disruptions and accommodations—It was our expectation based on previous research that daily patterned routines would be highly vulnerable to major family stressors (Fiese & Wamboldt, 2000) and that caregivers would talk about disruptions following their traumas. We were surprised that caregivers did not talk very much or at all about disruptions in routines immediately following traumas. We speculated on several reasons for the lack of subjective reports of disruption despite objectively disruptive traumatic events: Perhaps the routines in these families are frequently interrupted by daily stressors and crises and the families are habituated to such disruptions. In this case, disruptions particular to one specific trauma may not be especially salient (Wolfer, 1999). Or perhaps these disruptions were relatively brief and thus were not seen as important in retrospect. Or perhaps the families' self-righting mechanisms were strong and they continued to maintain their daily routines in the immediate aftermath of traumatic events.

On the other hand, it was apparent that over time caregivers made accommodations to their daily routines either to reorganize their family life to address altered circumstances or to meet the needs of their distressed children. Such accommodations, as illustrated, have both positive and negative impacts (Bernheimer & Weisner, 2007). Going to school to deal with a child's problems simultaneously increases caregiver support and connectedness and adds "hassle" to the already arduous schedule of most caregivers. According to the caregivers

interviewed and consistent with studies of family routine, maintenance of these changes in routine is related to their perceptions of how well the new routines address their children's needs, how much additional burden is created, and how consistent the changes are with the families' values and goals (Bernheimer & Weisner, 2007).

Meaning of family routines—Family routine theory hypothesizes and research demonstrates that the value and meaning of family routines is a central factor related to psychosocial adjustment to stressors including urban poverty, illness, and pain (Fiese & Wamboldt, 2000; Seaton & Taylor, 2003), while devaluing or feeling overwhelmed by daily routine is associated with lower reports of quality of life (Spagnola & Fiese, 2007). As confirmed in a study focused on risk-protective factors among single, African American mothers surviving urban poverty, setting children and immediate family as a priority and building courage from the positive meanings attached to and small pleasures gained from taking care of their children are important components of successful adaptation (Brodsky, 1999).

However, burden is a common theme reflected in the stories of families living in urban poverty (Lareau, 2003). It was obvious from all of the interviews that as caregivers discussed how they spent their days, they devoted a great deal of their time and energy taking care of their children. From some of the caregivers, this was expressed with a sense of pride. They clearly valued their parenting role and all of the responsibilities that went along with it. More often than not, though, caregivers expressed a sense of frustration associated with their parenting role related to the daily hassles and major stressors associated with living in low-income urban communities. Their frustration was compounded by the extra demands of taking care of a child with PTSD and other trauma-related symptoms. Quantitative data on family routines from the original larger sample may support this finding, suggesting that the sense of burden, "getting by," and struggle reflected in the interviews may be associated with a relatively lower value or meaning placed on family routines by these caregivers (Kiser et al., 2007; H. I. McCubbin, McCubbin, & Thompson, 1986). These findings raise interesting questions for further research regarding how urban poverty and trauma exposures affect the parenting role in relationship to the value and meaning of daily routines.

The impact of trauma on family routines points the way toward potential intervention strategies. Gaining knowledge and understanding of family routine accommodations in response to both discrete and chronic traumas could help in designing and implementing mental health services for distressed families (Bernheimer & Weisner, 2007). Helping families understand their children's responses to traumas and evaluate their routine accommodations in relationship to fulfillment of family members' needs is one potential way to increase meaning. Other interventions designed to increase the value and meaning of daily routines could be implemented. Such interventions should include efforts aimed at offering practical support to families to reduce the demands of urban poverty and child distress, thus decreasing the sense of burden experienced and improving caregivers' sense of parenting efficacy and optimism. One trauma-specific family intervention currently being evaluated, Strengthening Family Coping Resources (Kiser, 2006), uses family ritual and routine as coping resources for teaching families the importance of deliberating planning and following through with family activities even in the face of chronic stress and frequent crises and skill building related to increasing the quality of and commitment to shared family activity.

Positive changes in family routines—Because we used purposive sampling to identify children who were experiencing symptoms as a result of exposure to traumas, we anticipated talking about how the traumas had negatively affected family ritual and routine. Instead,

many caregivers related positive changes in their family's routines following the traumas. Findings of positive routine changes indicative of increased attention and support from caregivers coupled with reports of improved family relations, however, seem contrary to the empirical links demonstrating that the family context in which children live along with the amount of family support they receive are powerful predictors of outcomes following trauma (Banyard et al., 2001).

