RESILIENCE IN TRAUMA-EXPOSED YOUTH: A QUALITATIVE THEMATIC ANALYSIS OF INTERVIEWS WITH MULTIDISCIPLINARY CHILDHOOD TRAUMA EXPERTS

by

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I dedicate this dissertation to my extraordinary children. From the very beginning, they have expanded my view of the world, challenged me to learn and grow, and immensely enriched my life. Jaime, Brendan, and Logan, I love and admire each of you more than I can say. I am in awe of the remarkable humans you have become and beyond grateful to be your mom.

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ABSTRACT

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Exposure to childhood trauma is pervasive worldwide, and the impacts are significant. A vast body of research has confirmed the link between childhood trauma and negative health outcomes into adulthood. However, not every child exposed to trauma goes on to experience adverse health impacts. Resilience following childhood trauma is increasingly studied, yet there remains a lack of congruence related to the definition and conceptualization of resilience. Further, few studies of resilience in children integrate developmental perspective, leaving a gap related to how a child's specific developmental age may impact or be impacted by trauma.

This qualitative study explored views and perspectives on childhood trauma and resilience captured in pre-recorded interviews with 15 internationally known, multidisciplinary child trauma experts. Roy's Adaptation Model, rooted in the nursing discipline, provided the theoretical framework for the study, and through application of Braun & Clark's reflexive thematic analysis, two primary themes and seven subthemes, addressing the research aims, were produced from the expert narratives. Theme One, developmental perspective, illuminates the experts' perceptions of the intricate,

interactive relationship between a child's developmental age and their experiences of and responses to trauma. Theme Two, toward resilience, explores key factors that contribute to resilience in trauma-exposed youth. Most research on this topic stems from disciplines other than nursing, therefore, it was prudent to employ a nursing framework in this research, as nurses are ubiquitous across healthcare settings, spend significant time with patients, and build strong and trusting relationships through the provision of care. The findings of this study provide nurses with an accessible framework and enhanced knowledge to care for youth impacted by trauma and empower nurses to lead research and practice initiatives in this area.

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CHAPTER ONE

INTRODUCTION

Exposure to traumatic events during childhood is pervasive in the United States and globally and the immediate and long-term impacts of childhood trauma and adversity are significant (Bhushan et al., 2020; Walker et al., 2021; Yoon et al., 2021). Awareness of and interest in the impacts of childhood trauma has increased exponentially following the publication of the Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998). A vast body of subsequent research has confirmed the cumulative impact of traumatic events during childhood and a multitude of lifelong negative outcomes on physical and psychological health, relationships, and life experiences (Bhushan et al., 2020; Centers for Disease Control and Prevention [CDC], 2019, 2022; Walker et al., 2021). Importantly, not everyone who has been exposed to trauma during childhood goes on to experience the associated negative outcomes, and it is evident that resilience can and does occur in individuals with childhood trauma exposure (Bhushan et al., 2020; CDC, 2019, 2022; Yoon et al., 2021). To effectively promote resilience in trauma-exposed youth, nurses and professionals across disciplines working with the pediatric population must understand childhood trauma and its potential impact on children of all ages, as well as how resilience in children can be defined, recognized, and operationalized. The focus of this study is to elucidate the complexities of resilience through the exploration and analysis of the views and perspectives of child trauma experts across multiple disciplines based on their experiences working with trauma-exposed youth. The remainder of this

chapter presents the background and significance of this study, including an overview of childhood trauma and resilience, statements of the problem and the purpose of this study, and a chapter summary.

Background

Childhood Trauma

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2023), trauma is a result of:

> […] an event, series of events, or a set of circumstances an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Traumatic events may be experienced by an individual, a generation, or an entire community or culture" (p. vii).

There are many forms of trauma that may occur during childhood, which is defined as the period from birth to the age of 18 (SAMHSA, 2023). Childhood trauma may occur in many environments, such as in the home, at school, or within the community, and may also occur at a national or global level, as in the case of mass trauma or the global COVID-19 pandemic (SAMHSA, 2023).

