THE LIVED EXPERIENCE OF ADOPTIVE MOTHERS OF CHILDREN WITH EARLY COMPLEX
TRAUMA AND ATTACHMENT ISSUES: A QUALITATIVE STUDY

by

TABATHA P. ANDERSON

A Dissertation Submitted to the Graduate Faculty
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DEDICATION

I am dedicating this work to “trauma moms,” the women who show up day after day to love kids who may never be able to love them back. They are Wonder Women, making sacrifices in every area of their lives in hopes that their children can heal from a wound neither of them caused. I am so grateful to have been trusted with their stories and I am committed to educating others about their experiences.
ACKNOWLEDGMENTS

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Finally, I want to thank the participants who trusted me with their stories in hopes that it might make another mom’s journey easier one day. I am inspired by your strength and honored to be the conduit for your voices. I am better for having met you.
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ABSTRACT

TABATHA P. ANDERSON
THE LIVED EXPERIENCE OF ADOPTIVE MOTHERS OF CHILDREN WITH EARLY COMPLEX TRAUMA AND ATTACHMENT ISSUES, A QUALITATIVE STUDY
Under the direction of DR. HELEN HODGES

Beginning with Bowlby’s early work nearly 70 years ago, the importance of a child’s attachment to his or her mother or mother figure has been documented. Consequences of failing to develop a healthy attachment in infancy include the inability to give or receive affection, form long-term relationships, develop a conscience, or trust others. For the child who has experienced early complex trauma and attachment issues, rejection of the maternal figure is a learned survival mechanism wherein the child seeks to create disharmony and chaos that are more familiar than a sense of safety, trust, and attachment. Current literature has acknowledged the significance of the mother’s role in the healing of a child with early complex trauma and attachment issues but has largely ignored the mother’s experience. This descriptive phenomenological study of adoptive mothers sought to explore the mothers’ lived experiences and how those experiences affect the mothers physically, emotionally, intellectually, and spiritually.

A conceptual framework developed by the researcher and based on Rogers’ (1992) science of unitary human beings guided the study. Giorgi’s (2009) procedural
steps of data analysis and Saldaña’s (2013) processes of coding were used to guide data analysis. Four themes and twelve subthemes emerged from the data describing the experience of being an adoptive mother of a child with early trauma and attachment issues. Findings reflected effects of the child’s interaction with the mother on the mothers’ physical, emotional, intellectual, and spiritual behaviors and health. By exploring these mothers’ experiences and the meaning attached to those experiences, nurses and other healthcare providers may be able to more effectively provide support, education, and health promotion. Further, bettering the mothers has the potential to not only affect their lives but the lives of their children.
CHAPTER 1
INTRODUCTION TO THE STUDY

Martha Rogers (1992) stated, “The purpose of nursing is to promote human betterment wherever people are” (p. 265). Rogers’ concept of betterment and its interventions, particularly related to health and quality of life, are unique to each individual or population encountered. One goal of the Office of Disease Prevention and Health Promotion’s (ODPHP, n.d.) Healthy People 2020 is health promotion at all stages of life. One subgroup identified is mothers, infants, and children, with recognition that healthy behaviors and development in this population impacts the current and future well-being of families, communities, and health care systems (ODPHP, n.d.). However, the objectives of Healthy People 2020 focus primarily on individual’s morbidity and mortality rather than quality of life. For mothers, the focus is on pregnancy and childbirth rather than child rearing. This is reflective of a general medical model of illness rather than a Rogerian view of wellness as well as the view that mothers and children are seen as a single unit. To better assist with the improvement of mothers’ health nurses must seek understanding of a mother’s experiences and the meaning attached to those experiences (Munhall, 2012).

National organizations such as the Institute for Healthcare Improvement (IHI) are becoming increasingly aware of the value of patients’ life experiences to quality care.
Despite this recognition and common use of the term patient-centered care to describe modern healthcare, individual patient experiences are often overlooked by healthcare providers (Barry & Edgman-Levitan, 2012). Inspired by an article written by Barry and Edgman-Levitan (2012), the IHI (n.d.) encourages providers to ask patients “What matters to you?” in addition to “What is the matter?” The IHI (n.d.) believes this shift in focus encourages a partnership between the patient and provider which improves care and patient outcomes. However, in addition to the question, welcome reception of the answer must follow as well. Providers must foster a supportive environment in which patients feel free to express their opinions and experiences without judgment, which requires access to care and a shift from the historically paternalistic medical model (Barry & Edgman-Levitan, 2012).

Phenomenon of Interest

Mothering is a unique experience in which one’s mental and physical energies are expended even without unexpected challenges (Mercer, 1990). The occurrence of additional stressors or unforeseen circumstances can result in an increased vulnerability of the parents. Mercer (1990) explored the experience of biological parents facing challenges to the parenting role such as obstetrical risk, congenital defects, prematurity, and alternative family structures. Such circumstances increase parental stress and threaten the parents’ ability to nurture their child and adapt to and enjoy the parental role (Mercer, 1990). Although Mercer’s work focused only on understanding experiences and common challenges to biological parents, one could extrapolate
adoptive parents who experience increased stress also may face difficulties in their abilities to nurture their adopted child and adapt to and enjoy the parental role.

While there are stressors common to both adoptive and biological parents, there are unique experiences to each as well. Unfortunately, the experiences and challenges of adoptive parents are largely absent from current theory. To improve the health of mothers, infants, and children as identified by Healthy People 2020, the experiences of adoptive families must be explored in addition to those of biological families. This study will focus on the experience of adoptive mothers of children with early complex trauma and attachment issues. While attachment issues can occur in biological families, it is much more common in adoptive families.

According to 2010 United States census data, there were 2,072,312 adoptees living with their parents with 1,527,020 of those under the age of 18 (Krieder & Lofquist, 2014). While no literature could be found which provided an estimate of the number of persons with attachment issues in the United States, each of those adoptees likely has faced a separation from a primary caregiver putting them at risk for attachment issues. Infants instinctively seek proximity to their attachment figure to survive and flourish. Temporary or permanent separation of a child from his/her mother or mother figure can influence attachment and lead to psychological disturbances for the child which may continue into adulthood (Bowlby, 1982). Consequences of failing to develop a healthy attachment in infancy include the inability to give or receive affection, form long-term relationships, develop a conscience, or trust others. Bowlby’s (1982) theory
of human attachment is foundational to current understanding of attachment issues as well as a birth mother’s role in a child’s healthy attachment and development.

Current literature supports this view and also adds childhood maltreatment and exposure to violence as risk factors for attachment issues, developmental delays, behavior problems, and physical and psychological effects throughout the life span (Centers for Disease Control and Prevention, 2014a). According to the Centers for Disease Control and Prevention (2014b), child maltreatment includes physical, sexual, or emotional abuse and neglect. The U.S. Department of Health and Human Services (2012) estimates 686,000 (9.2 per 1000) children were victims of maltreatment in 2012. However, this number may underestimate the actual occurrence of child maltreatment because it is based on reports made to state and local child protective service agencies (The U.S. Department of Health and Human Services, 2012). Maltreatment that was not reported or that occurred in internationally adopted children prior to coming to the United States is difficult to quantify. A study by Finkelhor, Turner, Ormond, and Hamby (2013) estimated 1 in 4 children in the United States are victims of maltreatment.

Trauma is a term which includes child maltreatment and other similar negative experiences which can adversely affect a child’s physical and psychological development. In addition to physical, sexual, or emotional abuse and neglect, trauma includes community violence, domestic violence, medical trauma, natural disasters, refugee trauma, school violence, terrorism, and traumatic grief (National Child Traumatic Stress Network, n.d.). Complex trauma refers to the exposure of children to multiple traumatic experiences and the long-term effects of such experiences (National
Child Traumatic Stress Network, 2014a). The effects of complex trauma are varied but commonly include difficulty forming healthy attachments and relationships, abnormal stress responses, impaired brain and nervous system development, impaired sensory processing, abnormal emotional responses, dissociation, thinking and learning difficulties, shame, guilt, poor self-esteem, impulse control, high-risk behaviors, and chronic illness (National Child Traumatic Stress Network, 2014a). Research has not established why some children seem to be more profoundly affected by complex trauma, but young children ages 0 to 6 years seem to be most at risk due to an immature and rapidly developing brain (National Child Traumatic Stress Network, 2010). Due to the similar symptoms, prognosis, effects, and the separation from a primary caregiver also being a traumatic experience, the terms early complex trauma and attachment often appear together.

For the child who has experienced early complex trauma and attachment issues, rejection of the maternal figure is a learned survival mechanism (Institute for Attachment and Child Development, 2016). Rejection behaviors are subtle and may go unnoticed by others. These behaviors may include withdrawing or becoming stiff in response to a mother’s hug, challenging or ignoring requests made by the mother but complying with the same request from another, and refusing his/her favorite foods when presented by the mother. More aggressive behaviors can include use of profanity or unkind language toward the mother indicating she is a bad parent, lying to other adults about the mother’s behavior in an attempt to make her appear irrational or unkind, destroying gifts given by the mother, purposely causing damage which others
mistake for accidents, and urinating or defecating in inappropriate places (Institute for Attachment and Child Development, 2016). The subtlety of the behaviors and the child’s usual target being only the mother or primary caregiver can lead to inappropriate diagnosis and treatment of the child by providers as well as poor support or blaming of the mother or primary caregiver.

Both in Bowlby’s attachment theory and American sociocultural tradition, the mother’s role is as a caretaker and protector. American society expects mothers to be selfless, consistently nurturing, and untiring (Thomas, 1997). However, in a child with attachment issues the primary caregiver’s compassion, protection, and nurturing are resisted. The mother becomes a “nurturing enemy” which describes the relational dynamic in which the child rejects the caregiver who tries to attach to them emotionally (Institute for Attachment and Child Development, 2016, para. 2). Although the cited blog post seems to be the introduction of the term nurturing enemy, the term has now become routinely used by adoptive mothers in blogs, posts, and conversation. In a recent update to a blog post offering explanation of the phenomenon of the nurturing enemy and support for mothers parenting children with attachment issues, The Institute for Attachment and Child Development identified the post as its most popular. Furthermore, the Institute reported multiple daily calls and e-mails from adoptive mothers expressing experiences of isolation, failing marriages, hopelessness, inability to find a knowledgeable therapist, and not being heard or believed (Institute for Attachment and Child Development, 2016).
Despite the impact of early complex trauma and attachment issues, literature on the topic is limited, especially as it relates to the experiences of adoptive mothers. Additionally, historical views of adoption, evident through legislation, further promote the notion that adoption circumstances should be hidden, not shared or discussed. For example, current laws in most states continue to require the sealing of adoption records regardless of the parents’ or adoptees’ wishes or circumstances (U.S. Department of Health and Human Services, Children’s Bureau, 2106). There is a saying in the adoption community, for which an original source could not be found, that adoption loss is the only trauma in the world where everyone expects those involved to be grateful and appreciative. Adopted children are expected to be grateful for being given a home, family, and better life by their adoptive parents and adoptive parents are expected to be grateful the child they longed for is now home and that the birthmother was generous and selfless. This ideology along with societal expectations of mothering, and the way early complex trauma and attachment related behavior appears to others, may contribute to the voicelessness of adoptive mothers.

To foster healing and attachment of children with early complex trauma and attachment issues, parents must learn and implement therapeutic parenting strategies. Therapeutic parenting behaviors cultivate feelings of safety and connection in the child as the process of healing is slow and intense (Attachment and Trauma Network, n.d.). Successful therapeutic parenting must include attention to safety, connection, structure, nurture, and frequent reevaluation - all focused on a child fearful of attachment and exhibiting the rejection behaviors mentioned above. Both actual and perceived safety
must be a priority. In fact, the actual safety of each member of the family, including the adoptee, can be of concern due to the adoptee’s behaviors (Attachment and Trauma Network, n.d.).

Because of prior experience(s), the adoptee with a history of early complex trauma and attachment issues does not feel safe (Attachment and Trauma Network, n.d.). Unfortunately, no specific amount of time or merely living in a safe environment with safe, attentive parents is sufficient to make the adoptee feel safe. Traumatic experiences, even when they occur to a newborn or preverbal child, are stored in the brain in a way which prevents it from being changed by later experiences (Gobbel, 2013). In fact, even if the child cannot explicitly remember the memory, certain triggers can cause the child to feel and the body to behave as if the trauma was happening in the present. This is very frightening to the child and misunderstood by many (Gobbel, 2013). Therapeutic parenting and attachment informed therapy can assist the child in healing and promote proper storage of the traumatic memories. Increased structure with consistent routine and boundaries contribute to the child with early complex trauma and attachment issues feelings of safety, but the structure must be enforced by parents in a calm, kind, connected, and respectful manner (Attachment and Trauma Network, n.d.). If a parent responds to the rejection behavior of a child with early complex trauma and attachment issues with anger, withdrawal, or leniency, the child internalizes the message the parent is unsafe, uncaring, and not strong enough to handle the child’s biggest and darkest feelings. This further perpetuates attachment issues.
Nurturing children with early complex trauma and attachment issues can seem like a tight rope walk to parents. Until healing begins to occur, positive emotions are rarely reciprocated by the child and nurturing is met by an equal or increased measure of resistance. Too much nurturing by the parent feels suspicious to the child and perpetuates the sense the parent is not strong enough or trustworthy. Additionally, too much praise, attention, or gifts is likely in conflict with the child’s sense of poor self-worth which further results in the child’s resistance and sabotaging behaviors (Attachment and Trauma Network, n.d.). Nurturing is an important part of therapeutic parenting, but the amount of nurturing that a child with early complex trauma and attachment issues needs and can handle is a fine balance which can change from day to day and even moment to moment.

To help their child heal, adoptive mothers of children with early complex trauma and attachment issues must practice therapeutic parenting by remaining calm, kind, connected, and respectful with a child who is actively, forcefully, and sometimes dangerously trying to resist her connection (Attachment and Trauma Network, n.d.). Failure of the mother to continue therapeutically parenting through the slow process of healing can have long lasting effects for the child. Although sociocultural expectations are that a mother should be able to tirelessly nurture her child, the impossibility of such behavior is logical. It follows that the interaction within this relationship, which seeks healing of the child, could affect the mother as well.
Purpose of the Study

Recognizing the national campaign to improve the lives of mothers and children in the United States and acknowledging the value of the lived experience to developing such improvements, the purpose of this study is to explore the experiences of adoptive mothers of children with early complex trauma and attachment issues.

Research Questions

1. What is the lived experience of adoptive mothers of children with early complex trauma and attachment issues?
2. What effect has the experience of mothering a child with early complex trauma and attachment issues had on adoptive mothers’ physical, emotional, intellectual, and spiritual health?

Conceptual Framework

Martha Rogers’ (1992) science of unitary human beings, inspired by the rapidly progressing scientific advancement of the late 20th century, encouraged nurse researchers to think beyond existing boundaries, even to space. Rogers was concerned about community health, including population wellness, illness prevention, and access to care. Her work advocated for viewing health and wellness through new and creative ways asserting “so-called pathology on earth today may signify health for the space-bound” (Rogers, 1992, p. 256). Nurse researchers were encouraged by Rogers to look beyond existing theories and explanations of how the world works and expand to what is seen happening in the world. Bowlby (1973) explained how the world should work for children to develop healthy attachment. Mercer (1990) explained how the world
worked for biological parents in stressful situations. Few researchers have ventured into the world of adoption and trauma, particularly in relation to the experiences of adoptive mothers of children with early complex trauma and attachment issues.

The science of unitary human beings offers a way to approach clients beyond traditional science, the medical model, or a holistic approach. Rogers (1992) stated “what may be quite valid in describing biological phenomena does not describe unitary human beings, any more than describing a molecule tells you about laughter” (p. 30). Although utilization of Rogers’ work may require one to step away from more traditional, comfortable schools of thought, it provides an appropriate conceptual framework for a study addressing non-traditional and possibly uncomfortable topics.

Rogers stated, “the pressing need to study people in ways that would enhance their humanness has coordinated with the accelerating technological advances and forced a search for new models” (Rogers, 1992, p. 27). Exploring one’s humanness reaches beyond sociocultural norms and expected biological processes to the unexpected and unexplained. The clients in Rogers’ science of unitary human beings are Homo sapiens, earth beings, and Homo spatialis, space beings (Rogers, 1992). The environment identified by Rogers (1992) is broad and includes both earth and space. Interestingly, “Parenting in Outer Space” (located at parentinginouterspace.com) is a resource for therapeutic parenting due to the very unique and foreign experience of parenting children with attachment issues. This study will join both concepts of space exploration through the research of areas currently unexamined.
According to Rogers (1992), human beings and their environments are “irreducible wholes” and “a whole cannot be understood when it is reduced to its particulars” (p. 29). Rogers differentiated this terminology from the word holistic which indicates a sum of parts. The experience of being a mother is so complex and individual that to describe it using only one perspective would be nearly impossible. Neither can the experience be summarized by the listing of its associated experiences. Although we can describe the process of attachment and therapeutic parenting behaviors, this description cannot adequately describe the experience of the mother who is nurturing the child with early complex trauma and attachment issues. Likewise, the care of mothers and children individually cannot be fully informed by research which explores their experiences only together as one mother-child unit. Rogers’ concept of field offers a way in which the irreducible wholes of persons and their environments may be perceived.

Rogers’ (1992) science of unitary human beings proposed all living and non-living things in the universe fundamentally consist of energy fields. Energy fields of humans and their environments are integral, infinite, and in continuous motion. Infinite contacts occur between one’s energy field and one’s environment. In Rogers’ (1992) work, pattern is a term used only in reference to an energy field wherein patterns are unique, abstract, and changing, and identify the field. Pattern cannot be observed directly but rather the manifestations of the field patterning such as being pragmatic, needing more or less sleep, and experiencing time as slower or faster.
Although individuals’ energy patterns are unique, their continuous motion and infinite interactions result in continuous pattern changes (Rogers, 1992). Certainly, it follows that contact with another person would result in the interaction of their energy fields. Whether momentarily or permanently, a new pattern is created. Although behaviors are not the energy field but rather the manifestation of it, the interaction and change in pattern can be observed in behaviors. Consider the experience of enjoying reading while sitting on a park bench on a beautiful day and then having a stranger come and sit close. Perhaps one can relate to an uneventful commute to work listening to calm music when an accident nearly occurs or interaction with someone who is noticeably hostile or angry. Without any words or physical interaction, the energy pattern is changed which could be manifested emotionally through feelings of being uncomfortable, excited, anxious, nervous, or angry, and physically through increased heart rate, increased blood pressure, sweaty palms, flushing, or nausea. Abrupt patterning changes such as these can occur multiple times daily, but once the conflicting energy is removed, one’s own dominant energy pattern reemerges. However, more consistent interactions with the patterns of others or the environment can cause fundamental pattern changes.

Bowlby’s (1973) attachment theory and Mercer’s (1990) work on parental role attainment reflect fundamental changes which can occur through the interaction of mother and child. Bowlby (1973) asserts that infants are born with a number of behavioral systems awaiting activation through interaction with their mothers. Positive interactions and having their needs met leads to healthy attachment patterns whereas
negative interactions leads to unhealthy attachment patterns. According to Bowlby, the establishment of these patterns is directly related to the infant’s environment and interactions with his/her mother. The patterning is developed in the first three years of life and is distinctive and persistent throughout the lifespan (Bowlby, 1973). Mercer (1990) examined “forces” interacting in an early parenting relationship including the influence of the infant’s learned and unlearned characteristics on the parents who are also influencing the child. Such forces could also be referred to as patterning or energy fields if using Rogers’ (1992) vocabulary.

In adoption parenting, two established energies which may have never interacted are now influencing one another. Mercer (1986) as cited in Mercer (1990) identified four levels of adaptation within the stages of parental role acquisition when becoming a new parent to a biological child. The levels include physical or biological, psychological or emotional, cognitive, and social. Although the process of adoptive mother and child attachment is unique, Mercer’s levels are fundamental to human nature. The adoptive mother and child who live together are in frequent interaction with one another. The mother has an established pattern consisting of physical, emotional, intellectual, and spiritual energies. Children with early complex trauma and attachment issues operate from a survival pattern learned from their early experiences in which the world is unsafe and caregivers cannot be trusted. The child’s energy pattern repels all attempts from the mother to establish a bond and to change the child’s patterning from one of survival to one of safety and attachment. Instead, the child actively seeks to create a pattern change of disharmony in the mother which
creates a sense of safety and familiarity for the child. This disturbance of energy patterning, regardless of whether it is recognized as such to the mother, could manifest itself in one’s physical, emotional, intellectual, and spiritual behaviors and health.