We offer two potential explanations for this finding, both of which are consistent with resilience and post-traumatic growth theories and have implications for working with traumatized families. We suggest that further research is necessary to better understand which of the two, if either, explains this finding.

First, as these caregivers talked about changing routines to gain control, such as holding hands while crossing the street or altering their schedules to be more available to their children, they described trying to right themselves. According to qualitative studies of families healing from domestic violence, Wuest, Merritt-Gray, and Ford-Gilboe (2004) elucidate a similar process, which they label *regenerating family*. The caregivers interviewed described doing many constructive things that families can do to organize themselves, stabilize their family routines, and respond to their children's distress. Engaging families around these positive changes in routines may help them better understand how their response following trauma is a health-promoting family process—that is, pulling together, supporting, and protecting each other.

Second, a variety of family therapy approaches are based on the hypothesis that the symptoms of the identified patient function to preserve either positive or negative patterns of interaction within the family (Nichols, 2006; Walsh, 2003). Theories of posttraumatic growth suggest that the struggle to cope with traumas may promote positive change (Calhoun & Tedeschi, 1998). An important question to raise, then, is whether the children's PTSD symptoms are both bringing about and maintaining the positive changes in family routines and relationships described.

In either case, helping families be aware of and strengthen these positive changes and incorporate them in a consistent and meaningful way into daily family life may be a worthwhile therapeutic strategy. Intervention strategies designed to recognize and strengthen family coping skills, increase the family's sense of safety, and improve family communication about, support for, and understanding of the traumas they have experienced may give the distressed children in these families "permission" to relinquish their symptoms.

Meaning Making and Spirituality

For many individuals living in urban poverty, coping is tied to strong religious and spiritual beliefs, and they rely on these powerful values especially in times of hardship (Benard, 1991; Evans et al., 2008). Their belief in a higher order helps to make sense of chronic adversity and otherwise apparently random events. Thus, the spiritual has direct implications for concrete coping and resilience. We saw these prior research findings reflected in this study's caregiver interviews. Many caregivers, but certainly not all, expressed a personal belief system that they used to cope with or explain the bad things that happen to them. This belief system relied heavily on "God" as a resource beyond individual responsibility and seemed to help participants put their energy into challenges they can influence rather than those outside their control. We wondered how this sense of determinism interacts with parental efficacy and deliberateness in molding how parents/families gain some sense of control over this dangerous environment. Additionally, although many caregivers said "no" when asked directly if trauma had an effect on their religious belief or spirituality, their descriptions of coping with trauma included indirect indications of trauma's impact on their

beliefs. This notion of a two-way street between trauma and religion or spirituality might be a fruitful avenue for future exploration.

From a family perspective, we were also interested in whether caregivers used their personal spiritual beliefs to help their children understand the bad things that happened. For some African American families, positive adaptation to high-risk contexts has been linked to spirituality and shared belief systems (Evans et al., 2008; Haight, 1998). Families often try to explain traumatic circumstances by putting them in the context of their shared beliefs and worldview using their fundamental notion of life's purpose and their beliefs about whether it is "comprehensible, manageable, and meaningful" (Bradley & Corwyn, 2000; Greeff & Human, 2004; Higgins & McCabe, 2003; Patterson, 2002). In this study, very few of the caregivers reported using their spiritual beliefs about God in talking with their children about what happened. Most caregivers preferred or were more comfortable using factual information to explain to their children about the traumatic events that occurred. Although spirituality is often ignored in conventional trauma treatment, interventions to help families engage children in the development of shared spiritual beliefs and coping might be another strategy for working with families to heal following traumas (Evans et al., 2008; Haight, 1998; Hodge, 2004; Larimore, Parker, & Crowther, 2002).

Study Limitations

The sample for this study was relatively small, which limited our ability to deeply explore the phenomena reported and to know how widely these participants' views might be shared among others in similar situations. The themes outlined here reflect the voices of female, primarily African American caregivers living in urban poverty. Caregivers of different ethnicities living in different contexts may not be affected by traumatic events in quite the same ways. Although the use of a structured interview guide ensured a systematic approach to data collection, we also felt somewhat constrained by it. Our review of the transcripts often raised additional questions that, unfortunately, we did not have an opportunity to ask. For example, we do not have as full an understanding of the spirituality themes as we might under different conditions, such as possible connections between God as helper, moral behavior, and religion/spirituality helps me slow down, which we could only speculate about. Finally, this study's findings may have been clearer if we had had the opportunity and resources to interview a contrasting sample of caregivers whose children were exposed to multiple traumas but who were not symptomatic. Nonetheless, the themes summarized reflected the views of the majority of caregivers interviewed and bear keeping in mind for interventions and further research.