Adverse Childhood Experiences

Several forms of childhood trauma are captured under the broad term of adverse childhood experiences or ACEs (CDC, 2022; Jones et al., 2020; SAMHSA, 2023). In the landmark ACEs study (Felitti et al., 1998), ACEs are defined as various types of potentially traumatic events occurring in childhood that can have long-lasting impacts on health and well-being. Subsequent research supports the findings of the original ACEs

study, linking ACEs to significant long-term negative health outcomes in children and adults (CDC, 2019, 2022; Jones et al., 2020; SAMHSA, 2023). Instances of ACEs include physical, sexual, or psychological abuse; physical or emotional neglect; and a spectrum of household circumstances such as having an incarcerated parent, witnessing violence in the home, living with a parent or other family member with mental illness, or substance misuse in the home (CDC, 2022; Felitti et al., 1998; SAMHSA, 2023). Other forms of childhood trauma, such as exposure to war or armed conflict, bullying, terrorism, serious injury or illness, and community violence have also been linked to negative long-term outcomes (CDC, 2019, 2022; De Bellis & Zisk, 2014; Jones et al., 2020; SAMHSA, 2023). Notably, social determinants of health (SDOH), such as the impacts of sustained racism, living in poverty or under-resourced communities, and experiencing food or housing insecurity may amplify the negative impacts of ACEs (De Bellis & Zisk, 2014; Jones et al., 2020; SAMHSA, 2023). Examples of ACEs and SDOH are presented in Table 1.1.

Table 1.1

Forms and Amplifiers of Childhood Trauma

Original ACEs	Additional forms of childhood trauma	Social determinants of health (amplifiers)
Abuse: Physical, sexual, emotional Neglect: Physical, emotional Household challenges: Incarceration of a family member Interpersonal violence in the home Parental separation or divorce Mental illness in the home Substance abuse in the home	Natural disasters War Armed conflict Bullying Exposure to community violence Serious illness or injury	Impacts of racism Living in poverty or under-resourced communities Food or housing insecurity

(CDC, 2019; De Bellis & Zisk, 2014; Jones et al., 2020; SAMHSA, 2023)

Impacts of Childhood Trauma and ACEs

Prolonged exposure to adversity in childhood can lead to toxic stress, which, through disruptions in hormonal, epigenetic, and neurodevelopmental processes, impacts the developing brain and several of the body's regulatory systems, thus increasing the risk for physical, behavioral, and mental health disorders (Bhushan et al., 2020; Felitti et al., 1998; Jean-Thorn et al., 2022; Webster, 2022). Toxic stress is defined by the National Academies of Sciences, Engineering, and Medicine (NASEM, 2019) as the "prolonged activation of the stress response systems that can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years" (p. 38). ACEs can also negatively impact a child's emotions, growth and development, cognition, interpersonal relationships, and

overall well-being, and are associated with increased health risk behaviors, such as substance use disorders and sexual promiscuity, and mental health disorders, such as depression, anxiety, and suicidality, in teens, young adults, and adults (SAMHSA, 2023; CDC, 2019, 2022; Felitti et al., 1998; Jones et al., 2020). Furthermore, exposure to ACEs is linked to poor school performance, learning difficulties, decreased school attendance, reduced employment potential, and lack of insurance coverage (Bellis et al., 2018; Jones et al., 2020; Webster, 2022). Risk for chronic disease in adulthood, such as cancer, diabetes, heart disease, obesity, and chronic obstructive pulmonary disease (COPD) increases with ACE exposure, demonstrating the cumulative impact of childhood trauma (Bhushan et al., 2020; CDC, 2019, 2022; Felitti et al., 1998). The economic burden of ACEs is high, and annual costs associated with ACEs are estimated at hundreds of billions of dollars, most of which are healthcare-related (Jones et al., 2020; United States Department of Health & Human Services [USDHHS], 2024).

It is estimated that more than 65% of adults and approximately half of children in the United States have been exposed to ACEs (Bethell & Gombojav, 2019; CDC, 2022; USDHHS, 2024). Because the prevalence of childhood adversity is high, and the lifelong impacts can be severe, exposure to childhood trauma is considered by experts as a critical public health crisis, and ACEs are among the greatest unaddressed public health threats in our nation (Bhushan et al., 2020; Klika et al., 2020). However, not all trauma-exposed children experience lifelong adverse outcomes, and there is increasing interest in the identification and measurement of protective factors that may mitigate the negative health impacts of childhood adversity and promote resilience in trauma-exposed youth (CDC, 2022; Masten et al., 2021; Merrick et al., 2019; Yoon et al., 2021).