Building upon Rogers’ (1992) science of unitary human beings, the following has been developed to guide this study. Other individual sources cannot be identified as the concept has evolved through years of experience as and with adoptive mothers of children with early complex trauma and attachment issues. Each pre-adoptive mother has an established, unique energy field prior to meeting her child. Her fundamental energy field is made up of the combined patterning of physical, emotional, intellectual, and spiritual energies (Appendix A). Although these energies can be discussed individually, the pandimensionality of the mother is recognized by Rogerian science. Separating each of these energies is nearly impossible as they all have influence on one another and are in constant interaction with others and the environment. When a mother interacts with her child, we may identify a predominant energy pattern, but it would be impossible for that pattern to be interacting in isolation. For example, a mother may hug her child (physical manifestation), but her emotional energy would be interacting with the child as well. The emotional energy could be loving and supportive or obligatory and resentful. Another example could be the mother is frustrated (emotional) with a child’s behavior. Physical patterning could manifest as a furrowed brow and tense muscles, or a calm and controlled demeanor; intellectually the mother could understand why the child is behaving in a certain way and respond therapeutically or utilize traditional parenting techniques and respond non-therapeutically. These
conflicting energies could happen in any relationship, but they are of particular importance in the relationship between an adoptive mother and her child with early complex trauma and attachment issues.

Instead of developing stable, age appropriate patterning, children with early complex trauma and attachment issues develop a pattern which is focused on survival (Appendix 2). Even when safe, the child’s patterning manifests as if the child was in danger. The child resists all calm or affectionate patterning, instead seeking control and chaos which feels more familiar to the child and offers a false sense of safety. The child’s physical, emotional, and intellectual energies are nearly always in conflict. For example, a child can see a pantry full of food and have recently eaten a meal (physical), and the child can verbalize “We have enough food” (intellectual), but the child is consistently worried there will not be enough food (emotional) and therefore hoards food or gorges. Also, many children with early complex trauma and attachment issues develop keen senses of discernment and the ability to act in a way contradictory to their patterning through surviving trauma. For example, they can remain stoic and largely unresponsive to intense physical pain. They may also exhibit a learned behavior reflective of an expected but false emotion which results in manipulation of others. An example of this would be a tearful account of mistreatment by the adoptive mother when in fact the allegation is false and the true emotion is fear and/or anger.

Significance of the Study

Without reestablishing attachment, children with early complex trauma and attachment issues likely will not heal. However, therapeutic parenting is difficult and
strongly resisted by the children who need it. Mothers of children with early complex trauma and attachment issues are faced with a unique situation. Traditional parenting is not effective; children are threatened by love and resist nurturing, yet sociocultural norms demand it and even blame mothers for any pathology of their children (Thomas, 1997). Research related to early complex trauma and attachment has been focused on the areas of issues in adoption (Foli et al., 2012; Lionetti, Massimiliano, & Barone, 2015; Timm, Mooradian, & Hock, 2011), attachment disorder presentations (Niemann & Weiss, 2011; Zeanah & Gleason, 2014), attachment disorder causes (Mikic & Terradas, 2014; Zeanah & Gleason, 2014), attachment disorder treatments (Barth, Cre, John, Thoburn, & Quinton, 2005; Shi, 2014; Wimmer, Vonk, & Reeves, 2010; Zeanah & Gleason, 2014), and the effect of parents’ behaviors/health on adoptees (Barone & Lionetti, 2011; Barth et al., 2005; Foli et al., 2012; Lionetti et al., 2015; Pace & Zavattini, 2010; Pace, Zavattini, & D’Alessio, 2012; Vitale & O’Connor, 2006). Although this research is valuable in the recognition and understanding of attachment disorders and associated issues, mothers’ roles in the research and literature have been nearly exclusively depicted as causative variables for healthy or unhealthy attachments. In places where these adoptive mothers’ voices are shared, such as blog posts, message boards, and social media, there is an overwhelming expression of loneliness, struggle, fear, and frustration.

Rogers (1992) encouraged examination of common events through the science of unitary human beings to identify new questions, perspectives, and explanations. She believed the potential growth of nursing’s body of knowledge from this system was
infinite. Rogers (1992) stated “everyone needs to care; the nature of caring in a given field depends entirely on the body of scientific knowledge specific to the field” (p. 33). There is a great opportunity to improve the nature of caring for mothers of children with early complex trauma and attachment issues by expanding the body of scientific knowledge based on their experiences.

Thomas (1997) identified that health extends beyond biological phenomena to sociocultural phenomena and urged researchers not only to ask women what health means, but also to listen to the answers. The parenting experience of mothering a child with early complex trauma and attachment issues is unique and underrepresented in literature. By exploring these mothers’ experiences and the meaning attached to those experiences, nurses and other healthcare providers will be able to more effectively provide support, education, and health promotion. Further, bettering the mothers has the potential to not only affect their lives but the lives of their children.

Assumptions and Biases

As the adoptive mother of two children with early complex trauma and attachment issues, this researcher has experienced the lack of scientific research and literature on the topic firsthand. Much of the information that has been helpful to parenting her children has come from other mothers who are in the same situation via blogs, social media posts, and support groups. Personal experience and interactions with other mothers have led to the following assumptions and biases:
• The type of trauma, age at traumatic event, and whether the trauma was reoccurring results in different presentations, different diagnoses, and different levels of healing for each child.

• Helpful interventions or therapies differ for each child.

• Mothers have very different experiences with resources including availability of mental health resources.

• Children with early complex trauma and attachment issues may be with their biological family, a foster family, or an adoptive family.

• There are commonalities in the experiences of adoptive mothers of children with early complex trauma and attachment issues in the areas of physical, emotional, intellectual, and spiritual responses.

• Adoptive mothers of children with early complex trauma and attachment issues are changed by the relationship with their child in both positive and negative ways.

• Adoptive mothers of children with early complex trauma and attachment issues who have been parenting for several years are fiercely committed.

• There is not enough support readily available for adoptive mothers of children with early complex trauma and attachment issues.

• Observers do not understand trauma parenting.

• There is not enough support for children with trauma and attachment histories.

• Children can heal.
• Adoptive mothers of children with early complex trauma and attachment issues are the best sources for understanding their experience and its effect on their health.

Definition of Terms

Adoptee: One who joins a family through adoption (“Adoptee,” 2019).

Adoption: A legal process which results in one permanently becoming a son or daughter of someone other than a biological parent (“Adoption,” 2019).

Adoptive mother: A female parent to an adopted person.

Attachment: The relationship formed between a child and his or her primary caregiver which begins at birth. If the child’s needs are met and care is safe and consistent, the child develops a healthy attachment. If the child’s needs are not met or care is unsafe and/or inconsistent, the child may develop an attachment disorder (Bowlby, 1982; Greenberg, 1999).

Attachment disorder: Psychological sequelae experienced by a child (most commonly prior to age 2) whose needs were not met or whose care was unsafe and/or inconsistent. The most severe attachment disorder is Reactive Attachment Disorder (RAD) (Greenberg, 1999).

Child Maltreatment: Unkind treatment of a child including physical, sexual, or emotional abuse, and neglect (Centers for Disease Control and Prevention, 2014b).

Energy field: Fundamental unit of the living and non-living which are integral, infinite, in continuous motion, and constant interaction with the fields around them (Rogers, 1992).

Neurotypical: Pertaining to normal or typical neurologic development (“Neurotypical,” 2019).

Patterning: Characteristic by which the energy field is identified. Patterns are unique, abstract, and constantly changing. Pattern cannot be observed directly but rather the manifestations of the patterning including behaviors and emotions (Rogers, 1992).

Trauma: An intensely distressing experience including community violence, domestic violence, medical trauma, natural disasters, refugee trauma, school violence, terrorism, and traumatic grief which may result in long-term psychological effects (National Child Traumatic Stress Network, n.d.).

Trauma mom: A casual term that mothers of children with early complex trauma and attachment issues use to refer to themselves.

Trauma parenting or Therapeutic parenting: A method of interaction used by parents with a child with attachment disorder to promote attachment (Attachment and Trauma Network, n.d.).

Traumatic grief: Process of grief which extends beyond typical grief reaction (National Child Traumatic Stress Network, n.d.).
Summary

This chapter provided an introduction to the study through discussion of the phenomenon of interest. Both the purpose and significance of the study were discussed and the research questions given. The researcher’s assumptions and biases were provided as well as a list of terms and definitions utilized in the study.
CHAPTER 2

REVIEW OF RELATED LITERATURE

The purpose of this study was to explore, through qualitative research, the experiences of adoptive mothers of children with early complex trauma and attachment issues. The necessity of such a study was supported by the review of related literature which demonstrated research in the area of early trauma and attachment parenting is limited overall, and no articles were found that examined the mother’s experience and how she is affected. When included, the voices of adoptive mothers of children with early trauma and attachment issues were most often implicit. In addition to a synthesis of current literature and research related to adoption and attachment, this chapter presents historical, experiential, and philosophical contexts for the study.

Theoretical underpinnings of early work in attachment theory and research provide historical context for this study and highlight underdeveloped areas that support the purpose of this study. Experiential context is presented through the researcher’s experience as an adoptive mother to children with early complex trauma and attachment issues. Discussion of Rogers’ science of unitary human beings provides philosophical context for the study and the conceptual framework developed by the researcher.
Context of the Study

Historical Context

In 1950, the World Health Organization (WHO) recognized a potential mental health concern in homeless children. This marked the first organization to recognize a possible relationship between attachment, trauma, and mental health. Recognizing similarities in Bowlby’s work in the previous decade, the WHO asked Bowlby to research the issue on their behalf (Bowlby, 1982).

Bowlby’s early work was prompted by his work in a home for troubled boys following graduation from Cambridge University (Cassidy, 1999). Bowlby’s interactions with the boys led to belief that disruption in a child’s relationship with the mother causes both immediate distress and long-term effects. Bowlby became interested in why this occurred because commonly accepted theories at the time did not seem to explain observations of distress despite someone else fulfilling the mother’s role. Social learning and psychoanalytic theorists believed the infant’s affinity toward the mother was related to meeting physical needs such as being fed. Although Bowlby’s experiences were foundational to the development of his attachment theory, the results were not published for more than a decade. Bowlby’s retrospective account “Forty-Four Juvenile Thieves: Their Characters and Home Life” was published in 1944 (Cassidy, 1999).

While working on the WHO report Bowlby (1982) met with experts in the fields of child care and child psychiatry and found there to be a significant consensus
regarding the underlying principles of childhood mental health and the ways in which mental health is to be protected. One of the essential principles identified by Bowlby (1950, as cited in Bowlby, 1982) was “the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment” (p. xi-xii). In the same report Bowlby described related actions necessary to protect the mental health of children separated from their families. At that time, Bowlby recognized that much was said about the types of deprivation which can adversely affect children, the types of resultant adverse effects, and how to prevent such effects. Bowlby (1982) further identified the knowledge gap as the processes by which the effects occur. This work informed care for vulnerable children, encouraged further research, and further contributed to Bowlby’s theory of attachment.

Early attachment research focused on personality development and observations of children before, during, and after a separation from their mother and without a consistent mother figure (Bowlby, 1982). Profound and intense responses were noted, but scholars disagreed on the causes, significance, and effects of such reactions. Bowlby and his colleagues, through experience and observation, concluded that loss of the maternal figure was the primary cause of the protest, despair, and detachment reactions in their children. Such behaviors were exhibited even when other conditions were favorable, thereby leading to the conclusion that the child’s desire for her mother’s presence and love are as significant as her desire for nourishment (Bowlby,
1982). This finding was in stark contrast to the aforementioned, and still widely held belief, that an infant’s attachment to the mother was primarily for/related to feeding (Kobak, 1999).

Initial evidence which supported Bowlby’s views was found in animal studies such as a 1935 study in which Lorenz discovered baby geese developed attachment to their parents despite not being fed by them (Cassidy, 1999). A later study found monkeys sought closeness with a likeness which was soft and therefore provided physical comfort, rather than a wire likeness that provided food (Harlow, 1958, as cited in Cassidy, 1999). Bowlby (1982) continued to draw upon studies from multiple disciplines in the development and support of his attachment theory.

Bowlby’s own research in the early to mid-1950s focused on the behaviors of children while separated from their mothers and when reunited. Bowlby felt his research complemented traditional data from adult subjects. Once reunited, Bowlby noted the child would respond with rejection or an extreme need to be with the mother, either of which could last for years. Bowlby also noted adult manifestations of such childhood experiences included a propensity for making unrealistic demands of others and having a disproportionate reaction when such demands are not met, and inability to form intimate relationships (Bowlby, 1973). The results of Bowlby’s research, as well as the rationale for the studies, were published in papers between 1952 and 1954 (Bowlby, 1982). Bowlby then wrote a series of papers published between 1958 and 1963 which became the basis of three volumes that addressed more in-depth Bowlby’s theoretical exploration of attachment, separation, and loss. The first
The third edition of the three volumes was published in 1969. The second edition of the first volume was published in 1982 following additional research.

Bowlby’s attachment theory is a seminal work, and has become widely used to understand attachment and sequelae. Bowlby’s work continues to be influential in current literature on attachment (Narad & Mason, 2004; Mikic & Terradas, 2014; Shi, 2014; Barth, Crea, John, Thoburn, & Quinton, 2005; Coakley & Berrick, 2008). Despite Bowlby’s groundbreaking work linking attachment and psychopathology, most studies continued to focus on normal infant development (Greenberg, 1999). Further, despite the known consequences of early attachment issues, a resultant disorder was not recognized until 1980 when Reactive Attachment Disorder (RAD) was first included in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) (Greenberg, 1999). Since that time, diagnostic criteria have continued to evolve. Unfortunately, the changes were not often a result of research (Zeanah, 1996). For nearly twenty years after first appearing in the *DSM-III*, attachment disorders remained largely ignored by researchers with the first study specifically addressing the validity of diagnostic criteria being published in 1998 (Boris, Zeanah, Larrieu, Scheeringa, & Heller, 1998). Given the relational dependence, which is unique to each individual, and the early and continued focus on aberrant behaviors for diagnosis, which can change based on to whom the behavior is directed, nomenclature related to and understanding of reactive attachment disorder continued to evolve as well (Greenberg, 1999).

Much progress has been made over the last decade regarding attachment disorders particularly in the area of behaviors exhibited by those with the disorders
(Zeanah & Gleason, 2015). Unfortunately, recognition of behaviors toward primary caregivers has not prompted research in this area. Although Bowlby identified the essential principle of mutual enjoyment and satisfaction in the relationship between mother and child nearly 70 years ago, the mother’s experience in this relationship, aside from contributing to the child’s enjoyment and satisfaction, is missing in attachment research history. This will be discussed in more detail in the synthesis of literature.

Experiential Context

Approximately ten years ago, my husband and I saw the pictures of our youngest daughters for the first time. After two years of waiting, we instantly knew they were ours and we would travel around the world to get them. As best we could, we prepared ourselves to parent these precious girls. Books about international adoption were ordered and read, blogs were scoured, and online videos of adoption journeys and joyous homecomings were watched, often in the wee hours of the morning when we were awake dreaming of the day our girls would be safely in our arms. We were fully aware that we would face challenges. We naively thought we knew the difficulties that awaited us and that we were more than capable of handling them. After all, we had a strong marriage, solid faith, and loving support system; we were successfully raising a daughter, and we had educated ourselves about adoption related issues.

Adoption related literature, including the book we were assigned to read by our home study agency, addressed attachment. We recognized the importance of developing attachment with our girls and sent a letter to all close friends and family outlining how they could help us promote attachment. A few lines of the volumes of
literature we read were devoted to attachment disorders. Attachment disorders, specifically reactive attachment disorder (RAD), were presented as a possible, but unlikely, occurrence in adopted children. Children affected were most likely institutionalized during infancy or were victims of neglect or abuse. To our knowledge these characteristics did not describe our girls, but even if they turned out to have RAD, the literature was clear that proper attachment to adoptive parents was the cure.

We met our daughters. They were every bit as beautiful, smart, and spunky as we had envisioned. We had no idea how strong and brave they were. They loved one another fiercely, but due to early complex trauma and its attachment effects, they found it very hard to love and trust their new family. The details of my children’s stories are theirs to share if and when they choose, but my story, and the stories of countless adoptive moms like me, are far too rarely heard. As we faced the diagnosis of RAD in our own family, I began seeking other moms in the same situation. Social media has made it much easier to find one another and I now have “trauma mom” friends all over the United States and Canada. We share stories, tears, resources, hope, and heartbreak. None of our stories includes a RAD child quickly and easily cured in the way that so much of the adoption literature nine years ago claimed, and much still does.

This study is a result of years of seeing, hearing, and sharing the experiences of mothering children with early trauma and attachment issues. I have seen and experienced the effects on the mothers’ physical, emotional, intellectual, and spiritual energies and patterning. Unfortunately, the realities of our lives parenting a child with early childhood trauma and attachment issues are not often reflected in literature. My
sleepless nights are now spent looking for therapeutic parenting resources, how to handle behavior, trying to understand the specialized needs of my children, and reaching out to other parents. As a nurse, nurse practitioner, and now nurse researcher, I have looked to my profession’s literature and research to help inform my journey as a mother of children with early trauma and attachment issues and have found it to be significantly lacking. This study seeks to contribute to nursing’s body of knowledge as well as promote understanding of mothers’ unique experiences when parenting a child with early complex trauma and attachment issues.

Philosophical Context

While attachment theory is important in understanding the background and need for this study, years of research related to attachment has not led to theory inclusive of adoptive mothers’ experiences in the process. Further, the relational aspects as well as the uniqueness of individual attachment experiences, which has proved challenging for those making advancements in other areas of attachment research, lends itself to a more fluid philosophical approach. The philosophical guide for this study is Rogers’ science of unitary human beings.

While Bowlby was working on attachment theory, Rogers was working on what would become the science of unitary human beings. Both were experiencing similar scientific advancements and human struggles, both influenced by other disciplines and looking at phenomena of which there was no explanation. Like Bowlby’s theory, Rogers’ theory evolved over several decades and multiple publications.
Malinski’s (1994) excerpts of interviews with Rogers, her family, and friends reflects a fun loving, hardworking, independent, and loyal woman. Her educational background reveals a lifelong learner, intrinsic drive, enthusiasm for higher education, and interest in higher level math and science. Rogers’ experiential background reveals concern with access to care and wellness promotion, creativity, innovativeness, and passion for improving nursing education and science. In a sociocultural context, Rogers’ work evolved during a time of great technological advancement. Rogers (1992) was keenly aware of the theoretical changes and advancements within science. She also saw great possibilities for the advancement of nursing science with the dawn of space travel and seemed to be inspired by the once seemingly impossible idea of space travel becoming possible. Rogers also lived, studied, and worked in an era in which she challenged gender roles. Rogers was the only female in her college algebra class and when she began her quest to increase the rigor of nursing school, females who were admitted had only a fourth grade understanding of basic math (Malinski, 1994). The science of unitary human beings reflected Rogers’ values regarding access to care, promotion of wellness, human betterment and caring interactions, as well as her passion for rigor in nursing education, growth of a nursing specific body of knowledge, and a worldview beyond current understanding.

Rogers created a theory which allowed and continues to allow nurse researchers to challenge current understanding in the pursuit of expanding nursing science while maintaining the foundational art of nursing. Rogers viewed nursing as both a science and an art. The art of nursing, Rogers (1992) stated “is the creative use of the science of
nursing for human betterment” (p. 28). According to Rogers (1992), there may be multiple abstract systems or paradigms within a specific science but the “phenomena of concern” is unchanged (p. 28). These phenomena, which are the impetus for expanding nursing knowledge, are “people and their worlds in a pandimensional universe” (Rogers, 1992, p. 29). This study seeks to expand nursing science through better understanding of the experiences of adoptive mothers of children with early complex trauma and attachment issues. Such understanding is essential to inform the art of nursing and promote betterment for the same population and their families.

Rogers’ professional nursing practice began in rural Michigan where she worked as a public health nurse (Malinski, 1994). Rogers went on to earn multiple advanced degrees including the Master of Public Health and Doctor of Science degrees from Johns Hopkins University in Baltimore, Maryland. Rogers was an early proponent of the differentiation of nursing and medicine, and served as a catalyst in increasing academic rigor in nursing programs and developing nursing science (Malinski, 1994). Rogers articulated the purpose of nursing as assisting persons toward optimum health and began to lay the theoretical groundwork for the science of unitary human beings. The publication of *Reveille in Nursing* followed in 1964. Rogers expounded on some of the ideas she introduced in *Educational Revolution in Nursing* (1961) and predicted a shift in focus from what nurses do to what they know (Malinski, 1994).

Roger’s (1970) work *Theoretical Basis of Nursing* marked the introduction of the Rogerian framework which stood in stark contrast to the medical model previously used by nursing. Rogers (1970) pioneered the push toward the development of nursing-
specific scientific knowledge. Her assumptions then, which contributed to the structure of what would become the science of unitary human beings, were evident in her discussions of the principles of reciprocity, synchrony, helicy, resonancy, and homeodynamics (Rogers, 1990). In 1980, Rogers authored a chapter in Riehl and Roy’s Conceptual Models for Nursing Practice titled “Nursing: A Science of Unitary Man.” In 1986, “Science of Unitary Human Beings” was published as a chapter in Malinski’s book Explorations on Martha Rogers’ Science of Unitary Human Beings (Malinski, 1994). Then, “Nursing: Science of Unitary, Irreducible, Human Beings: Update 1990” was published in Visions of Rogers’ Science-Based Nursing (1990). Rogers’ final published update to the science of unitary human beings was in 1992 as “Nursing Science and the Space Age.” This publication was two years prior to her death and provides the theoretical framework for this study.