Summary

This qualitative study provides rich evidence of how dealing with multiple, often ongoing, traumas affects family life and suggests possible strategies for intervening with families to diminish the impact of traumas. Our findings suggest that the majority of caregivers found their caregiving responsibilities stressful and reported making gradual changes to their families' daily routines to accommodate chronic trauma exposure and child distress. Caregivers also described the ways that religion/spirituality supports their individual coping with trauma, although not necessarily useful in explaining trauma to their children. Clinicians might help families find ways of increasing the value and positive valence of daily caregiving routines, use practical strategies for decreasing caregiving burden, support natural healing processes, and construct shared spiritual beliefs about why bad things happen. Chronically traumatized families should be encouraged to feel efficacious in the positive steps that they take to protect themselves, support one another, and use their spiritual coping resources.

Acknowledgments

References

Ackerman BP, Kogos J, Youngstrom E, Schoff K, Izard C. Family instability and the problem behaviors of children from economically disadvantaged families. Developmental Psychology 1999;35:258–268. [PubMed: 9923480]

American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th. Washington, DC: Author; 1994.

Banyard VL, Rozelle D, Englund DW. Parenting the traumatized child: Attending to the needs of nonoffending caregivers of traumatized children. Psychotherapy 2001;38(1):74–87.

Benard, B. Fostering resiliency in kids: Protective factors in the family, school, and community. Portland, OR: Western Regional Center for Drug Free Schools and Communities; 1991.

Bernheimer LP, Weisner TS. "Let me just tell you what I do all day …": The family story at the center of intervention research and practice. Infants & Young Children 2007;20(3):192–201.

Bradley RH, Corwyn RF. Moderating effect of perceived amount of family conflict on the relation between home environmental processes and the well-being of adolescents. Journal of Family Psychology 2000;14(3):349–364. [PubMed: 11025929]

Briere J, Spinazzola J. Phenomenology and psychological assessment of complex posttraumatic states. Journal of Traumatic Stress 2005;18(5):401–412. [PubMed: 16281238]

Brodsky AE. "Making it": The components and process of resilience among urban, African-American, single mothers. American Journal of Orthopsychiatry 1999;69(2):148–160. [PubMed: 10234381]

Brody GH, Flor DL. Maternal psychological functioning, family processes, and child adjustment in rural, single-parent, African American families. Developmental Psychology 1997;33(6):1000–1011. [PubMed: 9383622]

Burton LM, Jarrett RL. In the mix, yet on the margins: The place of families in urban neighborhood and child development research. Journal of Marriage & the Family 2000;62(4):1114–1135.

Calhoun L, Tedeschi R. Beyond recovery from trauma: Implications for clinical practice and research. Journal of Social Issues 1998;54:357–371.

Ceballo R, McLoyd VC. Social support and parenting in poor, dangerous neighborhoods. Child Development 2002;73(4):1310–1321. [PubMed: 12146749]

Clark AF, Barrett L, Kolvin I. Inner city disadvantage and family functioning. European Child & Adolescent Psychiatry 2000;9(2):77–83. [PubMed: 10926056]

Creswell, JW. Research design: Qualitative and quantitative approache. Newbury Park, CA: Sage; 1994.

Dempsey M, Overstreet S, Moely B. "Approach" and "avoidance" coping and PTSD symptoms in inner-city youth. Current Psychology 2000;19(1):28–46.

Evans CJ, Boustead RS, Owens C. Expressions of spirituality in parents with at-risk children. Families in Society 2008;89(2):245–252.

Evans GW, Maxwell LE, Hart B. Parental language and verbal responsiveness to children in crowded homes. Developmental Psychology 1999;35(4):1020–1023. [PubMed: 10442870]

Falsetti SA, Resick PA, Davis JL. Changes in religious beliefs following trauma. Journal of Traumatic Stress 2003;16(4):391–398. [PubMed: 12895022]

Fiese BH, Wamboldt FS. Family routines, rituals, and asthma management: A proposal for family-based strategies to increase treatment adherence. Families, Systems & Health 2000;18(4):405–418.

Figley, CR. Post-traumatic family therapy. In: Ochberg, FM., editor. Post-traumatic therapy and victims of violence. New York: Bruner/Mazel; 1988. p. 83-109.

Gaudin JM, Polansky NA, Kilpatrick AC, Shilton P. Family functioning in neglectful families. Child Abuse & Neglect 1996;20(4):363–377. [PubMed: 8730772]

Glaser, BG.; Strauss, AL. The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine; 1967.

Goetz, JP.; LeCompte, MD. Ethnography and qualitative design in educational research. Orlando, FL: Academic Press; 1984.