Meleis (2012) describes the structure of a theory by identifying the concepts on which it is based. The concepts may be primitive or derived and are described in terms of their clarity, definition, properties, and boundaries (Meleis, 2012). Rogers (1992) uses the term “postulates” in reference to the concepts central to the science of unitary human beings which are “energy fields, openness, pattern, and pandimensionality” (p. 29). Rogers (1992) clearly defined these concepts in table format and indicated the most recent revision was completed in 1991. Energy field is defined by Rogers (1992) as “a unifying concept,” “the fundamental unit of the living and the non-living,” signifying “the dynamic nature of the field,” “in continuous motion,” and “infinite” (p. 29). Rogers (1992) defined pattern as “the distinguishing characteristic of an energy field perceived
as a single wave” (p. 29). Pandimensional, which was called four-dimensional and multidimensional in previous versions of the science of unitary human beings, was defined by Rogers in 1992 as “a non-linear domain without spatial or temporal attributes” (p. 29). Rogers (1992) defined unitary human being, or human field, as “an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts” (p. 29). Environment, or environmental field, was defined by Rogers (1992) as “an irreducible, pandimensional energy field identified by pattern and integral with the human field” (p. 29). She recognized the importance of clarity and definition of concepts within the language of her work, stating “terms specific to the system are defined for clarity, precision, and communication so that rigorous research can be pursued and replicated” (p. 29).

While only one source (Schodt, 1989) could be identified linking Rogers theory development and attachment work, in 1983, Martha Rogers identified families as an appropriate focus for application of her theory (Malinski, 1986). Rogers indicated that the term family could extend beyond a traditional definition and understanding of the word to include a variety of relationships. In this way, the family energy field would become the focus with manifestations observed such as sleep-wake and activity patterns (Malinski, 1986). Although this study is not looking at family energy fields independently, Rogers certainly recognized the energy fields of family members interact and affect the patterning of one another.
Rogers’ science of unitary human beings has been used as the theoretical framework for both qualitative and quantitative research. Schodt (1989), in the only study found on parental-child attachment which utilized Rogers’ theory, posited that fathers could interact and attach to their unborn child via their prospective energy fields. Schodt hypothesized this interaction could be responsible for couvade experiences which are pregnancy-like symptoms experienced by a prospective father during his partner’s pregnancy. Although the study did not find a significant correlation between fathers’ attachment to their unborn baby and the experience of couvade, it reinforces the idea that Rogers’ theory can be used to examine the interactions between parent and child. Rogers’ theory has also been used as the theoretical framework for energy healing therapies such as therapeutic touch (Aghabati, Mohammadi, & Esmaiel, 2008) and reiki (Catlin & Taylor-Ford, 2011; Vitale & O’Connor, 2006). In addition to research on energy fields, Rogers’ science of unitary human beings has also been used to guide research regarding perception of time (Rawnsley, 1986), perception of self and hope (Salerno, 2002), and the relation of creativity, actualization, and empathy (Alligood, 1986).

These studies demonstrate the use of Rogers’ science of unitary human beings to guide the study of experiences which could be unique to the individual participant and difficult to quantify or describe without the idea of patterning. Some examples of this within the area of proposed study are seen in the case study of a four year-old child with reactive attachment disorder (RAD) (Shi, 2014). Shi (2014) described the child as having “intense frustrating energy,” “negative energy” (p. 7), and “internal chaos” (p. 10).
Though previously unexplored, Rogers’ science of unitary human beings will allow study of how the energy fields of mothers of children with early complex trauma and attachment issues interact with their adopted children and how the child’s patterning affects the mother’s overall patterning and in the areas of physical, emotional, intellectual, and spiritual patterning.

Synthesis of Literature

Extensive literature searches were conducted on the CINAHL, MEDLINE, OVID, and PsycARTICLES databases. Searches included both individual and combinations of the terms attachment, adoption, mother, trauma, early trauma, parent, attachment theory, attachment parenting and childhood trauma. Articles were limited to English language, but no further search limitations were instituted due to the limited research available. The results were then reviewed for appropriateness. Articles were excluded if they addressed biological mother and child attachment, childhood trauma only, and adoption without attachment or parental connection. In total 21 sources including original research, literature reviews, and informational articles were chosen. Only 15 articles were original research in the area of attachment which included adoptive parents. This literature review yielded consistent results with Zeanah and Gleason’s (2015) literature review findings that research in the last decade has given us more insight into attachment disorders in early childhood, but many unanswered questions remain.
Mechanisms of Attachment

The largest single topic of research within this literature review was mechanisms of attachment, specifically how parental support or parental attachment influences child attachment. This research consisted of six quantitative studies (Barone & Lionetti, 2011; Beijersbergen, Juffer, Bakermans-Kranenburg, & IJzendoorn, 2012; Pace & Zavattini, 2010; Pace, Zavattini, & D’Alessio, 2012; Verissimo & Salvaterra, 2006; Voort et al., 2014). Participants included 125 early adopted adolescents (Beijersbergen, et al., 2012), 106 mother-child dyads (Verissimo & Salvaterra, 2006, 86 adopted young adults (Voort et al., 2014), 20 adoptive dyads and 12 genetically related dyads (Pace & Zavattini, 2010), 48 late adopted children and their mothers (Pace, Zavattini, & D’Alessio, 2012), and 20 adopted children and their parents (Barone & Lionetti, 2011). Participants were recruited from adoption related organizations. Three of the studies were longitudinal, measuring attachment over time (Beijersbergen, et al., 2012; Pace & Zavattini, 2010; Voort et al., 2014). Data were collected through participant interviews (with consistent use of the Adult Attachment Interview tool for parents), observation, and a variety of tools to assess child attachment. Although interviews and observation were used, data were transferred to quantitative measures.

Study findings included positive correlation between attachment in children and maternal sensitive support (Beijersbergen, et al., 2012) and secure attachment in parent(s) (Barone & Lionetti, 2011; Pace & Zavattini, 2010; Pace et al., 2012; Verissimo & Salvaterra, 2006). Later adopted children may have more difficulty moving toward secure attachment, but those who do are more likely to have secure adoptive mothers
The mothers’ attachment security (or insecurity) would be a result of their own attachment history carried through to adulthood. Secure attachment in children was significantly associated with performance on an emotional comprehension task (Barone & Lionetti, 2011). Neither adoptees’ attachment nor maternal sensitivity was correlated with young adult adoptees’ diurnal cortisol curve (Voort et al., 2014). While the researchers recognized, and the findings supported, the important role of the adoptive mother in the attachment process, none of the studies considered the mothers’ experiences.

Adoptive Parent Experiences and Perceptions

Although varied in objectives, adoptive parent experiences and perceptions were investigated in seven studies (Follan & McNamara, 2013; Rykkje, 2007; Smit, 2010; Taft, Ramsay, & Schlein, 2015; Timm, Mooradian, & Hock, 2011; Wimmer, Vonk, & Reeves, 2009; Zosky, Howard, Smith, Howard, & Shelvin, 2005). Wimmer et al. (2010) and Zosky et al. (2005) explored perceptions of interventions and their impacts on the family, specifically reactive attachment disorder (RAD) therapy and adoption preservation services utilizing qualitative designs. Sixteen adoptive mothers were interviewed regarding their perceptions of attachment therapy and its impact on the functioning of their family (Wimmer et al., 2010). Six themes emerged from the data including therapy as “consistently supportive,” “emotionally painful,” “physically safe,” and “preserved the family structure,” adoptions being “unquestionably permanent,” and living with a child with reactive attachment disorder (RAD) as “continuously stressful” (Wimmer et al., 2010, p.124). Zosky et al. (2005) examined the qualitative section of 835 returned
surveys addressing the experience of post-adoption preservation services. The number of responses ranged from 8-21 with an overwhelming positive response to the services but also feeling the services needed to be provided longer than one year (Zosky, et al., 2005).

Timm et al. (2011) utilized a mixed methods design to investigate the incidence of previously identified core issues in adoption and their experience by adoptive mothers and fathers individually and in marriage. As part of a more extensive federally funded project to design and implement a marriage enrichment program for parents who adopted from the child welfare system, Timm et al. (2011) found more than half of the sample of 104 adoptive mothers reported experiencing issues of loss and grief, unmatched expectations, bonding and attachment, and mastery and control both individually and as a couple.

Follan and McNamara (2013) and Taft et al. (2015) conducted qualitative studies exploring the experiences of adoptive parents of children diagnosed with reactive attachment disorder (RAD). Interviews of eight adoptive parents including two married couples found four themes related to caring for a child with RAD, being profoundly unprepared, insecurity, having unexpected emotions, and commitment (Follan & McNamara, 2013). Two themes emerged from interviews conducted with 10 parents of children with Reactive Attachment Disorder (RAD), inappropriate and unpredictable behaviors and threatening behaviors (Taft et al., 2015).

Rykkje (2007) and Smit’s (2010) qualitative studies addressed health care experiences and needs of international adoptive families. Utilizing a sample of four
adoptive mothers, nine couples of adoptive mothers and fathers, three public health nurses, and four adult adoptees, Rykkje (2007) found a “substantial demand” for increased knowledge and understanding by nurses and other welfare professions regarding the specialized needs of adoptive families including transracial adoption, grief, attachment challenges, and biological heritage (p. 507). Smit (2010) found four themes emerged from data from 107 adoptive parents of internationally adopted children. The themes were “coming home: like a lobster thrown into a boiling pot,” “vigilance: is my child healthy today, will my child be healthy tomorrow,” “unique healthcare needs of international adoption families: we are different,” “importance of support by health care providers: do they know or care” (Smit, 2010, p. 254). Purposive sampling was used by each of the investigators. Adoptive parents were included in each of the seven studies though the participants were not necessarily restricted to adoptive parents.

Data from these studies reflected both challenges and strengths of adoptive families. Researchers expressed the lack of knowledge and understanding regarding adoptive families’ journeys as being both the catalyst for their studies and the reason for additional challenges for adoptive families. Due to sample sizes and methodology, the results of these studies cannot be generalized but together demonstrate adoptive families have unique needs at home, in school, and within the healthcare system. Although attachment was not the focus of the studies, and was a keyword in only two studies (Follan & McNamara, 2013; Wimmer et al., 2009), attachment was discussed by every author. Together, these studies demonstrate the important link between
attachment and the experience of adoptive parents, the need for continued research in this area, and the uniqueness of the adoptive family journey.

Post-adoptions Depression in Adoptive Mothers

Two final studies examined post-adoption depression in adoptive mothers (Foli et al., 2012; Gair, 1999). Foli et al. (2012) examined rates of depression in adoptive mothers due to the documented negative effects of mothers’ depression on their biological children. Gair (1999) challenged earlier held beliefs that depression after becoming a mother through pregnancy was largely related to hormonal imbalances and recognized often overlooked difficulties of becoming a mother through adoption. Sample sizes were 19 and 233, respectively (Foli et al., 2012; Gair, 1999). Both studies identified recently adoptive mothers as being vulnerable to depression. Tools used in both studies were designed for postpartum biological mothers which could skew the results and presents an area for future research and development. The studies also recognized the need for greater knowledge and understanding of the experiences of adoptive mothers (Foli et al., 2012; Gair, 1999).

International and Nursing Recognition of Significance of Attachment in Adopted Children

The diversity of countries in which the studies took place speaks to the international recognition of significance of attachment in adopted children. For the studies addressing mechanisms of attachment, three studies were conducted in Italy (Barone & Lionetti, 2011; Pace & Zavattini, 2010; Pace et al., 2012), two in the Netherlands (Beijersbergen, et al., 2012; Voort et al., 2014) and one in Portugal
(Verissimo & Salvaterra, 2006). Unfortunately, neither the United States nor nursing researchers were represented in this group of studies. For adoptive parent experiences and perceptions, one study took place in Ireland (Follan & McNamara, 2013), another in Norway (Rykkje, 2007) and the remainder were conducted in the United States. Nurse researchers (Follan & McNamara, 2013; Rykkje, 2007; Smit, 2010) are represented in the adoptive parent experiences and perceptions group of studies as well as social workers (Wimmer et al., 2009; Timm et al., 2011), educators (Taft et al., 2015), and adoption (Zosky et al., 2005) researchers. For the studies addressing postadoption depression, one study was nursing research conducted in the United States (Foli, South, & Lim, 2012) while the other was social work research conducted in Australia (Gair, 1999).

Some of the aforementioned researchers explicitly stated their areas of study have been “largely unexplored” (Taft et al., 2015, p. 237), “noticeably missing” (Timm et al., 2011, p. 269), “almost nonexistent” (Rykkje, 2007, p. 507), or never previously studied (Follan & McNamara, 2013; Wimmer et al., 2009). The researchers who conducted all fifteen of the studies discussed above agreed too little research in this area has been done and more research is needed to support their findings. Larger sample sizes, more rigorous participant selection, and consistency in measurement tools are needed in replicating the studies and to strengthen and support the data. These studies demonstrate the recognition by researchers of the importance of attachment and the continuation of Bowlby’s work in identifying the mechanisms of attachment.
Two literature reviews were included in the literature obtained in this search. The most recent was a research review on clinical presentation, causes, correlates, and treatment of attachment disorders in early childhood (Zeanah & Gleason, 2014). The authors provided a brief historical account of attachment theory and study as well as the diagnoses of reactive attachment disorder (RAD) and Disinhibited Social Engagement Disorder (DSED) which is “aberrant social behavior” focused more on unfamiliar adults than caregivers (Zeanah & Gleason, 2014, p. 209). The authors link both diagnoses to attachment issues and conclude that RAD is much more responsive to “enhanced caregiving” than DSED (Zeanah & Gleason, 2014, p. 218). While the authors discussed the importance of maternal involvement in developing and treating attachment disorders, no discussion was made or literature cited which explored mothers’ experiences.

In a statement referring to only three studies of adopted children from institutions published 10-40 years prior to the article, Zeanah and Gleason (2014) stated “Implicit in these studies is the notion that the enhanced caregiving following adoption will ameliorate signs of attachment disorders” (p. 217). The authors then postulate that given inadequate care contributes to the development of attachment disorders, it follows that foster care or adoption would eliminate or greatly reduce signs of the disorders. However, Zeanah and Gleason (2014) identified more research, particularly longitudinal, could be helpful. In an area of study in which researchers have reported a need for further research, this assumption of implicit statements to such a significant
effect of caregiving is premature. The authors gave six areas of potential future research including child vulnerabilities, neurobiology, related caregiving insufficiencies, and long-term difficulties/sequelae/effects for children with attachment disorders (Zeanah & Gleason, 2014) which also seems to be contradictory to the previous quote.

The second literature review addressed the prevention of adoption disruption which refers to dissolution of an adoption or an adoptive placement (Coakley & Berrick, 2008). The authors offered a brief historical account of adoption policies and reviewed the literature in an attempt to seek ways to improve adoption outcomes and recommend areas needing additional research. The authors reviewed research regarding characteristics of the adoptee, adoptive parents, and adoption agency that may be associated with an increased risk of disruption. The discussion of pertinent family characteristics included mothers, but the variables were limited to marital status, education level, parenting experience, and relationship with the child prior to adoption. Attachment challenges were mentioned as a characteristic of the child which correlates to adoption disruption. In addition to policy changes and recommendations for case workers, the authors recommended further study on the characteristics of families who successfully adopt as well as the role of adoption in affecting children’s emotional and social challenges (Coakley & Berrick, 2008). Experiences of the mother were not recommended but could offer valuable insight into adoption disruption as well.

Evidence Based Approaches for Care

In addition to the previously mentioned research findings, Gribble (2007) and Narad and Mason (2004) developed evidence-based approaches related to caring for a
post institutionalized child and international adoption, respectively. Gribble’s (2007) evidence-based model for caring for a post institutionalized child is based upon replicating newborn care which research has shown to be physiologically expected by infants and important to development. In addition to the mother’s role in caring for the child, Gribble (2007) discussed the experiences of parents as rationale for developing the model, specifically, parental difficulty in caring for and concern for the newly adopted child. Additionally, parents may be offered inappropriate advice by friends or healthcare professionals with poor understanding of the needs of post-institutionalized children (Gribble, 2007). Narad and Mason (2004) recognized a need for education regarding adoptive families using an evidence-based approach to address five myths and realities of international adoptions including potential physical health needs, developmental delays, and transition into an adoptive family. The authors thoroughly and succinctly cover common difficulties faced by adoptive parents and adoptees. Although the intended audience is pediatric nurses, this article could be useful to anyone involved in the care of an adoptee or support of adoptive parents.

The literature discussed thus far has provided an important view of topics of current research and literature in the area of early complex trauma and attachment issues. The significant findings are varied, the objectives differ, but there is a common refrain calling for additional research. Another commonality, which could be easily overlooked as it does not often appear in bold or as more than part of an explanation of attachment or in the description of caregiving, is the adoptive mother. As an adoptive mother, this author recognizes her voice and experiences in the data but not as much in
the discussion of the data. The importance of maternal sensitive support (Beijersbergen, et al., 2012) and a secure-autonomous adoptive mother (Pace et al., 2012) is documented as well as the challenges and complexity of treating attachment disorders (Barth et al., 2005; Narad & Mason, 2004).

In these studies, this adoptive mother recognizes the absence of the mothers’ perspective when she is given tasks without attention to how they will affect her and when her point of view is overlooked in a list of rejection behaviors attributed to her child. Her voice is silenced when there is no mention of her in research discussing the incidence and weight of secondary traumatic stress in mental health professionals caring for children with traumatic experiences (Nelson-Gardell & Harris, 2003; Shannonhouse, Barden, Jones, Gonzales, & Murphy, 2016). Researchers have documented, and Bowlby’s work has shown, what happens when infants and small children experience rejection, but they have not asked how this affects the mother over the years.

The adoptive mother’s voice is most clearly heard in research by Ahmann and Dokken (2013), Follan and McNamara (2013), Shi (2014), and Taft et al. (2015). Shi (2014) presented a case study of a 4-year-old diagnosed with RAD and adopted by his foster parents. The purpose of the case study was to highlight the therapeutic interventions used which produced a positive clinical outcome. Although not the focus of the study, the author includes challenges faced by the foster/adoptive mother. The challenges included the experiences of divorce (which was implied to be related to disagreements about the child), warning from the therapist that the child may never
heal, statement from the therapist that she did not want to continue to work with the child if he showed no sign of reconnection, lies from the child of being severely beaten by the mother, disturbing behavior by the child including “without any warning he started fighting his mother and again screaming and running like a wild animal, refusing to be hugged or held” (Shi, 2014, p. 9). The few areas of recognition of the mothers’ perception noted she was “understandably upset” and asked herself if the child’s healing was “wishful thinking?” (Shi, 2014, p. 7). The author referred to the nine month process of therapy and therapeutic parenting as “magical” (p. 12) and the mother as “courageous, diligent, and persistent” (p. 11). Would the mother’s account include the word magical? Noticeably absent is the perspective from the mother as to the source of her courage, diligence, and persistence.

Ahmann, who is the mother of a child with mental health challenges, interviewed four mothers about “making meaning” when parenting a child with mental illness (Ahmann & Dokken, 2013, p. 202). One of the mothers interviewed is an adoptive mother of a child with an attachment disorder. She reported feelings of isolation and being misunderstood and judged by others. She has been able to reach beyond her struggles and find meaning through developing a therapeutic parenting support group. Taft et al. (2015) proposed the isolation and possible feelings of incompetence experienced by parents of children with RAD may prevent the parents from sharing their experiences which could complicate diagnosis or treatment for the child. Through research which shares these experiences, other caretakers of children with attachment issues may be empowered. The study highlighted behaviors exhibited
in the home and at school by children with RAD under the headings of inappropriate and unpredictable behaviors and threatening behaviors. The authors also clearly stated one characteristic of behavior that often leads to misunderstanding and judgment of the parents is different behaviors with different people. Follan and McNamara (2013) found four elements fundamental to caring for a child with RAD including being unprepared, feeling insecure, having many unexpected emotions, and commitment which they expressed were relevant to clinical practice for use in the pre-adoption phase. While each of these articles is a valuable contribution toward understanding the mothers’ voices, only Ahmann and Dokken’s (2013) article reached beyond the mother’s account to how it, or perhaps she, changed her patterning.

Inferences for Current Study

The literature review has demonstrated research in the area of parenting a child with early complex trauma and attachment issues is limited. When included, the voices of adoptive mothers of children with early complex trauma and attachment issues are most often implicit. No articles were found that examined the mother’s experience and how she is affected physically, emotionally, intellectually, and spiritually. Only one article moved beyond experience to pattern change. All of the research, and the limited number of evidence-based articles available on this topic, indicated further research is needed in this area. To promote betterment for adoptive mothers of children with early complex trauma and attachment issues, nurses need to listen to the experiences of mothers and the impacts of these experiences on them. This study will explore the lived
experience of mothers of children with early complex trauma and attachment issues
and the impact of those experiences on their physical, emotional, intellectual, and
spiritual patterning.