Greeff AP, Human B. Resilience in families in which a parent has died. American Journal of Family Therapy 2004;32(1):27–42.

Haight W. "Gathering the Spirit" at First Baptist Church: Spirituality as a protective factor in the lives of African American children. Social Work 1998;43(3):213–221. [PubMed: 9597945]

Higgins DJ, McCabe MP. Maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. Journal of Family Violence 2003;18(2):107–120.

Hill NE, Herman-Stahl MA. Neighborhood safety and social involvement: Associations with parenting behaviors and depressive symptoms among African-American and Euro-American mothers. Journal of Family Psychology 2002;16(2):209–219. [PubMed: 12085733]

Hodge DR. Spirituality and people with mental illness: Developing spiritual competency in assessment and intervention. Families in Society 2004;85(1):36–44.

Kaufman J, Birmaher B, Brent D, Rao U, Flynn C, Moreci P, et al. Schedule for Affective Disorders and Schizophrenia for School-Age Children–Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. Journal of the American Academy of Child & Adolescent Psychiatry 1997;36(7):980–988. [PubMed: 9204677]

Kiser, LJ. Strengthening family coping resources: Multi-family groups for families affected by trauma. 2006. Unpublished manual

Kiser LJ, Bennett L, Heston JD, Paavola M. Family ritual and routine: Comparing clinical and non-clinical families. Journal of Child and Family Studies 2005;14(3):357–372.

Kiser, LJ.; Medoff, D.; Black, MM. Urban poverty, childhood traumatic stress, and family processes. 2007. Submitted for publication

Kliewer W, Murrelle L, Mejia R, Torresde GY, Angold A. Exposure to violence against a family member and internalizing symptoms in Colombian adolescents: The protective effects of family support. Journal of Consulting and Clinical Psychology 2001;69:971–982. [PubMed: 11777124]

Knight, C. Introduction to working with adult survivors of childhood trauma. Belmont, CA: Thomson, Brooks/Cole; 2007.

Lareau, A. Unequal childhoods: Class, race, and family life. Berkeley: University of California Press; 2003.

Larimore WL, Parker M, Crowther M. Should clinicians incorporate positive spirituality into their practices? What does the evidence say? Annals of Behavioral Medicine 2002;24(1):69–73. [PubMed: 12008796]

Lauterbach D, Koch EI, Porter K. The relationship between childhood support and later emergence of PTSD. Journal of Traumatic Stress 2007;20(5):857–867. [PubMed: 17955546]

Levendosky AA, Graham-Bermann SA. The moderating effects of parenting stress on children's adjustment in woman-abusing families. Journal of Interpersonal Violence 1998;13(3):363–397.

Macy, RD.; Barry, S.; Noam, GG. Threat and trauma: An overview. In: Macy, RD.; Barry, S.; Noam, GG., editors. New directions for youth development: Youth facing threat and terror, supporting preparedness and resilience. Vol. 98. San Francisco: Jossey-Bass; 2003. p. 11-28.

McCubbin, HI.; McCubbin, MA.; Thompson, AI. Family Time and Routines Index (FTRI). In: McCubbin, HI.; Thompson, AI.; McCubbin, MA., editors. Family assessment: Resiliency, coping and adaptation–Inventories for research and practice. Madison: University of Wisconsin System; 1986. p. 325-340.

McCubbin, MA.; McCubbin, HI. Families coping with illness: The resiliency model of family stress, adjustment, and adaptation. St. Louis, MO: Mosby Year Book Inc.; 1993.

Meyers SA, Varkey S, Aguirre AM. Ecological correlates of family functioning. American Journal of Family Therapy 2002;30(3):257–273.

Mirza KA, Bhadrinath BR, Goodyer IM, Gilmour C. Post-traumatic stress disorder in children and adolescents following road traffic accidents. British Journal of Psychiatry 1998;172:443–447. [PubMed: 9747409]

Nichols, MP. Family therapy concepts and methods. 7th. Boston: Pearson Education; 2006.

Patterson JM. Integrating family resilience and family stress theory. Journal of Marriage and the Family 2002;64(2):349–360.

Peebles-Kleiger MJ, Kleiger JH. Re-integration stress for Desert Storm families: Wartime deployments and family trauma. Journal of Traumatic Stress 1994;7(2):173–194. [PubMed: 8012742]

Pfefferbaum B. Posttraumatic stress disorder in children: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry 1997;36(11):1503–1511. [PubMed: 9394934]

Repetti, RL.; Wood, J. Families accommodating to chronic stress: Unintended and unnoticed processes. In: Gottlieb, BH., editor. Coping with chronic stress. The Plenum series on stress and coping. New York: Plenum Press; 1997. p. 191-220.

Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health. Journal of the American Medical Association 1997;278(10):823–832. [PubMed: 9293990]

Ribbe, D. Psychometric review of Traumatic Event Screening Instrument for Children (TESI-C). In: Stamm, BH., editor. Measurement of stress, trauma, and adaptation. Lutherville, MD: Sidran Press; 1996. p. 386-387.

Saakvitne KW, Tennen H, Affleck G. Exploring thriving in the context of clinical trauma theory: Constructivist self development theory. Journal of Social Issues 1998;54(2):279–299.

Salloum, A.; Rynearson, EK. Family resilience after violent death. In: Rynearson, EK., editor. Violent death: Resilience and intervention beyond the crisis. New York: Routledge; 2006. p. 47-63.

Seaton EK, Taylor RD. Exploring familial processes in urban, low-income African American families. Journal of Family Issues 2003;24(5):627–644.

Shapiro, ER. Grief as a family process. New York: Guilford; 1994.

Spagnola M, Fiese BH. Family routines and rituals: A context from development in young children. Infants & Young Children 2007;20(4):284–299.

Walsh, F. Strategic/systems approach. In: Walsh, F., editor. Normal family process. 3rd. New York: Guilford; 2003. p. 31-32.

Weisner, TS.; Bernheimer, L.; Coots, J. The Ecocultural Family Interview manual. Los Angeles: UCLA Center for Culture and Health; 1997.

Whittlesey SW, Allen JR, Bell BD, Lindsey ED, Speed LF, Lucas AF, et al. Avoidance in trauma: Conscious and unconscious defense, pathology, and health. Psychiatry 1999;62:303–312. [PubMed: 10693225]

Wolfer TA. "It happens all the time": Overcoming the limits of memory and method for chronic community violence experience. Journal of Interpersonal Violence 1999;14(10):1070–1094.

Wolin, SJ.; Jacobs, J. Your current family and the family you grew up in: A cultural interview and questionnaire. 1989. Unpublished interview

Wuest J, Merritt-Gray M, Ford-Gilboe M. Regenerating family: Strengthening the emotional health of mothers and children in the context of intimate partner violence. Advances in Nursing Science 2004;27(4):257–274. [PubMed: 15602278]

Table 1

Demographic Characteristics of the Sample

Caregiver	N = 100	N = 28	N = 16
Age in years	N = 99		
18 to 24	16	4	2
25 to 29	19	4	2
30 to 34	22	7	2
35 to 39	16	3	2
Older than 40	26	10	8
Gender			
Male	1		
Female	99	28	16
Race			
Asian/Pacific Island	1		
Black/African American	92	25	13
White (non-Hispanic)	6	2	2
Other	1	1	1
Education	N = 99	N = 27	
Less than 8th grade	3		
Some high school	25	7	4
High school diploma/GED	42	8	2
Some college	23	9	6
College or higher	6	3	3
Household income	N = 99	N = 27	
Less than $20,000	70	24	14
$20,000 to $35,000	20	2	1
$35,000 to $50,000	5	1	1
More than $50,000	4	1	
Child			
Age in years			
6	33	8	5
7	26	5	2
8	24	8	7
9	17	7	2
Gender			
Male	50	13	5
Female	50	15	11
Race			
Asian/Pacific Island			
Black/African American	93	25	13
White (non-Hispanic)	4	1	1
Other	3	2	2

Table 2

Major Themes

Changes in Rituals and Routines After Child Trauma

Impact on Family Celebrations, Traditions, Rituals

Mostly unchanged after trauma:

- Celebrations, traditions, rituals stayed "normal" for most families

Impact of Trauma on Family Routines

Little disruption reported in the immediate aftermath:	Routines altered to deal with child distress:	Positive changes in routines:
• Even when disruption seemed obvious from nature of trauma	• Daily routines = "getting by," basic tasks needed to get through the day • Child needing more attention/ supervision at home • School problems • Caregiver routine changes as a result	• Overall stress decrease if domestic violence resolved • More communication among family • More protective and attentive

Meaning Making and Spirituality

God determines why things happen as they do:	God made it not worse:	Religion/spirituality as help in difficult times:
• Comforting attribution of meaning to otherwise meaningless misfortune • Acknowledge what one cannot control, concentrate one's energy on things one can influence	• Subset example of previous theme • Coping through downward social comparison	• Faith/God's presence as strengthening and comforting • Values/tenets as guide for moral behavior • Encourages reflection and thoughtful action