Summary

This chapter provided a review of related literature which supported this study’s
purpose to explore, through qualitative research, the experiences of adoptive mothers
of children with early complex trauma and attachment issues. A discussion of the
paucity of related research and the topics of that research was also included. In
addition to a synthesis of current literature and research related to adoption and
attachment, this chapter presented historical, experiential, and philosophical contexts
for the study. Early attachment theory and research provided historical context for this
study. The researcher’s experience as an adoptive mother to children with early
complex trauma and attachment issues provided experiential context for this study.
Rogers’ science of unitary human beings provided philosophical context for the study
and the conceptual framework developed by the researcher.
CHAPTER 3

METHODOLOGY

This chapter will explain the research method and design chosen for this study, and the rationale for the research approach. Descriptions of the setting, participants, process of data collection, and protection of human subjects are provided. Discussion of methods of data processing, data analysis, and trustworthiness and rigor are included as well.

Research Method and Design

Rogers (1992) was an advocate for the development of new nursing knowledge and proposed that research approaches within both qualitative and quantitative methods were appropriate for studies utilizing the science of unitary human beings. The research method best suited to answer the question “What is the lived experience of adoptive mothers with early complex trauma and attachment issues?” was qualitative research, specifically descriptive phenomenology. The purpose of phenomenology is to describe specific phenomena as lived experience (Streubert & Carpenter, 2011). Human experiences of phenomena are brought to language through phenomenological inquiry, and guided by philosophical propositions instead of theory (Munhall, 2012).

Husserl (1859-1938) is credited with developing the philosophy of phenomenology as an alternative to positivism, which he felt lacked context and human
reality (Munhall, 2012). Formulated in the early 19th century, the positivist approach was widely utilized by the natural and social sciences and focused on the scientific method, quantitative data, and theoretical support (Kincaid, 2005). Husserl attempted to revitalize philosophy through recognition of the value of human experience (Munhall, 2012). Husserl believed empirical knowledge was superseded by knowledge from essence and intuition. He valued individual understanding and perception, believing each individual is capable of intuition, doubt, imagination, preferences, and reflection (Moustakas, 1994). Individual differences result in unique interpretations and perceptions. Husserl’s philosophy focused on one’s conscious experience of life as it is seen, heard, remembered, assessed, and felt (Polit & Beck, 2012). This unique, individual experience is at the center of phenomenology (Munhall, 2012).

While other sciences and disciplines have defined and concerned themselves with a variety of phenomena, the philosophy of phenomenology is often concerned with similar phenomena but from a different vantage point (Husserl, 1958). Phenomenology is the study of phenomena as they are experienced through one’s consciousness (Giorgi, 2009). According to Husserl, knowledge begins with consciousness and cannot be achieved without consciousness. A phenomenon is anything “present to consciousness” (Giorgi, 2009, p. 10). Phenomenology is concerned with both the presence of the phenomenon and the experience of the phenomenon by the conscious.

Husserl used the term “lifeworld” to describe the commonplace or ordinary world into which we are born and dwell (Giorgi, 2009, p. 10). All other unique worlds come from the lifeworld. To understand unique worlds, one must understand the
lifeworld (Giorgi, 2009). The lifeworld for this study is mothering attachment. While multiple other experiences and unique worlds may emerge from the lifeworld of ordinary attachment, this study is concerned with the unique world of early complex trauma and attachment issues between child and mother. In this study it is the child with early complex trauma and attachment issues to the mother and the experience of this in the mother’s consciousness.

Husserl, influenced by Descartes’ epoché of doubt, or the suspension of judgment, advanced the concept of phenomenological epoché (Moustakas, 1994). “Epoche requires the elimination of suppositions and the raising of knowledge above every possible doubt” (Moustakas, 1994, p. 26). Husserl’s phenomenological epoché became one of the core features of his developing method of descriptive phenomenological research. In practice, phenomenological epoché was developed as method through the practice of bracketing, which describes the act of suspending judgment by the researcher. Thus, the phenomenologist conveys descriptions from a first-person point of view without preconceived judgment.

Franz Brentano was also an early influence on Husserl. Brentano’s view of intentionality was foundational to Husserl’s early development of phenomenology (Follesdal, 2005). Intentionality is the mind’s ability to direct itself on something, an act of consciousness (Follesdal, 2005). Unlike Brentano’s intentionality which required an object for every act of consciousness, Husserl’s intentionality recognized consciousness of an object and “as if of” an object (Follesdal, 2005, p. 418). There can be conscious experience of a physically present object and of objects on which the mind is focused.
but are not physical objects. Thus an object can be a material article as well as an event, person, action, or process (Follesdal, 2005). Husserl’s intentionality also recognizes an interconnectedness of different aspects of consciousness that allow for unique experiences of one object (Follesdal, 2005). Central to this idea are the concepts of noema and noesis (Husserl, 1931). The noema is the phenomenon and the noesis is the fundamental meaning (Moustakas, 1994). In other words, the noema is the “perceived as such” while the noesis is “perfect self-evidence” (Moustakas, 1994, p. 31). Intentionality allows for the interaction between the noema and the noesis. Noema can be further broken down into one’s experiences of different aspects of a single object and the type of experience such as remembering or thinking about the object (Follesdal, 2005).

Husserl’s journey through the development of phenomenological philosophy is evident in multiple publications and more than 40,000 unpublished pages (Giorgi, 2009). These manuscripts are likely indicative of Husserl’s wrestling with and continued evolution of his own philosophy and provide room for numerous interpretations of his work and expansions to phenomenological methods of research (Giorgi, 1985). Within the phenomenological method of research, there are a variety of procedural interpretations which guide data gathering, processing, and analysis (Streubert & Carpenter, 2011). The appropriate approach is one which provides the most rigor and accuracy for the phenomena being studied. The researcher must choose a suitable
approach based upon an understanding of its philosophical foundations and ability to best elicit the data being sought by the study. Giorgi’s (1985, 2009) interpretation of phenomenology will guide this study.

Giorgi, a 20th century psychologist who studied the philosophy of phenomenology, especially the work of Husserl and Merleau-Ponty, expanded upon Husserl’s work to demonstrate rigor and provide a method of application of phenomenology to psychological phenomena. Giorgi’s (1985) understanding of phenomenological philosophy was further influenced by Merleau-Ponty, an existential phenomenologist who believed “consciousness is life”; one cannot exist without consciousness and vice versa (Munhall, 2012, p. 127). Thus, knowing of the world is possible only through being in the world and through consciousness comes knowledge (Munhall, 2012).

Giorgi (1985) attributes four characteristics to phenomenology. First, phenomenology is descriptive. This description should precede and be free from any explanation or analysis. Phenomenological reduction, the second characteristic of phenomenology, is the systematic procedure of inquiring deeply into the participant’s consciousness, recognizing “the difference between the way in which a situation is and the way it is experienced” (Giorgi, 1985, p. 49). “In other words, while it may be the subject’s role to believe in what he experiences, it is the psychologist’s role to understand the subject, and that requires the reduction” (Giorgi, 1985, p. 50). Thirdly is the examination for essences. An essence is reflective of the consistent aspects of a phenomenon gleaned during the exploration of a description. In identifying essences,
the phenomenologist identifies “what meanings must necessarily belong to the phenomenon for it to be a phenomenon of a certain type” (Giorgi, 1985, p. 43).

Intentionality is the last characteristic. Like Husserl, Merleau-Ponty recognized intentionality as an important aspect of phenomenology. Merleau-Ponty’s intentionality was the recognition that “consciousness is always directed or oriented toward something that is not consciousness itself” (Giorgi, 1985, p. 43).

Giorgi’s (2009) procedural steps for Husserl’s phenomenological inquiry includes three steps. First, the philosopher must take on a phenomenological attitude which results in objects being viewed from the vantage point of how they are experienced in consciousness regardless of the limitations one’s natural attitude might impose. Next is the search for the essence of the phenomenon. In this step, the researcher focuses on an example of the object to determine what makes the object an example of a particular phenomenon and how best to convey this information. Thirdly is description of the essence. This description distinguishes Husserlian phenomenology from other philosophical interpretations of phenomenology. Description utilizes language to convey “the intentional objects of experience” (Giorgi, 2009, p. 89). In contrast, interpretative phenomenology, advanced by Heidegger, uses an additional component such as a theory, assumption, or hypothesis to convey the object of experience (Giorgi, 2009).

Unique to Husserlian phenomenology is the process of bracketing. Giorgi (2009) explained bracketing as a shift in attitude during reduction to promote rigor. Researchers are to bracket their own past related experiences as to not “diminish the
present experience by interpreting it as being identical to the past ones” (Giorgi, 2009, p. 92). Bracketing does not require researchers to forget their own knowledge of the phenomenon, but rather disengage from past experience to be fully present and attentive to the present experience (Giorgi, 2009).

Rationale for Research Approach

Nursing, according to Rogers (1999), was similar to other sciences in that it was focused on a central phenomenon. For nursing, the phenomenon is people and their environments. Rogers (1999) identified a necessity “to study people in ways that would enhance their humanness” (p. 257). Likewise, Streubert and Carpenter (2011) felt phenomenology to be appropriate for nursing research due to professional nursing practice being so closely involved with the life experiences of those being cared for. The philosophy of phenomenology can guide one’s interactions, understanding of self and others, and nursing practice and research (Munhall, 2012). It follows that phenomenology as a research method could be a natural extension for a nurse researcher whose professional practice is reflective of phenomenological philosophy.

Although he wrote specifically about application of phenomenology to psychology, Giorgi (2009) believed that the method could be utilized by any science engaged with human beings. Nursing was listed specifically by Giorgi as a discipline which could utilize phenomenology. Foundational to nursing practice is the idea of holistic care in which one’s body, mind, and spirit are cared for together (Streubert & Carpenter, 2011). Though Rogers (1992) draws a distinction between her philosophy and usage of the term holistic, the idea of humans as irreducible wholes is an
assumption of Rogers’ science of unitary human beings. It follows that phenomenology is appropriate for nursing research and studies utilizing Rogers’ philosophy because phenomenology studies the human experience as a whole (Streubert & Carpenter, 2011). Qualitative research recognizes the individual’s engagement in the world and interactions with others but does not seek to reduce individuals or experiences into unconnected parts for investigation (Munhall, 2012).

Specific to the phenomenon of interest for this study is phenomenology’s reflection of “the ‘realness’ of people’s lives” (Munhall, 2012, p. 17). As a researcher who has experienced the phenomenon being researched, it is notable current research in the area is lacking this ‘realness’. This is a sentiment also expressed by others experiencing the same phenomenon. Munhall (2012) states “Often objectivity is a sterile state, devoid of humanistic characteristics, and it ignores the situated context where the phenomenon is located” (p. 115). This study seeks to capture the reality and humanity of the phenomenon of interest in this study, the lived experience of adoptive mothers of children with early complex trauma and attachment issues. Nursing science lacks a description of and understanding about essences of this phenomenon.

For 70 years much of the information gleaned about attachment has been from the “normal” parenting experience, the attached or unattached child, and observances of interactions. The mothers’ stories, specifically those of unattached children, have remained largely untold. Giorgi (1985) recognized the limitations of much research during this time overlooking or distorting aspects of phenomena as experienced because natural science research was focused on phenomena of nature rather than
experienced phenomena. Phenomenological study findings can inform policy or practice changes, raise awareness, and improve care and compassion for those experiencing phenomena previously unknown or misunderstood (Munhall, 2012). This writer’s current understanding of the phenomenon of interest indicates the need for policy and practice changes, better awareness, and better care and compassion for adoptive mothers of children with early complex trauma and attachment issues.

Sample and Setting

Settings included participants across the United States and Canada. Data were collected at a time agreed upon by the researcher and the participant. Setting was determined by the participant. For example, if a participant was unable or preferred not to speak by phone, questions were emailed to the participant at the e-mail address of their choice. Phone interviews from participant’s homes may not have been preferable for participants whose children were home and required close or line-of-sight supervision due to safety concerns. Additionally, participants may not have felt free to fully express their experience if the child or other children could hear and childcare arrangements may have been difficult.

Purposive sampling was used to recruit participants from an online parenting support group for mothers of children with attachment issues with more than 20,000 members. Purposive sampling involves selecting participants who have experienced the phenomenon of interest (Streubert & Carpenter, 2011). Qualitative researchers utilize sampling techniques to obtain a thorough description of a phenomenon rather than techniques that promote generalizability of the results (Streubert & Carpenter, 2011). If
saturation had not been reached utilizing purposive sampling, snowball sampling would have been used. Snowball sampling, or nominate sampling, uses referrals from participants to find others who have experienced the phenomenon of interest (Streubert & Carpenter, 2011). Snowball sampling was not necessary.

Inclusion criteria included: Mothers who self-identified as being adoptive mothers of children (age <18) with early complex trauma and attachment issues and have parented the child(ren) for more than 5 years (Mothers of children living outside the home may participate if the child lived with them for at least 5 years); participants living in the United States or Canada and able to read, write, speak, and understand English; and participants with an email address where they could send and receive study documents such as consent forms and interview questions/answers if they opted not to have a phone interview.

The researcher had a general acquaintance with some participants in the study. This did not exclude any participants and could have encouraged participation because of a sense of rapport. Participants could decide whether or not they wished to participate based on familiarity with the investigator whose name appeared on the recruitment post. No participants expressed concern or opted out of participation due to this aspect of the study.

Instruments

Instruments utilized for this study included a Demographic Survey (Appendix E) and a semi-structured Interview Guide (Appendix F). The Demographic Survey was
administered via Survey Monkey®. The same interview guide was used for both email
and telephone interviews depending upon participant preference for interview format.

Data Collection

Demographic data were collected via Survey Monkey® according to the
approved Demographic Survey (Appendix E). The following demographic data were
asked of all participants:

1. Age
2. Marital Status
3. Number of Children, Current Ages, Biological or Adopted
4. Current age(s) of children with early trauma and attachment issues, age at adoption,
and age when began showing symptoms of early trauma and attachment issues
5. A pseudonym unrelated to the participant’s real name that can be used in transcripts
and reporting data
6. Pseudonym(s)/letters/numbers unrelated to the child(ren)’s real name(s) that can be
used in the interview, transcripts, and writing

Data were collected by interview via phone or email using the approved semi-
structured interview guide (APPENDIX F). The following are examples of questions that
were asked of or emailed to participants:

1. Please tell me what it’s like to be the mother of a child(ren) with early trauma and
attachment issues?
2. How has being the mother of a child(ren) with early trauma and attachment issues
affected you?
3. What dimensions, incidents, and people connected with your experiences stand out for you? (positive or negative)

4. What do you wish you had known prior to mothering a child with early trauma and attachment issues that you know now?

5. If you have children without early trauma and attachment issues or with different types/severities of early trauma and attachment issues, how is the experience of mothering them different?

6. Please provide an example of an interaction, incident, or event that you feel captures the experience of being a trauma mom.

Procedures

Data collection began following approval by the Institutional Review Boards’ (IRB) of Mercer University (Appendix G) and the college where the researcher is employed (Appendix H). Approval was also obtained from the governing board of the online support group to place a recruitment post (Appendix C) on a social media subgroup of approximately 200 moms with permission to post in the larger group if more participants were needed. Adequate response to reach saturation was obtained through purposive sampling within the smaller subgroup.

The online recruitment post contained a link to a Survey Monkey® online form developed by the Mercer University Information Technology Department. Potential participants were able to access and approve the informed consent form through the online form which included information concerning confidentiality, participants’ choice to withdraw at any time, and the potential for the interview to cause an emotional
response. The researcher’s contact information was provided for any additional questions or concerns though none were expressed. If the potential participant agreed to continue with participation in the study, they were directed to a demographic survey which included questions regarding inclusion criteria, demographic data, preferred method and time of contact, and directions to choose pseudonyms.

First and second cycle coding methods were discussed with the dissertation committee chair prior to beginning the interviews. Participants who preferred email interviews were sent the interview guide and any follow up questions individually to their chosen email address. Email correspondence was sent from and participant’s returned responses to the researcher’s password protected Mercer University email account. Once the email interview correspondence was complete, interview questions and verbatim answers were transferred to a Microsoft Word document. Participants who preferred phone interviews were contacted via their provided email address or phone number to arrange a time for a phone interview. Phone interviews were conducted from the researcher’s private office and were digitally recorded with participants’ knowledge and consent. Phone interviews were transcribed verbatim from the recording to a Microsoft Word document by the transcriptionist who had signed a confidentiality agreement.

The researcher journaled following each interview and each reading of a written interview to bracket feelings and past knowledge or experiences that were felt, remembered, or engaged during the process. Giorgi (2009) recognizes the inability to forget such aspects and encourages the practice of bracketing to disengage that part of
self so as to approach the participant’s experience with the presence of a natural attitude. Periodic scheduled meetings were held between the researcher and the dissertation committee chair to debrief and discuss data analysis.

Data Management and Analysis

The researcher verified all transcripts for accuracy with the audio recording and corrections were made as needed. Potentially identifying information such as specific dates, places, ages, and/or unique family situations were redacted from both the email and telephone interview transcripts and replaced by a more general descriptor to provide context if needed. Pseudonyms chosen by the participants were used in place of names in the transcripts. A spreadsheet linking participant number and pseudonym was maintained as an additional source of data separately from the transcripts in a locked file cabinet in the researcher’s private office. Electronic transcripts were stored on the researcher’s password protected private computer, printed for analysis by the researcher, and emailed to the dissertation committee chair for review via official Mercer University email accounts. Raw data (transcripts) were provided to the dissertation committee chair and will be maintained at Mercer University per protocol. Data reduction and analysis documents were provided to the dissertation committee chair and will be kept by the researcher along with field notes and journaling.

Journaling during qualitative research helps the researcher identify his or her thoughts, ideas, and biases related to the research topic (Munhall, 2012; Streubert & Carpenter, 2011). By making the researcher’s perceptions explicit, the researcher is reminded to pay attention to the individual experiences of the participants rather than
validating the researcher’s ideas. Journaling also plays a role in the descriptive
phenomenological practice of bracketing (Polit & Beck, 2012; Streubert & Carpenter,
2011). Bracketing is a component of Giorgi’s (2009) understanding of Husserl’s
phenomenological method which involves the conscious decision to set aside one’s own
judgments, thoughts, or views about the research topic and to remain open to the
experience of the participant. Journaling can also include annotations made throughout
the process which help the researcher identify areas needing clarification or follow-up.
Journaling and bracketing took place throughout data collection and analysis phases of
research, as did field notes (Streubert & Carpenter, 2011). Field notes include
observations made by the researcher that may not have been captured on a voice
recording or transcript. Journaling and field notes are considered data and were taken
into account during data analysis (Streubert & Carpenter, 2011).

Data analysis began following the first interview. The first four interviews were
manually coded in order of interview completion. All data analysis was undertaken
following Giorgi’s (2009) methodical steps and using Saldaña’s (2013) method of coding
within each transcript. Giorgi’s procedure includes three steps of data analysis. First,
“read for the sense of the whole” (Giorgi, 2009, p. 128). Each transcript was first read in
its entirety to get a sense of the description as a whole. Giorgi explained the necessity
of this step is due to the holism of the phenomenological approach in which “meanings
within a description can have forward and backward references and so analyses of the
first part of a description without awareness of the last part are too incomplete” (Giorgi,
2009, p. 128). There is no analysis or clarification at this stage, merely a reading for a general overview and sense of the experience (Giorgi, 2009).

The second step is “determination of meaning units” (Giorgi, 2009, p. 129). Due to the length of most descriptions, Giorgi recommended breaking them into manageable parts. Meaning units should be established in a way to make sense with the overall goal of providing meaning to the experience. To establish meaning units, the description is reread from the beginning and the transcript is marked each time a “significant shift in meaning” occurs (Giorgi, 2009, p. 130). Again, no analysis occurs in this step. In keeping with Giorgi’s method, the process was spontaneous and somewhat arbitrary rather than intellectual. Meaning units were marked in the margins of the transcripts in accordance with Saldaña’s (2013) preliminary jottings and first cycle coding. First cycle coding was repeated multiple times until codes were clear and distinctive. Twenty-four initial codes were reduced to nine.

Giorgi’s (2009) final step is “transformation of participant’s natural attitude expressions into phenomenologically psychologically sensitive expressions” (p. 130). The researcher approaches the data from both a scientific phenomenological perspective and a disciplinary perspective. Since the nursing perspective is congruent with the phenomenologic perspective, this is an appropriate process for nursing research (Giorgi, 2009). During this step, the researcher examined the description which had been broken into meaning units. The researcher examined the units and transformed the description of the lifeworld experience into its essence. The essence “has to be detected, drawn out, and elaborated” (Giorgi, 2009, p. 131). Saldaña’s (2013)
Second cycle coding instructions were used to further inform this process. Second cycle coding focused on collapsing codes into broader patterns and categories.

Descriptive, In Vivo, emotion, and process coding were used for first cycle coding (Saldaña, 2013). Different colored pens and highlighters were used to differentiate the codes. Through descriptive coding, the researcher identified general topics in the data which then provided a framework for organizing and categorizing further coding and data analysis (Saldaña, 2013). In Vivo coding was suitable for this study because it is appropriate for phenomenologic studies and for novice researchers as it uses exact words or phrases of the participants (Saldaña, 2013). Through use of exact quotes, In Vivo coding allowed the researcher to “prioritize and honor the participant’s voice” (Saldaña, 2013, p. 91). As the researcher reread each transcript, salient words or brief phrases were identified and highlighted. Emotion coding was used because it is appropriate for studies investigating interpersonal and intrapersonal experiences. Emotions explicitly stated, implied, and demonstrated by the participant were recorded by the researcher and grouped to provide an emotional storyline of the experience (Saldaña, 2013). During process coding, the researcher identified actions in the data and coded them using gerunds (words ending in – ing).

Through reflection and second cycle coding, the codes were condensed. Pattern coding was used for second cycle coding. In pattern coding, similar In Vivo, descriptive, and/or emotion codes were grouped together (Saldaña, 2013). This was completed by the researcher by writing codes of a single type on a piece of paper and then drawing circles or highlighting to group similar codes together. Multiple rounds of both first
cycle and second cycle coding were conducted. Themes, or essences, using Giorgi’s (2009) vocabulary, emerged from the groupings of codes (Saldaña, 2013). Ultimately, four themes and twelve subthemes emerged from the data.

Trustworthiness and Rigor

Giorgi (2009) sought to demonstrate the phenomenological method is no less rigorous or scientific than empirical methods and expressed application of the philosophy of phenomenology to qualitative study provides legitimation and rigor. Although differing in style and character, Giorgi asserted “a qualitative analysis of descriptions can yield psychological insight of a value at least equal to what quantitative approaches yield” (Giorgi, 1985, p. 2). Giorgi’s process has been previously described in this chapter.

Lincoln and Guba (1985) identified four specific techniques that promote trustworthiness in qualitative studies. These techniques include credibility, dependability, confirmability, and transferability. Credibility includes techniques that increase the likelihood of credible interpretations and findings. These activities include peer debriefing, negative case analysis, referential adequacy, member checks, prolonged engagement, persistent observation, and triangulation (Lincoln & Guba, 1985). Prolonged engagement and persistent observation occurred as this researcher has experienced the phenomenon being studied. Both promote credibility through the practice of being present with and learning the culture, and establishing trust to the extent that the researcher is able to recognize distortions that may occur as well as identify events that are salient to the experience being studied (Shenton, 2004).
Prolonged engagement also occurred through immersion in data collection over time, return to follow up discussions, and immersion in data analysis and peer debriefing with the dissertation chair. The risk of personal familiarity influencing the researcher’s judgment was countered by the researcher consciously bracketing her own experiences during data collection and analysis, and debriefing with the dissertation committee chair. Bracketing was conducted according to Giorgi’s (2009) guidelines. Triangulation occurred through participant demographic variability in age, location, and number of children.

Dependability was established when credibility was demonstrated and was further strengthened by an audit trail which occurred as the researcher’s dissertation committee chair guided and supervised the research (Lincoln & Guba, 1985). Confirmability is documented by establishing an audit trail of evidence and the researcher’s thought processes regarding data analysis which can be followed by others (Lincoln & Guba, 1985). The audit trail included the researcher’s journals which were also considered in the data analysis process. Journaling along with frequent debriefing with the dissertation committee chair addressed the researcher’s own assumptions and biases in order to confirm the study’s findings as true to the participants’ lived experiences. Journaling also included design procedures, decisions, and changes as data emerged. The determination of a study’s transferability is made by future prospective users of the data but the researcher is responsible for providing findings which make this determination possible (Lincoln & Guba, 1985). Rich, thick descriptions have been obtained and a detailed audit trail will be maintained to promote transferability.
Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained from both Mercer University and the researcher’s employer prior to initiation of the study. Each participant was informed, prior to the study, of the following processes taken to ensure confidentiality. Audio recordings were destroyed after the study’s completion, a pseudonym of the participant’s choice was used in lieu of the participant’s name, pseudonyms of the participants’ choice, unrelated to their child(ren)’s names, were chosen by the participants or assigned by the researcher so that children’s names were not used in the transcripts, age ranges of the child(ren) were used rather than specific ages, no identifying child backgrounds were used, transcripts have been kept in a locked cabinet in the researcher’s home office, and email and/or any computer documents related to the study are password protected. Data will be stored and destroyed according to Mercer University protocol.

Summary

This chapter explained the research method and design chosen for this study and the rationale for the research approach. Descriptions of the setting, participants, process of data gathering and protection of human subjects were also provided. Discussion of methods of data processing, data analysis, and trustworthiness and rigor were included as well.
CHAPTER FOUR

RESULTS

This chapter provides the study’s results including summaries of the four themes and twelve subthemes that emerged from the data. Data were analyzed using Giorgi’s (2009) procedures for data analysis and Saldaña’s (2013) processes of coding. Giorgi's procedural steps follow Husserl’s descriptive phenomenology and were appropriate for this study because so little is known, in a research sense, about the experience of being the mother of a child with early complex trauma and attachment issues that the experience first needed to be described. Saldaña’s (2013) coding processes complement Giorgi’s (2009) procedural steps and inform the process by which data are organized, categorized, grouped to provide a storyline of the experience. Data are presented herein without analysis which will be the focus of chapter five. This chapter also includes a brief overview of data management and analysis undertaken, a description of the participant sample, and detailed findings as they relate to emergent themes. Explanation is also given for the application of descriptive, In Vivo, emotion, and process coding use for first cycle coding as well as the processes of second cycle coding and emergence of themes.
Overview of Data Management and Analysis

Email and telephone interviews took place simultaneously depending on participant preference. The same semi-structured interview guide (Appendix F) was used for both types of interviews. Interview questions were sent via electronic mail to 19 persons who preferred email interviews; four interviews were completed and returned to the researcher. The researcher asked for clarification via email as needed; all follow-up questions were also answered by the participants. Phone interviews were preferred by 11 persons; 10 interviews were scheduled and completed. The researcher and the dissertation committee chair met periodically for debriefing and to discuss the research process, including data management and analysis. Journaling and bracketing took place throughout the data collection and analysis phases of research, as did field notes (Streubert & Carpenter, 2011).

After two interviews, the researcher added the interview question “Can you tell me about an experience that you feel encompasses the experience of mothering a child with early trauma and attachment issues that would help explain this experience to others?” This new question was added as a result of the researcher’s reflection and journaling during and after the initial interviews. While the researcher bracketed her own understanding of the experiences shared by the participants, she observed an overall picture was not emerging that would help someone unfamiliar with the experience understand its breadth and depth. Participants were able to answer this question and provide another level of richness to the data.
As data analysis was begun and following discussion and debriefing with the dissertation committee chair, four additional questions were added which could further enhance the study. The topics of respite, coping, and child behaviors were mentioned by the participants consistently as part of the lived experience of being the mother of a child with early complex trauma and attachment issues, but there were no specific interview questions to elicit this data or to provide consistency to what was asked or shared. The fourth question was added because the original interview questions were not fully capturing the experience of energy interactions in the participants’ own voices. The questions included:

1. Do you have respite or get a break? What is that like?

2. What are your methods of coping? How do you get through each day?

3. Of the behaviors exhibited by your child with early trauma and attachment issues, which is the most distressing? What worries about your child keep you up at night?

4. Can you tell me about a time when your child walked in the room and without any interaction you could feel their energy? If you have a child without early trauma and attachment, how is this different?

All phone interviews were digitally recorded and transcribed as described previously. Transcripts were compared to recordings to verify accuracy prior to analysis then stored on a password protected computer. Email interviews were transposed to Microsoft® Word documents, verified for accuracy, and also stored on a password protected computer. Participant names were changed to pseudonyms on the transcripts and potentially identifying information such as location were removed.
A spreadsheet listing participant numbers and chosen pseudonyms was kept separately from the transcripts in a locked file cabinet in the researcher’s home office.

Data analysis was guided by Giorgi’s (2009) understanding of Husserl’s phenomenological method and three procedural steps. The first procedural step is “read for the sense of the whole” (Giorgi, 2009, p. 128). Each transcript was read in its entirety to get a sense of the description as a whole. There was no analysis or clarification at this stage, merely a reading for a general overview and sense of the experience. The second step is “determination of meaning units” (Giorgi, 2009, p. 129). Due to the length of most descriptions, Giorgi (2009) recommends breaking them into manageable parts. To establish meaning units, the description is reread from the beginning and the transcript is marked each time a “significant shift in meaning” occurs (Giorgi, 2009, p. 130). Again, no analysis occurred in this step. In the third and final step of Giorgi’s (2009) method, the researcher approaches the data from both a scientific phenomenological perspective and a disciplinary perspective. During this step, the researcher examined the description which was broken into meaning units and the essence or basic attributes of the phenomenon of being the adoptive mother of a child with early complex trauma and attachment issues.

Saldaña’s (2013) first and second cycle coding instructions were used to further inform step three. Descriptive, In Vivo, process, and emotion coding were used for first cycle coding whereby the researcher identified general topics in the data which then provided a framework for organizing and categorizing further coding and data analysis (Saldaña, 2013). Experiences explicitly stated, implied, and demonstrated by the
participant were recorded by the researcher and grouped to provide a storyline of the experience (Saldaña, 2013). First cycle coding was conducted on all transcripts as the interviews were completed. Multiple rounds of first cycle coding were conducted on all transcripts. Routine contact was made with the dissertation committee chair as first cycle coding was performed, additional interviews conducted, and patterns began to emerge. After 12 interviews were conducted and multiple rounds of first cycle coding completed, data saturation was thought to have been reached. Two additional interviews were conducted with no new data obtained and saturation was confirmed.

After several cycles of first cycle coding were completed on all transcripts by the researcher and the dissertation committee chair, second cycle coding was begun. Through reflection and multiple rounds of first and second cycle coding, individual codes were collapsed into broader categories as similar codes were grouped together. These categories were coded to reflect their meaning. Essences (Giorgi, 2009) or themes (Saldaña, 2013) emerged from the groupings of codes. Four major themes and twelve subthemes emerged.

Description of Sample Participants

The Survey Monkey® link was accessed 37 times with a total of 31 persons giving informed consent, meeting inclusion criteria, completing the demographic data, indicating preference for phone or email interview, and providing contact information. All participants self-reported as adoptive mothers of a child or children with early trauma and attachment issues. Participants also self-reported as having parented a child with early trauma and attachment issues for greater than 5 years. Both of these
self-reported characteristics were required inclusion criteria. Other inclusion criteria included participants must currently be living in the United States or Canada and be able to read, write, speak, and understand English. Additional participant characteristics including age and marital status are given in Table 1. Mothers who completed the interview ranged in age from 41 to 64 years with a mean age of 50 years (n=14). Marital status was reported as married by 11 mothers, single by two mothers, and divorced by one mother. Participants reported a total of one to five children with seven mothers reporting a combination of biological and adopted children and seven mothers reporting only adopted children. Six participants reported multiple children with early trauma and attachment issues. Ten participants reported currently having a child with early trauma and attachment issues living in their home. Specific demographic information regarding where participants currently live and if their adopted children with early trauma and attachment issues were adopted through international or domestic programs was not intentionally collected, but some participants shared this information during the interview. Participants were from both the United States and Canada.
Table 1

*Participant Characteristics (N=14)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>Observed Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>14</td>
<td>41-64 years</td>
<td>50 years</td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total children</td>
<td></td>
<td>1-5(n=40)</td>
<td>2.9</td>
</tr>
<tr>
<td>Children with ETAI*</td>
<td></td>
<td>1-3(n=22)</td>
<td>1.6</td>
</tr>
<tr>
<td>Adopted children only</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Adopted and bio**</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child(ren) with ETAI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>currently living at home</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*ETAI=early trauma and attachment issues
**bio=biologically related child*

Table 2 summarizes information regarding the participants’ children with early trauma and attachment issues. Twenty-two children with early trauma and attachment issues are parented by the 14 mothers who were interviewed for the study. These children range in age from 4 years old to 38 years old with a mean age of 17 years old (n=22). Age at adoption ranged from 6 months old to 14 years old with a mean age of 4 years old (n=22). The reported age at symptom onset was reported from 6 months to 14 years old as well and these ages very often were exactly the same as age at adoption. Therefore, the researcher believes the reported age at symptom onset is likely not a true indication of when the symptoms actually first occurred but rather when the
adoptive parents first had contact with the child and noticed the symptoms. For this reason, the reported age at symptom onset is not reported in Table 2.

Table 2

[Table 2: Characteristics of Participants’ Children with Early Trauma and Attachment Issues (ETAI) (N=22)]

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>Observed Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with ETAI</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Age</td>
<td>22</td>
<td>4-38 years</td>
<td>17</td>
</tr>
<tr>
<td>Age at Adoption</td>
<td>22</td>
<td>6months-14 years</td>
<td>4</td>
</tr>
</tbody>
</table>

As mothers to a total of 40 children, 22 of whom are children with early trauma and attachment issues, the 14 participants collectively have an extensive amount of mothering experience. Half of the participants had only parented children with early trauma and attachment issues while the other half had also parented children without early trauma and attachment issues. The current ages of the participants’ children with early trauma and attachment issues and their ages at adoption varied as indicated in Table 2. This diversity resulted in richness of the data, but there were also significant similarities in the participants’ experiences of being the mother of a child with early trauma and attachment issues.

Findings: Themes and Subthemes

1. ALL CONSUMING VIGILANCE
   
a. Safety For and From My Child

   b. Becoming a Trauma Expert
2. ADJUSTING EXPECTATIONS
   a. Moving from Traditional Parenting to Therapeutic Parenting
   b. Relationship with the Child
   c. Fixing the Trauma

3. PUSH/PULL
   a. Blame from Others
   b. Loss of Relationships
   c. Loss of Self

4. CHANGES IN PATTERNING
   a. Child Behaviors
   b. Energy Interactions
   c. Long-term Effects of Patterning Changes
   d. Coping Strategies

Four themes and twelve subthemes emerged from the data to answer the question: What is the lived experience of mothers of children with early complex trauma and attachment issues? These themes and subthemes will be introduced and discussed below. As mentioned earlier in this chapter, the researcher added an additional question after two interviews as a result of journaling and reflection during and after the interviews. In an attempt to better capture and describe the mother’s experience, the participants were asked: Can you tell me about an experience that you feel encompasses the experience of mothering a child with early trauma and attachment issues that would help explain this experience to others? Each mother who was asked
this question had a personal experience that included a child’s behavior and a mother’s response, each representative of her own experience but also very similar to the examples given by other participants. The following three answers are exemplars of the daily experience of being a mother of a child with early complex trauma and attachment issues. Katie answered both literally and figuratively:

So yeah, riding down the road and your four-year-old has managed to somehow get out of their car seat, literally kicking and screaming with adrenaline flowing, so superhuman strength at this point, is kicking windows, kicking the back of your chair, throwing things, milk cups, whatever they can get their hands on. So, it's a Sunday afternoon . . . Reasoning at that point is out the window. There is no reasoning whatsoever, but I pulled into the police station hoping that a man in uniform could absolutely talk some sense into this kid. At least maybe shock him out of this whole raging incident 'cause it's not safe, he's not in his car seat, it's not safe for me to drive when he's acting like this. So I pulled into the police department and it's closed! And as he's getting out of the car he says, “Fine, I'm arrested.” So that's it. I am desperate for help, somebody, for the love of God, help me with this kid. And they are closed. You know, whether it's the police department, or the church, or the psychiatrist, how many people are just closed to helping you with this kid that is so out of control?

Vicky answered the same question:

Well, the one that comes into my mind first was she had been out bar hopping in her teenage years, and she had left her car at one place, and she didn't have a ride home. So I went to meet her at [the local mall] to pick her up. See, that's where I was saying that you do things that you really don't want to do, you think no, you're old enough, you ought to get yourself home, I'm not doing this, but I went and I picked her up. That's that, you can't win no matter what you do. I would have felt horrible if I hadn't, because she might be in danger, and I felt stupid that I did. So I picked her up and when she got out of the car that she was in, this man was driving her, and she went to get her things out of her trunk, and she had totally different clothes on. She had her hair dyed white, which it always was at the time, white as a piece of paper, and she had on white fishnet hose and a short leather skirt and she looked like, like, it just struck me to the core that she totally looked like a prostitute getting out of that car. When she got in, she was in a good mood and I just was boiling about it. She was in a good mood and she asked me could we go shoe shopping as if nothing had happened. It told me that she almost didn't even think it was wrong, or certainly didn't care that I
did. She had no concern about the danger, or what she looked like, or the fact that I had driven 40 miles to pick her up. It was just total disregard for that, and “let’s just go have lunch,” but it was “let’s just go buy shoes.”

Sara answered the same question by giving several examples:

So some examples that I think of: when you’re trying to cook dinner and you have to go to your bedroom to get the knives because you can’t keep them in the kitchen. When you have to get in the lockbox to get Tylenol when you have a headache. When you enter into an event and as soon as you’re walking in, you’re scanning for the exits, like where my kid can escape from? When you go in and you’re positioning yourself seating wise for containment in the corner of a room. Also never traveling, never leaving the house, without snacks, water, it doesn’t matter if we’re leaving the house for 5 minutes or 2 hours, but like a bag of snacks and water. And for a real long season a change of clothes for trauma kid who would pee on herself, you know, well past the years of carrying a diaper bag. I think the other thing is like hearing the sort of venom that comes from their, you know, the degrading words and things that they say and lash out at you that you could only share with another mom that gets it. Versus “your kids said what?”

Although the quotes above are from three individual participants, the experiences are not unique. Each of the four themes can be found in the experiences above. Together, the themes and subthemes answer the research question: What is the lived experience of mothering a child with early complex trauma and attachment issues?

Theme One: All Consuming Vigilance

The theme *All Consuming Vigilance* refers to a level of alertness, attention, and caution required by mothers of children with early complex trauma and attachment issues, which exceeds that of normal parenting, in which the mother is constantly aware of, and her energy is consumed by, issues of safety and advocacy for her child. The level of mental, physical, and emotional vigilance required to parent a child with early complex trauma and attachment issues is also associated with little to no respite. Lucy
stated, “I wish I had known just how all-consuming [mothering a child with early trauma and attachment issues] would be.” Participants recognized, through their own experiences and learning, the level of vigilance required to provide safety for and from a child with early complex trauma and attachment issues was not easily understood or replicated by other caregivers. As a result, two parent families often do not get respite together due to the necessity of one of them staying home with the child or children. In addition, mothers also reported an increase in unsafe behaviors by the child or children with early complex trauma and attachment issues due to the stress of separation from the mother. Julia reflected on a lack of respite and the fear associated with others potentially not providing the level of vigilance needed:

There were a few times [of respite] but really, it was pretty minimal . . . but the few times that I remember it happening, that my parents were insistent, I was a nervous wreck the whole time. I don’t remember being able to relax or enjoy myself. You know, glued to my phone waiting for that emergency call of some sort.

Rebecca also discussed a lack of respite, lack of respite with her husband, and her children’s behaviors related to her leaving:

What's a break? We have no Community Support so if I do get a break it's because [my husband] provides it. Or occasionally in the past we have had other friends and sometimes family step in . . . but I don’t get a break in any tangible, meaningful way consistently. When I do get one it is like a highly orchestrated event that requires multiple people. As a result [my husband] and I almost never get a break together, because it's either one or the other of us because we can't leave our kids with other people . . . it's a safety issue, but it's also like an explanation of behavior that isn't possible. Like you really can't leave that jar of sugar in your cupboard because my kid is going to get a spoon and eat the entire thing and then they're going to be puking and you won’t know why. Like how do you explain that? . . . When they were little it was horrendous. There's always been a little bit of payback when I come home, but what's actually been harder is the behavior that they exhibit while I'm gone in an attempt to get me to come
home. Right? So the behaviors while I'm gone, have ranged from drugging their father with melatonin so that he would pass out while they play computer games to sneaking and hoarding food, waking each other up in the middle of the night and going downstairs to get alcohol and having a party... When [my daughter] was little it was actually the lead up to me going away that would be the bigger problem. She would do things like when one year she hid my glasses. She knew I couldn't drive anywhere without them. Things like that, like sabotaging things either before or during in an attempt to make it so I couldn't go.

The subthemes *Safety For and From My Child* and *Becoming a Trauma Expert* refer to the areas participants consistently reported as demanding vigilance. *Safety For and From My Child* or children with early complex trauma and attachment issues was a primary concern expressed by the participants. Behaviors will be discussed further below, as its own subtheme, but the exemplars and quotes above reveal a sample of the behaviors that pose a threat to the safety of the child and others such as raging in the car as the mother is driving, underage drinking and staying out all night, attempting to drug a parent, food binging, and behaviors that prompt the mother to lock up medications and knives. The level of vigilance required to provide safety for and from the child is often misunderstood by others including family and healthcare providers.

Sara stated:

> I think [health care professionals’] greatest disconnect is just the lack of understanding that parenting a kid of trauma is truly 24/7 and you are always thinking of what’s going to happen if they’re dysregulated, how can I keep my trauma kid safe? How can I keep my other kids safe? You know, how can I go to this meeting, or how can I go to the doctor for myself when I’m juggling trying to keep everybody else safe?

The following reflection by Katie is reflective of the way the threat to the mother’s own safety becomes so commonplace to her that her acknowledgement of the threat is...
given in a matter of fact manner, but is also evident of the vigilance required as the threat comes from a “calm” child. The juxtaposition of the calmness and the threat may also contribute to the misunderstanding by others. Katie reflected:

So when you sit across the table from your five or six year old, and it’s not in a fit of rage or not anything that he’s that distressed about apparently, or seemingly at the time, and he, as calm as he can be says “I will kill you one day.” And I think that my response was “I don’t doubt that you will try.”

The subtheme *Becoming a Trauma Expert* refers to the mothers’ vigilance in seeking help and healing for their children with early complex trauma and attachment issues. Participants reported having to educate themselves regarding early trauma and attachment issues and how/where to access care for their children. Mothers frequently expressed a sense of urgency and being consumed by the search for information and treatment for their children. Additionally, mothers expressed the sense that they were blazing their own trail and providing education to the professionals from whom they were seeking help. Kate stated:

What drains my energy is the literally constant worry that I should be doing something that will help save him right now...He is now [7-10 years old], and I have been trying to get him effective therapy since day one, but nobody could help me with a young child. It hurts me to watch his ship sinking in slow motion... I have to say that I am making myself a trauma expert. My brain is overloaded with horrible statistics and loads of different therapies that I want to try. I get overwhelmed and can’t think about it anymore, then I buy and read another book... I wish I knew how to help him. He is not the only child that has his issues that has gone through the system. Why am I left to research and discover everything? I feel like I am his only hope, and I have to completely blaze that trail.

Theme one *All Consuming Vigilance* reflects the mothers’ experiences of a continuous level of alertness, attention, and caution required to provide safety and
promote advocacy for their child or children with early trauma and attachment issues. This vigilance exceeds that of normal parenting and the mothers’ energy is consumed by this process. The level of vigilance required is also associated with little to no respite for the mother. The limited opportunities for respite are likely accompanied by an increase in unsafe or sabotaging behaviors by the child and continuous worry by the mother. Participants reported being consumed by the continuous attention toward keeping the child with early trauma and attachment issues safe as well as keeping themselves and others safe from the child. Participants also reported a sense of urgency and necessity to educate themselves about trauma and finding help for their child.

Theme Two: Adjusting Expectations

The theme *Adjusting Expectations* refers to the realization that the parenting of, the maternal/child relationship with, and the healing of a child with early complex trauma and attachment issues is different from traditional parenting roles and expectations. Although participants had different expectations and preparations preceding the adoptions of their child or children with early complex trauma and attachment issues, every participant verbalized the experience of adjusting their expectations. The three subthemes, *Moving from Traditional Parenting to Therapeutic Parenting*, *Relationship with the Child*, and *Fixing the Trauma*, are reflective of the areas most commonly affected by changing expectations.

*Moving from Traditional Parenting to Therapeutic Parenting* refers to the realization that the child or children with early trauma and attachment could not be successfully parented by traditional parenting techniques and that therapeutic
parenting is not instinctual. Therapeutic parenting focuses on cultivating feelings of security and connection in the child through attention to structure, nurture, and safety (Attachment and Trauma Network, n.d.). Although this description of therapeutic parenting seems to be similar to what is expected of traditional parents, the two are actually very different. Therapeutic parenting requires parents to nurture, seek connection, and discipline in a calm, kind, and respectful manner while the child with early complex trauma and attachment issues is resisting connection, rarely reciprocating positive emotions, and exhibiting unsafe behaviors such as the ones reported above (Attachment and Trauma Network, n.d.). Participants’ experiences differed as to when they discovered or began to use therapeutic parenting strategies, but all recognized the unique parenting approach needed. Julia stated:

I think that more than anything, I would have wanted to know [before being the mom to her first child with early trauma and attachment issues] that I had to focus solely and purely on making my child feel safe. It’s not about trying to make them see that they’re wrong, not on trying to make them see the consequences of their actions, not on trying to make them understand that’s how the world works, and that I’m right and they’re wrong, but about them being safe. Do you feel safe? Because if I can’t make you feel safe, I can’t reach you.

Although some nurturing is needed by children with early complex trauma and attachment behaviors, nurturing is resisted by the child and the amount they can handle continuously changes. Too much nurturing by the parent feels dubious to the child and perpetuates the child’s perception that the parent cannot be trusted (Attachment and Trauma Network, n.d.). Sadly, sometimes the amount of nurturing that the child can
handle is merely a single change of clothes and sometimes even that is too much.

Instinctively wanting to give her child so much more, Ava stated:

Therapeutic parenting alone just utterly destroys you as a person, I feel, because it is so opposite of what you want to do as the mother... Like sometimes you have to turn your house into almost like a group home where you pull everything back and all you're doing is feeding them, making sure they have clean clothes and that they get to school. That's all they can handle, so that's all that you can give them... so the rages go down, but as a parent I feel like it just destroys you because you are so going against that natural maternal instinct.

The subtheme *Relationship with the Child* refers to the adjustment by the mother from what she wanted or expected her relationship with her child to be.

Although the depth of the relationships differed between the participants and their child or children with early complex trauma and attachment issues, and future healing remains to be seen, none of the participants currently had an expectation of a traditional maternal/child relationship. Instead, most of the mothers had adjusted their expectations of a relationship with their child from a reciprocal relationship to a commitment to the child and hope the child could achieve his or her realistic potential.

Participants verbalized a commitment to their child despite the challenges, but most were also imagining how that might look in the future. In recounting her own adjusted expectations of a mother/daughter relationship, Ava acknowledged:

You've got to manage your own expectations as a parent that no matter how much help you get, there is just some things that cannot be undone. She and I may never have a good relationship, and I think I have come to terms with that. I'm okay with that as long as she can have a functional life. I may never be somebody that she can be close to, because I was the main parent, and at this point I think I'm okay with that. As long as she's healthy and can succeed, for whatever that means for her level, then I'll be fine. I'll be happy and I'll consider that we've all done our best.
Regarding her process from traditional expectations of a relationship to commitment despite the challenges, Vicky reflected:

I would honestly like to say it was my faith that it was going to be all right, it was going to turn out alright, and that I had confidence that working with [the relationship with the child with early trauma and attachment issues] would make it better, but it wasn’t true anymore. . . . I just had to make it. She was mine, it was my life and I had to make the best of it.

Katie imagined what her future relationship with her son with early complex trauma and attachment issues might entail compared to her neurotypical children:

But, you know, it has been an experience. It still is. It will be for the rest of my life I am sure. I think at this point, and the counselor and I have had this conversation, the older he gets, the more I'm going to have to work on having healthy boundaries for relinquishing what is my perceived control of his mental health. Whether it is counseling sessions, or medication administration compliance, or whatever, to give that to him and then I have boundaries. That is not something you ever think about. I've never thought about that with bio kids. They are going to be part of my life forever, they’re going to be great. Not that he won’t be part of my life, but if he leaves my house and he is out of counseling and he is off medication, there are going to have to be some real clear boundaries. What behaviors I accept and what I don’t. And that's not really fun to think about.

The subtheme Fixing the Trauma describes the mothers’ shared experiences of adjusting their expectations from being able to completely heal their child’s trauma. Most participants expressed an initial expectation that their child would be able to heal to the level of a non-traumatized child which was adjusted to the hope of their child being able to reach their own, individual healing and potential. The mothers discovered fixing the trauma may not happen regardless of their commitment, love, involvement, or interventions. Additionally, the participants recognized the responsibility of the child for their own healing. The level to which the mothers were able to facilitate or
participate in the healing of their child or children varied. Unfortunately, this adjustment in expectations often came as resignation after much guilt and pain.

Rebecca’s experience reflects the adjusted expectations of not being able to fix the trauma despite being well informed prior to the adoption of her children with early trauma and attachment issues. This is her response to the question of what she wished she had known prior to adoption that she knows now:

To be honest, I don’t think I could have come into it with my eyes much more open. We really did think that we had our heads on straight and that we knew what we were doing and that we could manage this and we could fix this. The only thing, perhaps, looking back at 30 year old me, the only thing that might have helped was if somebody set me down and explained that I might not be able to fix it. Because that is absolutely what’s happened with one of our kids. I couldn’t. You just have to learn to be okay with that. You love them and you do everything you can and it might not be enough. And even if someone had told me that, I probably wouldn’t have believed them, but it might not have been as soul-crushing when it happened.

Sara’s statement in response to the same question reflects the adjusted expectation that the mother alone cannot heal the child’s trauma, “I wish I had known that no matter how much love and how much energy and effort I put in, if they don’t want to heal they won’t.”

Theme Two, Adjusting Expectations, was experienced by the participants as they realized the parenting of, the maternal/child relationship with, and the healing of a child with early complex trauma and attachment issues were all different from their original expectations. Although the participants had different expectations and preparations preceding the adoptions of their child or children with early complex trauma and attachment issues, this experience was common among the mothers interviewed. The
three subthemes, *Moving from Traditional Parenting to Therapeutic Parenting*, *Relationship With the Child*, and *Fixing the Trauma*, are reflective of the areas most commonly affected by changing expectations.

Theme Three: Push/Pull

The third theme *Push/Pull* is representative of the relational dynamics that happen as a result of interactions with the child with early complex trauma and attachment issues. Threatened by attachment but also craving it, the child with early complex trauma and attachment both pushes the mother away and seeks closeness to her. Andrea describes it simply, “I am the worst person in the absolute world, but he can’t live without me. He has got to know exactly where I am all the time.” This push-pull behavior can also take the form of the child pushing away the mother (or other caretaker) seeking attachment and pulling toward themselves others who are not caretakers they can manipulate. This behavior may involve the child seeking pity for him or herself through lies about the mother. As a result, the first of three subthemes occurs which is *Blame from Others*. This is described by Andrea:

> The blame game is the hardest, the most horrid. I mean the school, it doesn't matter if I tell you that he has problems. First off, I'm the problem, I'm the abusive parent because he, that's one of the things that he will do, he'll tell you that I'm this terrible person. And, you know, unless you know me personally, you don't know that the child is blowing you up so that you can feel sorry for him and he can manipulate you. You know, he is good at it, he is very good at it.

Blaming the mother can also occur as a result of others’ perceptions of the child’s behaviors and the mother’s responsibility when those behaviors occur. Recounting when her daughter broke out a bedroom window and ran away from a sitter and the
police brought her home, and then her experience with finding placement for her son who was not safe at home, Julia stated:

And then the police yelled at me. How dare I suggest that there was anything wrong with this beautiful, little, innocent child? Um, I was losing my mind, and I didn’t know how to protect or keep everybody safe. I think the main thing was nobody believed me, nobody believed me, nobody believed that my kids needed help...My son, they told me, “Man if all kids who came here were like him we wouldn’t need places like this.” Until six months later when they were calling the police on him because he was robbing their apartment, and then I got a lot of apologies...I’ve had therapists call me and apologize because they didn’t believe me, because all that time that they wasted and not helping her and not listening to me was spent on, “So why do you think you have this troubled relationship with your mom?”

Ava described the disbelief of others about her daughter’s behavior because of how her daughter behaved with others with whom she had no attachment:

You know, you tell people [about the behaviors you deal with as the mom] and they just don't believe you. My daughter is absolutely beautiful and as a little girl she was amazingly adorable. She is very, very charming and she's brilliantly intelligent. If you had no attachment to her in her life, she is the most agreeable, fun, well-mannered, you know, can hold a conversation with an adult, child you've ever met. Every adult she has ever met absolutely loves her, wants to take her home.

All of the participants reported the loss of relationships among family and friends related to having a child with early complex trauma and attachment issues. The pull of others away from the mother, or subtheme two Loss of Relationships, can occur as a result of others’ perceptions of the mother and the behavior of the child with early complex trauma and attachment issues. Lisa reported the loss of longtime friends due to lies told to them about her by the child with early complex trauma and attachment issues:
I was constantly having to assure people that yes, he does have a coat, yes I do feed him, yes he has a bed, no we don’t beat him...no we don’t go on vacation without him, yes he has toys, no we didn’t kidnap him, no we didn’t refuse to let him play professional football. . . . People who had known me 20 years and watched my other three children grow up (including another adopted child) believed I was suddenly a monster.

Loss of relationships can also occur due to others’ inability to handle the difficult aspects of life with a child with early complex trauma and attachment issues. Reflecting on the loss of both friend and family relationships, Abby tearfully recounted:

My phone never rings. My phone never rings. My friends, I have like one friend who calls me. And I think you have to be really careful what you tell people because it’s just terrible. I think family tends to back off and not ask questions ‘cause when they hear a truthful answer I think it hurts them too. So they just stop asking. They just disappear, and I’m like “Where is my family?” And if you ask how my son's doing and I tell you the truth it's like, “Whoa!” And then they just never ask again. So I've just stopped talking to them about it. Which is sad but they don't even ask. Like I talked to my mother the other day, she didn't even ask how my son was. But do I even want her to ask? No, because does she even want to hear the truth? They just change the subject.

With a similar experience, Sara stated:

We’ve just lost, I would probably say 80% of our friendships over the last 15 years. Even some of those ones that were close, I think just couldn't handle hearing the crazy, they couldn’t handle hearing what all our daily life consisted of, or they got tired of hearing it.

Subtheme three, Loss of Self, describes the effects on the mother’s own identity as a result of the day to day behaviors toward them by their child or children with early complex trauma and attachment issues. Mothers used different language to describe this phenomenon and different aspects of themselves were identified, but they all reflected a sense of being whittled away, made different, or losing their identity, and
often losing parts of themselves they liked. Julia reflected on her sense of self related to her children’s behaviors:

It’s not only dealing with the effects of their trauma and what it causes their behaviors to be, but then defending yourself on a daily basis to outsiders that don’t understand and think that you’re the problem. Um, it is belittling. I am a shell of what I once was, and I don’t think I’ll ever get that back.

Ava described this loss of self as, “It’s like as a person you don’t exist anymore, you’re just a person that keeps her alive and moving through life so that one day, hopefully, she’ll be okay. That’s it, that’s all you have.” Vicky explained her loss of self in relation to a specific push away behavior:

She hated me to laugh, and she would ridicule [me] so I felt ridiculed, I felt like I was embarrassing her or like I was doing the wrong thing when I would be light-hearted, or laugh, or make a joke. She didn't like that at all. It would extremely upset her. So I really quit laughing. So I just shut down one piece at a time for a long time.

Loss of self was not always seen as entirely negative or as regret but was often expressed as difficult to explain. Katie has reframed the loss of who she was to a more positive view:

I mean I would just say unless you have lived it or walked it, it is very difficult to explain. It is very difficult to even put into words the effects, emotionally, spiritually, physically on every fiber of your being. I am by far not the same person. I have grown, I have changed. Would I do it all again? Yes. Pregnant pause, yes. Because I do feel like I am a better person, but only because I have had to work so hard at understanding someone else, not necessarily for of all the shit that we have been through.

The third theme Push/Pull is representative of the relational dynamics that happen as a result of interactions with the child with early complex trauma and attachment issues. Threatened by attachment but also craving it, the child with early
complex trauma and attachment both pushes the mother away and seeks her closeness. The child may also pull towards others he or she can manipulate with lies in an attempt to garner pity for themselves and judgment toward the mother. Unfortunately, participants experienced this blame from friends, family, police, and mental health professionals. The continuous Push/Pull behaviors also left mothers feeling isolated from others and fundamentally changed.

Theme Four: Changes in Patterning

Consistent with Rogers’ (1992) science of unitary human beings, is the belief that both mothers and children have unique energy patterns that interact with one another as their bodies are near one another. Both patterns are changed from this interaction creating a new pattern that can be temporary or permanent. Behaviors are a manifestation of one’s energy pattern and are a way in which we are able to observe patterning (Rogers, 1992). The subthemes within this theme include Child Behaviors, Energy Interactions, and Long-term Effects of Patterning Changes. All participants experienced and conveyed both temporary and permanent changes in patterning, representative of the mothers’ lived experiences and most clearly reflecting the interactions demonstrated by the conceptual framework.

Child Behaviors refers to behaviors exhibited by the child with early complex trauma and attachment toward the mother that are consistent with the child’s spiky protective energy depicted in the conceptual framework (Appendix B). The behaviors of the child with early complex trauma and attachment are a result of the child’s patterning that is chaotic, fearful, and focused on survival and control. The child
exhibits behaviors that push the mom away and create an environment of chaos. In this way, the child is in control and in an environment that feels familiar, both of which create a false sense of security for the child. Common child behaviors reported by participants included stealing, destroying property, death threats toward the mother, attempting to harm the mother, purposely soiling themselves or using the bathroom in inappropriate places, rages, lying, inappropriate sexual behaviors, and lack of empathy. Lisa recounted:

It [mothering a child with early complex trauma and attachment issues] is the most difficult thing I have ever done. Because of stealing and destruction we had to have locks and cameras. My son wanted me dead and so I could not leave a drink unattended. I had to constantly be aware of what he was doing...We lost family dinners because he would throw up on purpose at the table. Every night.

All participants who were asked (12 because the question was added later), acknowledged the occurrence of the phenomenon of sensing the child’s energy even before a physical interaction had taken place, and feeling the pattern change within themselves. The subtheme *Energy Interactions* encompasses the experience of the mother feeling the child’s energy within herself. While the descriptions were different, the participants all described the sensation in a negative way such as sucking, heavy, gross, panic, vibrating, and tense. If the participant had children without early complex trauma and attachment issues, they reported the sensation as very different, even when the neurotypical child was upset or angry. Andrea stated, “The effects on me. He wears me out. Sometimes I feel like he just sucks everything out of me.” Similarly, Mary stated, “When he was younger, it felt like he sucked the very marrow out of my bones,
he was so tiring. I literally needed to sleep after some interactions.” Julia described, “As soon as she walked in the room I could just feel my shoulders going up into my ears.

Oh, here she comes, what is it? Because it was take, take, take, take, take, just sucking the life out of the room.” Sara described:

Once I had put her to bed for the night and I started to let my guard down. If she came out of her room it was immediate panic because you had started to relax and then you had to basically put your armor back on. What’s the next battle going to be? Absolutely I can feel her energy walking into a room and knowing whether or not she is in a regulated spot or not.

Ava described:

Oh my word, her entire Elementary [school years], every time she would get in the car, it was like every time she would get in and that door would shut, you would feel like when you go outside and you can smell and feel like a thunderstorm coming, like you knew it. She didn't have to say anything, she didn't have to look at you, you can just feel that. It's almost like they are vibrating in their skin and then it just kind of flows off of them. And you know, if you have parented trauma kids for 5 minutes, you know that feeling and it triggers in me just a horrible [sensation], like where you're like tensing your whole body up and you don't know what direction that energy is going to take. It can be a meltdown crying, it can be raging, it can be I'm going to go seclude myself, and you don’t, you just never know.

Katie describes the differences in the energy of her child with and her children without early complex trauma and attachment issues:

[The child with early complex trauma and attachment issues] is a highly energetic kid, not in the sense that he's always excitable, but he has lots of energy. And it's either good, but more often than not, it's bad. My energy responds to that pretty quickly. He walks in and it just kind of this weight that you can automatically feel. Yeah, that’s it. I'm relaxed, and then he walks in and I'm heightened. That is my energetic response to his energy, but I can tell, even without seeing the look on his face, if we are going to have a good day or not. If we're going to have a good next 5 minutes or not...I can still sense their [the neurotypical children] energy, but it's not as heavy, if that makes sense. It is a lighter energy. It's more a presence versus a weight. I don't think I've ever really
even thought about that, to express that. But I know when they are there and it’s a good thing. Even when they are out of sorts, it’s not a heavy weight, in an energetic sense. I think they are more aligned.

The energy interactions discussed above are indicative of the immediate and short term feelings or brief pattern changes experienced by the mothers of children with early complex trauma and attachment issues, but there were also Long-term Effects of Patterning Changes experienced by the mothers as well. Such long-term effects are related to the continued exposure to the child’s chaotic energy to the extent that the mother’s patterning does not return to her baseline or established pattern (which was present prior to adoption). The most consistent changes reported by the mothers were intellectual, physical, emotional, and social. Intellectual pattern changes included reports of brain fog or difficulty with cognitive tasks. Physical effects included diagnosed or suspected autoimmune diseases, fatigue, and chronic pain. Emotionally, mothers expressed significant stress and sadness. Socially, mothers reported feeling lonely and isolated, and had difficulty relating to others parenting children without early complex trauma and attachment issues. Julia explained continued effects despite her children with early complex trauma and attachment issues now living outside her home:

I used to be very outgoing. Um, I used to thrive on social events. I dread them now because I feel like I can’t interact appropriately. I don’t, I don’t fit in anymore, and also I can’t seem to focus on what they’re talking about, as far as my mind is just elsewhere a lot. Especially, I find myself getting bitter with them because they’re talking about mundane stuff that I’m jealous of. I used to be a very quick learner at work. I can’t process any more, quickly. I can’t be put on the spot anymore, because I can’t think of the answers quickly. Um, it’s affected my job. It’s affected my work progression and growth. I hurt all the time.
The fourth subtheme, *Coping Strategies*, refers to the methods reported by the participants that enabled them to adjust to pattern changes and cope with the interactions with their children with early complex trauma and attachment issues. Exercise, faith, food, energy work, and pets were some of the coping methods reported. However, all participants reported the friendship and support of other mothers with children with early complex trauma and attachment issues were a positive aspect to their experience and some moms used even stronger language. For example, Lisa stated, “Meeting other moms dealing with similar issues saved me.” Andrea reflected on the difficulty of helping her son move through healing. Children with early complex trauma and attachment issues resist attaching and allowing parents to help them. This process feels very scary to them and they “kick and scream” both literally and figuratively as their mother helps move them from a place of trauma to healthy relationships “on the other side”:

I’m a fixer and if I can’t fix it I blame myself. “Oh you’re just not trying hard enough, you’re not doing enough.” It’s good to be with the women and hear them and know that there’s these other people that are going through this same hell and trying to come out on the other side and trying to drag those children kicking and screaming [to] the other side. Because you know they don’t want to come. They don’t.

Similarly, Sara explained a positive aspect of mothering a child with early complex trauma and attachment issues:

I think some of the positives would be like finding you, going to a retreat or group or something that opens your eyes to that you’re not on this parenting journey alone. There are other moms going through essentially exactly what you’re going through. I think so many of us can tell the exact same stories, and
it's just a different kid, but the exact same experiences. So that has been probably the most positive in just helping your mental health and knowing you're not alone.

Ava also found other methods of coping:

And get a dog. My parents dropped the puppy off for my daughter about six weeks ago, and of course she loved it until they left, and now she wants nothing to do with it. So I take care of him all day, and I'm his favorite, and that probably more than anything else, if you have a child that isn't going to harm animals of course, because my daughter has never shown any aggression towards animals. Honestly, having that unconditional love from something else, it's not like from a spouse. I'm serious, I'm not even a dog person, I don't even like animals, but this dog is the seriously the most healing thing I've had in my entire time parenting her. He is my baby and I am not ashamed. I [also] picked up a hobby. I picked up knitting, because my doctor said that even with the arthritis, I knit very slowly but, that it can be kind of meditative with the repetitive motions. So, while I can't knit very fast or very much I have noticed that that is very helpful. It requires me to physically do it and think about it and it just doesn't leave any time to dwell on her when I'm doing that. So I think that, plus any kind of meditative thing you can do, whatever that means for you personally is really helpful.

Consistent with Rogers’ (1992) science of unitary human beings, is the belief that both mothers and children have unique energy patterns that interact as they are near one another. Their individual patterns are changed from this interaction. The new pattern can be temporary or permanent. Behaviors are a manifestation of one’s energy pattern and are a way in which we are able to observe patterning (Rogers, 1992). All participants experienced and reported both temporary and permanent changes in patterning as a result of the interactions with their child or children with early complex trauma and attachment issues. The subthemes Child Behaviors, Energy Interactions,
Long-term Effects of Patterning Changes, and Coping Strategies represented both the lived experiences of the mothers and supported the conceptual framework outlined in Chapter One.

Conclusion

This chapter provided the study’s results including summaries of the four themes and twelve subthemes that emerged from the data. Details of data management and analysis, processes of theme development, and participant and setting descriptions were discussed. Giorgi’s (2009) procedures and Saldaña’s (2013) first and second cycle coding instructions were used to guide data analysis. Descriptive, In Vivo, emotion, and process coding were used for first cycle coding. The codes were then condensed through reflection and second cycle pattern coding. Themes emerged from the groupings of codes.
CHAPTER V
DISCUSSION

Recognizing the national campaign to improve the lives of mothers and children in the United States and acknowledging the value of the lived experience to developing such improvements, the purpose of this study was to explore the experiences of adoptive mothers of children with early complex trauma and attachment issues. A phenomenologic study was conducted that answered the research question: What is the lived experience of adoptive mothers of children with early complex trauma and attachment issues? Research related to early complex trauma and attachment is limited and mothers’ roles in the research and literature have been nearly exclusively depicted as causative variables for healthy or unhealthy attachments. In places where these adoptive mothers’ voices have been shared, such as blog posts, message boards, and social media, there is an overwhelming expression of loneliness, struggle, fear, and frustration. By exploring these mothers’ experiences and the meaning attached to those experiences, nurses and other healthcare providers will be able to more effectively provide support, education, and health promotion. Further, bettering the mothers has the potential to not only affect their lives but the lives of their children.

Although this is a unique study in an area with little previous research, congruencies were found between this study’s results and the works of others. These
congruencies are included in the discussion of findings to follow. Similarities in the lived experiences of mothers of children with challenges other than early trauma and attachment issues were also found and are included as well. The researcher also presents areas in which this study’s findings are unique and have not been previously reported.

This chapter provides a discussion of the findings presented in Chapter Four including the similarity to findings in other studies, trustworthiness of the data, rigor of the study, and study limitations. Implications of the study’s findings in the areas of clinical practice, political or policy practice, educational practice, and research are included. Finally, the researcher provides a reflection of the study and research process.

Discussion of Findings

Four themes and twelve subthemes captured the lived experience of being a mother to a child with early complex trauma and attachment issues as reported by the fourteen participants who took part in this study. Adoptive mothers of children with early complex trauma and attachment issues were recruited from a social media subgroup of an online support group with over 20,000 members. Themes and subthemes emerged as consistent experiences in the experience of being a mother of a child with early complex trauma and attachment issues. In total 14 mothers were interviewed before data saturation was confirmed.

Theme One: All Consuming Vigilance

The first theme is All Consuming Vigilance with two subthemes, Safety For and From My Child and Becoming a Trauma Expert. All consuming vigilance refers to a level
of alertness, attention, and caution required by mothers of children with early complex trauma and attachment issues that exceeds that of normal parenting. The vigilant mother is constantly aware of, and her energy is consumed by, issues of safety and advocacy for her child. The level of mental, physical, and emotional vigilance required to parent a child with early complex trauma and attachment issues is also associated with little to no respite whether or not the mother was able to be away from her child.

The Attachment and Trauma Network (n.d.) validates the need for safety for the adoptee and others and the importance of safety as part of therapeutic parenting. Successful therapeutic parenting must include attention to safety, connection, structure, nurture, and frequent reevaluation - all focused on a child fearful of attachment and exhibiting the rejection behaviors mentioned above. Both actual and perceived safety must be a priority. In fact, the actual safety of each member of the family, including the adoptee, can be of concern due to the adoptee’s behaviors (Attachment and Trauma Network, n.d.). While the necessity of safety is documented in general resources regarding early complex trauma and attachment and therapeutic parenting, no other studies of parents’ lived experiences were identified that shared the experience of such intense vigilance focused on safety for and from a child.

Two qualitative phenomenological studies corroborated the experiences of limited respite for mothers of children who require higher levels of supervision. The struggle of limited respite was documented as part of the lived experience of mothers who have more than one child with an intellectual disability (Kimura & Yamazaki, 2013). Similar to the findings of the current study, Kimura and Yamazaki (2013) also linked the
limited respite to difficulty finding someone able or willing to properly supervise the child or children and to the mothers’ feelings of mental and physical fatigue. Limited respite due to the challenge of finding someone capable of caring for their child was also part of the lived experience of caregivers of children with special needs (Redquest, Reinders, Bryden, Schneider, & Fletcher, 2015). Redquest et al. (2015) interviewed caregivers of children with physical and developmental disabilities and also found experiences of social isolation and difficulty finding childcare. Although the participants were not limited to mothers in the Redquest et al. study and the children’s challenges differed, the caregivers’ challenges of finding respite care providers and the mental, physical, and social effects of caring for the child was a common finding amongst the studies.

The mothers’ vigilance extended to seeking help and healing for their children with early complex trauma and attachment issues. Participants reported having to educate themselves regarding early complex trauma and attachment issues and how/where to access care for their children. Findings from a study conducted by Carlsson, Miniscalco, Kadesjö, and Laakso (2016) substantiated these findings. Parents of children with autism also had to educate themselves, educate healthcare providers, and advocate for their children. The findings also suggested that parents needed more support throughout the diagnostic process and obtaining resources for their child (Carlsson et al., 2016). Again, the diagnoses differ, but the parental experience is similar.
Smit (2010) conducted a qualitative study exploring healthcare needs of adoptive families. Although the study’s purpose was to “identify and describe the healthcare experiences of families with an internationally adopted child,” the authors did not address any aspects of health besides physical (Smit, 2010, p.253). One of the four themes “Vigilance: Is my child healthy today? Will my child be healthy tomorrow?” mirrored this study’s theme of vigilance, but Smit did not address mental health, safety, or advocacy. However, the shared theme of vigilance indicates a commonality in the commitment and attention of adoptive families.

Theme Two: Adjusting Expectations

The second theme, Adjusting Expectations, includes three subthemes, Moving from Traditional Parenting to Therapeutic Parenting, Relationship With the Child, and Fixing the Trauma. Adjusting expectations refers to the realization that the parenting of, the maternal/child relationship with, and the healing of a child with early complex trauma and attachment issues is different from traditional parenting roles and expectations. Although experiences varied, every participant verbalized the experience of adjusting their expectations.

Mothers shared the realization that the child or children with early complex trauma and attachment issues could not be successfully parented by traditional parenting techniques and that therapeutic parenting is not instinctual. The participants’ reports of therapeutic parenting necessity and interventions are consistent with the recommendations of the Attachment and Trauma Network (n.d.). Therapeutic parenting and attachment-informed therapy can assist the child in healing and promote
proper storage of traumatic memories. Increased structure with consistent routine and boundaries contribute to the child’s feelings of safety, but the structure must be enforced by parents in a calm, kind, connected, and respectful manner (Attachment and Trauma Network, n.d.). If a parent responds to the rejection behavior of a child with early complex trauma and attachment issues with anger, withdrawal, or leniency, the child internalizes the message that the parent is unsafe, uncaring, and not strong enough to handle the child’s biggest and darkest feelings. This further perpetuates attachment issues.

Mothers explained their adjustment from what they wanted or expected their relationship with their child to be to the reality of what is. Within this theme was the mothers’ expressed commitment to their child or children despite the challenges. This commitment was also recognized by Wimmer (2010) who reported a theme of adoptions being “unquestionably permanent” (p.124). Follan and McNamara (2013) explored parents’ experiences caring for children with reactive attachment disorder (RAD). The aim of the Follan and McNamara study was to better understand how the parents make meaning of their parenting experiences. They reported the participants being committed to their child despite challenges (Follan & McNamara, 2013). With an association strengthened by participant similarities, the Wimmer (2010) and Follan and McNamara (2013) studies substantiated this study’s findings of the mothers’ expressed commitment to their child or children despite the challenges faced.

The mothers also shared experiences of adjusting their expectations from being able to completely heal their child’s trauma to accepting their inability to assure healing
for their child. No research articles were found reflecting similar findings. Somewhat surprisingly, there were also no articles found that specifically reflected a mother’s experience of adjusting expectations or a general process of adjusting expectations in relation to normal parenting or to a child’s particular diagnosis. However, the more general search terms “adjusting parental expectations” yielded more than twenty million results. It seems that the adjustment of parental expectations is a much more common occurrence, as is the expectation of easy and/or instantaneous healing, than is reflected by current research, though experiences specific to mothers are virtually indiscernible in the literature.

Theme Three: Push/Pull

The third theme, Push/Pull, and subthemes Blame from Others, Loss of Relationships, and Loss of Self are representative of the relational dynamics that happen as a result of interactions with the child with early complex trauma and attachment issues. Threatened by attachment but also craving it, the child with early complex trauma and attachment issues both pushes the mother away and seeks her closeness. The push-pull interaction between the child and the mother is consistent with the “nurturing enemy” relational dynamic described in which the mother is both the nurturer and the adversary to the child (Institute for Attachment and Child Development, 2016, para. 2). Blaming the mother by others can occur as a result of others’ perceptions of the child’s behaviors and the mother’s responsibility when those behaviors occur or as a direct result of the child lying about the mother. Cummings (2018) validates the misunderstanding of therapeutic parenting in the blog post, “Why
Parents of R.A.D. Children Always Look Like A**holes” by giving examples of therapeutic parenting which makes the parent seem overbearing or strict to others. Participants also reported blaming from healthcare providers. Similarly, Smit (2010) reported a theme “importance of support by healthcare providers: do they know or care” which reflected adoptive families’ experiences encountering healthcare providers who were not aware of unique needs faced by international adoptees and their families nor did they seem interested in learning (p. 254).

Most participants, if not all, reported experiencing loss of relationships related to parenting a child with early complex trauma and attachment issues although the reasons for the loss differed. Some participants reported the loss occurred as a result of others’ judgments of the mother based on the child’s behavior or lies about the mother created by the child. Other participants reported avoidance of the child or child’s behaviors as the reason for the loss of relationships. Still others reported others’ inability to handle the realities of mothering a child with early complex trauma and attachment issues as the reason for avoidance of the mother and a subsequent loss in relationship. The mother of a child with Reactive Attachment Disorder (RAD), who was interviewed by Ahmann and Dokken (2013) about “making meaning” when parenting a child with mental illness, reported feeling isolated, misunderstood, and judged by others (p.202). Though brief, the mother’s reported experiences in the Ahmann and Dokken (2013) article were quite congruent with the experiences of the participants of this study.
Theme Four: Change in Patterning

The fourth theme is *Change in Patterning* with four subthemes which are *Child Behaviors, Energy Interactions, Long-term Effects of Patterning Changes, and Coping Strategies*. Consistent with Rogers’ (1992) science of unitary human beings is the belief that both mothers and children have unique energy patterns that interact with one another as their bodies are near one another. Their individual patterns are changed and new patterns formed which can be temporary or permanent. Although individuals’ energy patterns are unique, their continuous motion and infinite interactions result in continuous pattern changes (Rogers, 1992). Although behaviors are not the energy field but rather the manifestation of it, the interaction and change in pattern can be observed in behaviors (Rogers, 1992).

Child behaviors described by the participants were identical or very similar to those given by the Institute for Attachment and Child Development (2016) such as threats to their own or others’ safety, inappropriate sexual behaviors, lying, or stealing. No behaviors were mentioned by participants that were inconsistent with the published norms for early complex trauma and attachment behavioral issues. While the behaviors are documented elsewhere, the description of the behaviors as a patterning change due to early complex trauma and attachment issues is unique to this study. Also unique to this study is the description of the interaction between the mother’s patterning and the child’s patterning.

The idea of energy interaction encompasses the experience of the mother feeling the child’s energy within herself. The energy interactions reported by the
participants were indicative of the immediate and short term feelings or brief pattern changes experienced during interaction with their child with early complex trauma and attachment issues. Feelings can also be a way to identify pattern changes. Although other researchers have completed studies using Rogers’ theory, no studies were found that utilized Rogers’ science of unitary human beings to explain interaction in this way. This researcher believes that the unique way in which the child’s survival instinct results in his or her pushing the mother away and pulling close to her in a way that is not “normal,” causes the mother to recognize the patterning change because it is out of the ordinary. For example, one’s heart can beat normally hundreds of times per day and not be noticed, but a premature beat is noticed because of the unusual sensation. In the same way, participants were able to immediately identify the occurrence of feeling the energy of their child with early trauma and attachment issues and describe it when asked. Long-term effects of patterning changes are related to the mother’s continued exposure to the child’s chaotic energy to the extent that the mother’s patterning does not return to her baseline or established pattern (which was present prior to adoption). The ideas of energy interaction between mother and child and long-term effects of patterning changes related to those interactions are unique to this study.

*Coping Strategies* refer to the methods used by the participants to help them adjust to pattern changes or return their patterning to their baseline pattern. Although the relationship between coping strategies and patterning is unique to this study, the idea of coping certainly is not. The mother mentioned above, who was interviewed by Ahmann and Dokken (2013), coped with her feelings related to parenting a child with
attachment issues by developing a therapeutic parenting support group. Participation in a similar group, or developing friendships with other mothers of children with early complex trauma and attachment issues was a primary area of support and coping for the mothers in this study. Coping and support were also discussed by Kimura and Yamazaki (2013) and Redquest et al. (2015) who found that the mothers in both studies were looking for ways to cope with the challenges of special needs parenting and find positive aspects of their experiences. Although not explained through patterning, this search for coping mechanisms could certainly be viewed as the mothers’ search for a means to return to baseline patterning.

Although the second research question, What effect does the experience of mothering a child with early complex trauma and attachment issues have on the adoptive mother’s physical, emotional, intellectual, spiritual, and social health, was written in anticipation of the areas in which the mothers could be affected, and it did serve as a guide for prompting during the interviews, the answers and ways in which the mothers were affected were much more complex than the simplicity of the question. Consistent with Roger’s (1992) assertion that humans are “irreducible wholes,” participants often answered questions about effects of the experience on their physical, emotional, intellectual, spiritual, and social health with answers that overlapped one another. For example, some participants linked emotional effects such as stress to physical effects such as brain fog or difficulty concentrating to intellectual effects such as difficulty learning new things and/or poor job performance.
Even more than the researcher initially anticipated, the conceptual framework proved to have a significant correlation with the lived experiences of the mothers. The researcher was originally hesitant to ask the participants a question specifically about energy interaction, but once interviews were begun, she realized that aspect of the interaction was not being captured. Two new questions were added after discussing this issue with the dissertation committee chair: Can you tell me about a time when your child walked in the room and without any interaction you could feel their energy? If you have a child without early trauma and attachment, how is this different? Every participant who was asked the new question(s) (n=12) had an immediate recognition of the experience. However, even when not answering that specific question, the answers to how mothering a child with early trauma and attachment issues affected them, more easily fit the conceptual framework than the four discrete areas (physical, emotional, intellectual, and spiritual) would suggest.

Much of the experience of mothering a child with early complex trauma and attachment issues is directly related to the interaction depicted by the conceptual framework developed by the researcher as inspired by Rogers’ (1992) science of unitary human beings (Appendix 2). Themes All Consuming Vigilance, Push/Pull, and Changes in Patterning are all very closely related to the conceptual framework as energy interactions between mother and child contributing to physical, emotional, intellectual, and spiritual effects. In contrast, Adjusting Expectations occurs more unilaterally than relationally and is a more universal parenting experience differing only in intensity. The subthemes Energy Interactions, Long-term Effects of Patterning Changes, and Coping
Strategies, as they relate to patterning, are unique to this study and the researcher plans to explore these areas in more detail throughout her career.

The researcher did not include social in the discrete areas (physical, emotional, intellectual, and spiritual) affected by being the mother of a child with early complex trauma and attachment issues because the researcher suspected social effects were encompassed in the other areas. For example, not being able to continue to work would be intellectual and social, or church attendance would be spiritual and social. This did turn out to be true, but loss of relationships (also emotional) was so prevalent that it is a subtheme. Spiritual effects were not largely reported by the participants other than several who experienced the loss of church attendance due to their child’s behaviors and/or safety issues. Emotional and intellectual aspects were the areas in which participants reported the most effects and were also the areas that the participants felt had the most impact on other aspects of their lives and experiences.

Unfortunately, there is very little research on the effects of any aspect of parenting on mothers. Broad literature searches for “mothers’ lived experiences” or “mother of [numerous child diagnoses and attributes]” found few matches. While some of the findings were validated by other studies, limited research in this area, the uniqueness of the descriptions of energy interactions, and the overall limited research regarding mothers’ experiences highlight numerous implications for the study’s results.

Trustworthiness / Rigor

Lincoln and Guba (1985) identified four specific techniques that promote trustworthiness in qualitative studies. These techniques include credibility,
dependability, confirmability, and transferability. Five practices specifically promoted credibility of this study’s interpretations and findings. Prolonged engagement and persistent observation promoted credibility through the practice of being present with and learning the culture, and establishing trust to the extent that the researcher was able to recognize distortions that might occur as well as identify events that were salient to the experience being studied (Shenton, 2004). This researcher is an adoptive mother of children with early complex trauma and attachment issues which allowed her “an early familiarity with the culture” and an enhanced ability to develop rapport with the participants (Shenton, 2004, p. 65). Further, questions were rephrased or clarifying questions were asked if needed. Persistent observation also occurred as much time was spent reading and rereading the transcripts.

Recognizing the risk of “going native” (Lincoln & Guba, 1985, p. 303) and losing perspective as a researcher as a threat to the credibility of the study’s findings, this researcher included several additional practices due to sharing characteristics of the population being studied. First, in alignment with Giorgi’s (2009) guidelines, the researcher practiced bracketing in which the researcher’s experiences were set aside through conscious choice, identification of personal assumptions and biases, and journaling. The researcher made an intentional and overt decision to listen to each interviewee as if she had no experience or understanding of the topic. Participants knew the researcher had experience but would be asking for clarification on topics as if she did not. Triangulation occurred due to the different ages of the participants and their children, diversity of geographic locations, mix of adopted and biological children,
variety of domestic and international adoptions, sex of children, marital status, and occupations. Interviews were conducted until saturation was reached and the dissertation committee chair, an experienced researcher and not associated with the phenomenon being studied, also analyzed the data and concurred with the emergent themes. Peer debriefing occurred with the researcher’s dissertation committee chair through the data collection and analysis phases. Methodologic, theoretical, and analytical topics were discussed as well as processing the sometimes emotionally difficult content.

Dependability was established when credibility was demonstrated and was further strengthened by inquiry audit which has occurred as the researcher’s dissertation committee chair has guided and supervised this research (Lincoln & Guba, 1985). Confirmability was documented by establishing an audit trail of evidence and the researcher’s thought processes regarding data analysis which can be followed by others (Lincoln & Guba, 1985). The audit trail included the researcher’s journals which were also considered in the data analysis process. Journaling along with frequent debriefing with the dissertation committee chair addressed the researcher’s own assumptions and biases in order to confirm the study’s findings as true to the participants’ lived experiences. The raw data (transcripts) were provided to the dissertation committee chair and will be maintained by the researcher according to Mercer University protocol. Data reduction and analysis documents have been provided to the dissertation committee chair and will be kept by the researcher along with field notes and journaling. The determination of a study’s transferability will be made by future
prospective users of the data, but the researcher is responsible for providing findings which make this determination possible (Lincoln & Guba, 1985). Rich, thick descriptions have been obtained and a detailed audit trail will be maintained to promote transferability.

**Limitations**

Potential limitations of the study identified prior to the study included the potential for all mothers who participate being overly positive or negative which would skew the results, the possibility the data would not be reflective of the experience of mothering a child with early complex trauma and attachment issues if the participant’s experience was more reflective of healthy attachment, a novice researcher was conducting the study, and unexpectedly, there could be too few participants to reach saturation. Both positive and negative views and experiences were shared by the participants with no consistent polarization noted. Saturation was reached with the participants reporting similar experiences reflective of a unique parenting experience rather than healthy attachment. A novice researcher conducted the research, but efforts were made to decrease the impact on the study through regular contact with and guidance by the dissertation committee chair, an experienced researcher.

There were no limitations related to setting as the participants were able to choose a time and place suitable for them to be able to speak freely by phone or they could choose to complete the interview by email. Each of the participants who chose to complete the interview by email answered follow-up questions when clarity was needed. If the email respondents had not answered the follow-up questions, the data
would have been much less thorough. There were no issues with technology (including recording) or the telephone. Occasionally a word or phrase was difficult to understand or inaudible on the recording, but there were no instances in which this affected the overall understanding or meaning of the experience. There was no difficulty with communication or need for interpreters. There was no travel involved in the study for participants or researcher. No costs were accrued except the purchase of a digital recorder. Although the participants were varied in demographic variables, it is possible that their experiences could be skewed in some way because they all are members of a support group for mothers of children with early trauma and attachment issues.

Implications

In researching an area that has rarely been studied, and has never been studied in this way, the researcher has verified on a small scale the idea that mothers are affected by the interaction with a child with early complex trauma and attachment issues and themes emerged from the data as a description of the lived experience. Even when not supported by identical research, most of the subthemes were supported by literature or research regarding other types of special needs parenting. This support along with the consistency of the experiences reported by the participants of this study lends itself to confidence in suggesting implications for study findings. The study design and findings, specifically in the area of patterning gives rise to new questions and implications for research. The overall lack of research in this area indicates many questions remain and suggests a need for much more research.
Clinical Practice Implications

As part of the interview, participants were asked what they wished healthcare providers knew about parenting a child with early complex trauma and attachment. The most common responses were that the providers cannot know how hard it is unless they have lived it, believe the mother, and don’t blame the mother. Some variation of these responses was given by nearly all participants. Only one participant expressed she had an understanding healthcare provider, and that provider was also an adoptive mom. Though the number of participants was small, their common experience with healthcare providers, despite numerous other demographic differences, indicates there is likely a very significant lack of understanding about the effects of early complex trauma and attachment issues on the child as well as the mother. This is consistent with a lack of research in this area. This researcher hopes to disseminate the findings of this study to a variety of healthcare provider audiences in order to educate and promote understanding and compassion for children with early complex trauma and attachment issues and their mothers. Further research regarding the specific healthcare needs of this population of mothers such as the potential for higher stress and stress-related illnesses, and the need for focused, individualized screenings and interventions are also recommended.

Political or Policy Practice Implications

The most concerning political or policy implication revealed during the study came from a mother who reported that in order to access care for her 13 year old son who needed intense psychiatric care, she had to relinquish custody of him to the state.
This is a heartbreaking reality that should not be necessary. Would there be action by policymakers or a public outcry if children had to be relinquished in order to receive care for a physical ailment? Multiple participants also reported difficulty finding mental health resources for their children with early complex trauma and attachment issues. Lack of insurance coverage for psychiatric issues, lack of knowledge regarding the significant safety concerns surrounding early complex trauma and attachment issues, limited placements for mentally ill children, providers’ tendency to blame the mothers rather than address the child’s issues, and stigma related to mental health issues likely all contribute to issues related to access of care. These are issues that need to be addressed on a legislative level to create needed change. However, advocacy is needed from others besides mothers and widespread education is needed for that to occur.

Educational Practice Implications

A widespread lack of knowledge and understanding was encountered by the participants from friends, family, and professionals including teachers, counselors, law enforcement officers, social workers, and healthcare providers. Some of the participants attributed this to skillful manipulation by the child with early complex trauma and attachment issues and/or the natural tendency to believe a child would not or could not be manipulative to the level seen with early complex trauma and attachment issues. The participants also shared that they were doing their own research regarding therapeutic parenting, attachment behaviors, and therapies.

Several mothers specifically reported little to no education regarding early complex trauma and attachment issues from the adoption agency/foster care system
that placed their child with them. Certainly, education will need to be conducted in multiple areas/agencies to increase awareness and build the knowledge base of providers. Perhaps a trauma-informed nurse can make a change in one small school/office/hospital/prison/foster care agency which will lead to changes locally, then statewide, then statewide, then nationwide, then globally. Ultimately, prevention and early treatment of childhood trauma would be the goal of this campaign, but in the meantime, mothers can be supported and given tools which in turn helps support the child with early childhood trauma and attachment issues.

Research Implications

The research implications for this topic are vast due to the lack of research in this area. Hopefully, this study will be the catalyst for more research about the experiences of mothers of children with early complex trauma and attachment issues and their long-term effects. The number of children affected by trauma is significant as is the number of mothers who care for them. Although this study’s population was adoptive mothers, anyone who is a primary caregiver for a child with early complex trauma and attachment issues can have similar experiences to the ones reported by this study’s participants. The impact on the children, the caregivers, and the community is significant and any research which can lessen that impact at any point in the process should be considered.

Findings from this study highlight a number of areas where further research is needed. These areas include: quantitative studies of the effects of mothering a child with early trauma and attachment issues (including biological, foster, step, grandparent,
and guardian primary care providers), further study regarding the interaction between mother and child with early trauma and attachment issues, more thorough research on methods of coping and support for mothers of children with early trauma and attachment, and occurrence of autoimmune issues in this population. Although not the focus of this study, data also revealed some areas of research not directly related to the mother of a child with early trauma and attachment issues such as variables that affect a child’s response to trauma, variables that affect a child’s healing, therapists’ understanding of trauma, best practices for educating professionals about trauma, professionals/others’ tendency to blame mothers, and occurrence of barriers to care including custody.

Researcher Reflections

I am immensely proud of this research and being part of a group of mothers who do the incredibly hard work of loving children who can’t love them back. It feels like a holy endeavor to hold and now tell their stories. I am humbled and grateful that these fourteen mothers trusted me with the some of the most intimate details of their lives. I am proud to be the first researcher to study this experience and the energy interaction between mother and child. I look forward to developing this work.

There are few things in my life I feel worthy of being considered a “calling.” Nursing was the first calling I acted on and I have never regretted that decision. I practiced nursing as a phenomenologist long before I knew I was one. Long before I ever thought of becoming a nurse, as a young child, I knew I would adopt. Being an adoptive mom is the hardest thing I have ever done and is still the hardest thing I do
every single day. It is absolutely a calling. I tried to do a number of other dissertation topics, and any one of them would have been a fine topic, but they weren’t topics I believed in. Gandhi said, “To believe in something, and not live it, is dishonest.” I believe adoptive moms of children with early trauma and attachment issues are the strongest people I know and their stories and struggles need to be told. This is just the beginning of my calling.

Conclusion

The purpose of this study was to explore the experiences of adoptive mothers of children with early complex trauma and attachment issues. A phenomenological study was conducted that answered the research question: What is the lived experience of adoptive mothers of children with early trauma and attachment issues? Four themes and twelve subthemes emerged from the data. The four themes were All Consuming Vigilance, Adjusting Expectations, Push/Pull, and Changes in Patterning. These themes and their subthemes encompass the physical, emotional, intellectual, spiritual, and social effects of the experience of being an adoptive mother of a child with early trauma and attachment issues. This chapter provided a discussion of the findings presented in Chapter Four including the similarity to findings in other studies, trustworthiness of the data, rigor of the study, and study limitations. Implications of the study’s findings in the areas of clinical practice, political or policy practice, educational practice, and research were also given. The researcher also provided a reflection of the process.

Of particular importance, several unique findings were documented that may enrich the literature in this area. First, is the experience of intense vigilance and focus
on safety for and from a child. Next, adjusting expectations, particularly in the area of fixing the child’s trauma, was not found in other literature. Finally, the ideas of energy interaction between mother and child and long-term effects of patterning changes related to those interactions are unique to this study, as is the conceptual framework and its use of Rogers’ science of unitary human beings to explain the interactions.
REFERENCES


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APPENDICES
APPENDIX A

CONCEPTUAL FRAMEWORK: FUNDAMENTAL ENERGY PATTERNING
Conceptual Framework

Typical Child Patterning

 +/- Fundamental Energy Patterning

Emotional

Spiritual

Physical

Intellectual

Mother’s Patterning

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APPENDIX B

CONCEPTUAL FRAMEWORK: DISTURBANCE AND SURVIVAL PATTERNING
Conceptual Framework

Mother's Patterning

Emotional
Spiritual
Physical
Intellectual

Disturbance Patterning: Mother’s Inability to Maintain Fundamental Patterning

Survival Patterning: Seeking Chaos and Control

Child With Early Trauma and Attachment’s Patterning

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APPENDIX C

RECRUITMENT POST
Tabatha Anderson IRB Application

Recruitment Post

Study: The Lived Experiences of Adoptive Mothers of Children With Early Complex Trauma and Attachment Issues: A Phenomenological Study

My name is Tabatha Anderson. I am a student at Mercer University in the PhD nursing program and I am also a “trauma mom”. I am conducting a research study about the experiences of adoptive moms of children with early complex trauma and attachment issues and how it affects you physically, emotionally, intellectually, and spiritually. I am posting to ask if you would like to participate by completing an interview (via phone or e-mail) for this research project.

You are eligible to participate if you meet the following criteria: You are an adoptive mother of a child(ren) with early trauma and attachment issues and have parented the child(ren) for more than 5 years. Participants must currently be living in the United States or Canada and be able to read, write, speak, and understand English. Mothers of children living outside the home may participate if the child lived with them for at least 5 years. Participants must have an email address where they can send and receive study documents such as consent forms and interview questions/answers if they opt to not have a phone interview.

Mercer University’s IRB requires investigators to provide informed consent to the research participants. If you would be interested in participating, please click the following link for more information on how to participate: https://www.surveymonkey.com/r/YM9BJ7N

If you have any questions about the study, contact the Principal Investigator Tabatha Anderson by phone, 706-968-0777, or by sending an email to tabatha.peavy.anderson@live.mercer.edu.

Mercer University’s Institutional Review Board (IRB) reviewed study #H1810251 and approved it on 05-Oct-2018.
APPENDIX D

INFORMED CONSENT
Title of Project: The Lived Experiences of Adoptive Mothers of Children with Early Complex Trauma and Attachment Issues: A Phenomenological Study
Investigator Name: Tabatha P. Anderson
Email Contact Information: Tabatha.peavy.anderson@live.mercer.edu

You are invited to participate in an e-mail or phone interview for a research project conducted through Mercer University. Mercer University’s IRB requires investigators to provide informed consent to the research participants.

The purpose of this online research study is to examine the experiences of adoptive moms of children with early complex trauma and attachment issues. Your participation in the study will contribute to a better understanding of the physical, emotional, intellectual, and spiritual effects of parenting a child(ren) with early complex trauma and attachment issues, and potentially improve support by nurses and other healthcare providers. You must be at least 18 years old to participate.

If you agree to participate
The interview will take approximately one hour of your time. You will not be compensated.

Risks/Benefits/Confidentiality of Data

There are some possible risks or discomforts which could cause you to feel uncomfortable, distressed, sad, or anxious due to being asked about and/or discussing the physical, emotional, intellectual, and spiritual effects of parenting a child(ren) with early complex trauma and attachment issues.

There will be no costs for participating. Although your participation in this research may not benefit you personally, it will help us understand the physical, emotional, intellectual, and spiritual effects of parenting a child(ren) with early complex trauma and attachment issues and how to best support mothers in this situation. Your name and email address will be kept during the data collection phase.
for researcher tracking purposes only. Only myself and my dissertation chair will have access to the data during data collection and analysis. No identifying information such as names, location, specific ages, or identifying situational data will appear on the final dataset or in any published research report. You will choose pseudonyms for yourself and your family members prior to the interview which will be used in place of actual names on transcripts and publications. The data will be stored at Mercer University for at least 3 years after completion of the study but will be locked in the graduate studies department. Audio tapes will be destroyed after transcripts are made and verified. Consent forms will be stored separately so that participant’s transcripts cannot be identified.

**Participation or Withdrawal**

Your decision to participate or decline participation in this study is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with me or Mercer University in anyway. If you do not want to participate, you may click “stop survey” or close the browser window at any time.

If you do not want to receive any more reminders, you may email us at Tabatha.Peavy.Anderson@live.mercer.edu.

**Contacts**

If you have any questions about the study contact the investigator Tabatha P. Anderson at 706-968-0777 or send an email to Tabatha.Peavy.Anderson@live.mercer.edu. Mercer University’s Institutional Review Board (IRB) reviewed study #H1810251 and approved it on October 5, 2018.

**Questions about your rights as a research participant**

If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Institutional Review Board by phone at (478) 301-4101 or email at ORC_Research@Mercer.edu.

Thank you in advance for your time and participation!

Please do not forward this link to others.

Please print a copy of this document for your records.
APPENDIX E

DEMOGRAPHIC SURVEY
Tabatha Anderson IRB Application

Demographic Survey Monkey Information

Study: The Lived Experiences of Adoptive Mothers of Children with Early Complex Trauma and Attachment Issues: A Phenomenological Study

Thank you for your interest in this study!

Are you an adoptive mother of a child(ren) with early trauma and attachment issues?
Yes/No

Have parented the child(ren) with early trauma and attachment issues for more than 5 years?
Yes/No

Is the child(ren) with early trauma and attachment issues currently living in your home?
Yes/No

Are you currently living in the United States or Canada?
Yes/No

Do you prefer phone or e-mail interview?
phone/e-mail

Preferred phone number or email address for contact:

Preferred day/time for phone call:

Demographic Data:

1. Age

2. Marital Status

3. Number of Children, Current Ages, Biological or Adopted
4. Current age(s) of children with early trauma and attachment issues, age at adoption, age when began showing symptoms of early trauma and attachment issues

5. A pseudonym unrelated to the participant’s real name that can be used in transcripts, writing

6. A pseudonym(s) unrelated to the child(ren)’s real name(s) that can be used in the interview, transcripts, and writing

Researcher contact information:

Tabatha P. Anderson

(706)968-0777

Tabatha.Peavy.Anderson@live.mercer.edu
APPENDIX F

INTERVIEW GUIDE
Tabatha Anderson

Interview Guide

Study: The Lived Experiences of Adoptive Mothers of Children With Early Complex Trauma and Attachment Issues: A Phenomenological Study

The following questions will be asked of or mailed to participants:

1. Please tell me what it’s like to be the mother of a child(ren) with early trauma and attachment issues?

2. How has being the mother of a child(ren) with early trauma and attachment issues affected you?

3. What changes do you associate with being the mother of a child(ren) with early trauma and attachment issues?
   a. If not answered previously, do you feel mothering a child with early trauma and attachment issues has affected your life physically? If so, how? Tell me how that has felt to you physically
   b. If not answered previously, do you feel mothering a child with early trauma and attachment issues has affected your life emotionally? If so, how?
   c. If not answered previously, do you feel mothering a child with early trauma and attachment issues has affected your life spiritually? If so, how?
   d. If not answered previously, do you feel mothering a child with early trauma and attachment issues has affected your life intellectually? If so, how?
   e. If not answered previously, do you feel mothering a child with early trauma and attachment issues has affected your life socially? If so, how?

4. What dimensions, incidents, and people connected with your experiences stand out for you? (positive or negative)

5. What do you wish you had known prior to mothering a child with early trauma and attachment issues that you know now?

6. If you have children without early trauma and attachment issues or with different types/severities of early trauma and attachment issues, how has the experience of mothering them been different?

7. What do you wish health care providers knew about being the mother of a child with early trauma and attachment issues?
8. Is there anything else you would like to share about the experience of being the mother of a child(ren) with early trauma and attachment issues?

Additional Questions added after the study was begun:

1. Please provide an example of an interaction, incident, or event that you feel captures the experience of being a trauma mom.

2. How do you get a break? Do you have respite? If not, why not? If so, what does that look like? What do you do? How is it to come home?

3. What are your methods of coping? How do you get through each day? How have you learned to manage?

4. Of the behaviors exhibited by your trauma kid toward you, which is the most distressing?

5. What worries about your trauma kid keep you up at night?

6. Can you tell me about a time that your child walked in the room and you could feel their energy? What did it feel like to you?
APPENDIX G

IRB APPROVAL LETTER MERCER UNIVERSITY
Friday, October 5, 2018

Mr. ôtârtoñ Añøróñen
3000 Mercer University Drive
Georgia Baptist College of Nursing
Atlanta, GA 30342

RE: The Long-Distance Experience of Adoptive Mothers of Children with Early Complex Trauma and Attachment Issues: A Phenomenological Study (BC132551)

Dear Mr. Anderson:

On behalf of Mercer University’s Institutional Review Board for Human Subjects Research, your application submitted on 02 Oct 2018 for the above-referenced protocol was reviewed in accordance with Federal Regulations (21 CFR 56.102b) and 45 CFR 46.107 (for expedited review) and was approved under category [y](u) 07 per 45 CFR 46.104.

Your application was approved for one year of study on 02-Oct-2018. The protocol expires on 01-Oct-2019. If the study continues beyond one year, it must be re-reviewed by the IRB Committee.

Form(s) Approved:

A new protocol for a Descriptive phenomenological research study using one or more semistructured interviews will be administered to the participants. Interviews will be recorded and transcribed. The data collected will provide information about the experiences of adoptive mothers of children with early complex trauma and attachment issues.

NOTE: You MUST report to the Committee when the protocol is initiated. Report to the Committee immediately any changes in the protocol or consent forms and ALL adverse events that occur to your subjects as a result of this study.

We at the IRB and the Office of Research Compliance are dedicated to providing the best service to our research community. As one of our investigators, we value your feedback and ask that you please take a moment to complete our Feedback Survey and help us improve the quality of our services.

It has been a pleasure working with you, and we wish you much success with your project. If you need any further assistance, please feel free to contact our office.

Sincerely,

Ava Chandaloo Richardon, Ph.D., CF, CM
Director of Research Compliance
Member
Institutional Review Board

“Mercer University has adopted and agrees to conduct all clinical research studies in accordance with the International Conference on Harmonization’s (ICH) Guidelines for Good Clinical Practice.”

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Mercer University IRB & Office of Research Compliance
Phone: 478-301-4431 Fax: 478-301-3293
3000 Mercer University Drive, Macon, Georgia 31207-0591

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APPENDIX H

IRB APPROVAL LETTER PIEDMONT COLLEGE
October 10, 2018

Tabatha Anderson  
School of Nursing  
Piedmont College  
Demorest, Georgia

Dear Tabatha,

Your research proposal, titled “The Experience of Adoptive Mothers of Children with Trauma and Attachment Issues: A Phenomenologic Study” has been reviewed and approved by the Piedmont College Institutional Review Board. Your approved IRB # is 1803012. You have listed the start date for your project as 10/15/2018 and your ending date as 11/15/2019. If these dates change, you must contact our office for an extension. Should you decide to alter your methodology in any way, please submit those changes to our office. You are also responsible for obtaining permission from the local district, business, or relevant administrative authority where the research is to be conducted.

If you have any questions, please refer to https://portal.piedmont.edu/Academics/IRB/Pages/default.aspx or contact me at evance@piedmont.edu. Good luck with your research!

Sincerely,

Cynthia L. Vance, Ph.D.  
Professor of Psychology  
Human Subjects Research Coordinator