Protective Factors and Resilience

The use of the term "resilience" in research, practice, and policy, specifically related to ACEs and childhood trauma, has grown exponentially over the past several years (Aburn et al., 2016; Masten et al., 2021; Morse et al., 2021; Yoon et al., 2021). Research related to resilience in children and adolescents who have been exposed to trauma is expanding, and findings continue to support the perspective that there are protective factors (PFs) and positive childhood experiences (PCEs) which play a role in the mitigation of negative health outcomes of childhood adversity and the promotion of resilience (Bowling et al., 2022; Masten et al., 2021; Yoon et al., 2021). Individual protective factors, such as emotional regulation, problem-solving skills, self-esteem, effective daily functioning, and self-efficacy, the consistent presence of a trusted adult, and perceived social support, have been associated with resilience following childhood adversity (Southwick et al., 2014; Masten, 2011; Traub & Boynton-Jarrett, 2017; Yoon et al., 2021). The expansion of scholarly inquiry into the concept of resilience has contributed to a broadened awareness of factors, such as self-efficacy (Hamby, et al., 2018), that may be protective to trauma-exposed youth, yet wide variation persists within and across disciplines in terms of the definition, conceptualization, and measurement of resilience in this population (Southwick et al., 2014; Aburn et al., 2016; Masten et al., 2021; Morse et al., 2021; Masten & Monn, 2015; Solva et al., 2023; Yoon et al., 2021). For example, in the recent literature, resilience has been described in different ways, such as a personality trait (or set of traits), an ability, a capacity, a set of attitudes or behaviors, an outcome, and a dynamic process (American Psychological Association [APA], 2018; Daly, 2020; Jean-Thorn et al., 2022; Masten et al., 2021; Morse et al., 2021; Solva et al.,

2023; Yoon et al., 2021). Additionally, there is lack of consensus as to the indicators of resilience in children, which results in inconsistency in the way resilience may be assessed and measured (Solva et al., 2023). This continued incongruence may be inadvertently perpetuated through more intradisciplinary than multidisciplinary research related to resilience in children impacted by trauma.

Developmental Age and Developmental Periods of Childhood

Developmental age and developmental periods of childhood are conceptually foundational to explicating the impacts of childhood trauma and ways in which to assess and promote resilience in children. The term developmental age describes a child's current level of functioning in various domains, for example, cognitive capacity, physiologic adaptation, social relationships, and emotional regulation (Hockenberry & Wilson, 2021). Typical functioning in each of these domains is described by theorists such as Erikson and Piaget, as they define progressive stages of psychosocial and cognitive development, such as infancy and toddlerhood (Erikson) and sensorimotor and preoperational (Piaget), during which a child achieves anticipated milestones that align with their developmental age (Hockenberry & Wilson, 2021). These theories, among others, provide a framework for understanding a child's developmental progression from birth through late adolescence into young adulthood. As one example, Erikson defines the period of infancy as birth to 12 months of age, and asserts that, during this period, the infant is experiencing the developmental stage of "trust vs. mistrust" (Hockenberry & Wilson, 2021). In this stage, as the infant interacts with the people and the world around them, it is anticipated they will master the task of trust, which is promoted through responsive interactions to the infant's needs.

Developmental theories provide guidance to pediatric practitioners and clinicians in terms of understanding a child's anticipated level of functioning based on their chronologic age for the purposes of health assessment, promotion, and surveillance, and in providing care for young patients and clients in a variety of healthcare settings. For instance, in the pediatric healthcare setting, knowledge of anticipated developmental milestones enables practitioners to recognize alterations from anticipated functioning in young children and identify and implement interventions to improve outcomes (American Academy of Pediatrics [AAP], 2017).

Developmental Perspectives on Resilience

As a child grows, develops, and achieves milestones in domains such as cognitive capabilities, language acquisition, and emotional regulation, it is reasonable that at certain ages, specific protective factors and indicators of resilience may or may not be relevant or observable, or may vary over time. Resilience has been measured using tools such as the Resilience Scale (RS-25; RS-10), the Connor–Davidson Resilience Scale (CD-RISC-25; CD-RISC-10), and the Scale of Protective Factors (SPF-24) (Madewell & Ponce-Garcia, 2016). These scales contain items that measure protective factors such as "social skills, social support, and the quality of familial relationships, self-regulation, planning, executive functioning, problem-solving skills, and self-efficacy" (Madewell & Ponce-Garcia, 2016). However, understanding that the way in which resilience is recognized, assessed, and measured will also change with developmental age, these measures are not valid across stages of development. For example, a protective factor commonly associated with resilience is self-efficacy, defined by the APA (2023) as "an individual's subjective perception of their capability to perform in a given setting or to attain desired

results" (para. 1). Self-efficacy, by this definition, would not be observable or measurable in infants and young children due to their stage of cognitive development (Shorey & Lopez, 2021; Yoon et al., 2021; Yoon, 2021). Despite the significance of developmental age on the demonstration, recognition, and promotion of resilience, few studies of resilience in trauma-exposed youth include perspective on child developmental stages, a gap which has been identified in the literature as a priority for future research (Yoon et al., 2021; Yoon, 2021).

The lack of consensus on the definition of resilience in trauma-exposed youth, as well as the lack of integration of developmental perspective and context in the extant resilience research, are significant gaps that inhibit the advancement of knowledge of resilience in nursing and other disciplines and the integration of important findings into policy and practice. This study contributes to the nursing and multidisciplinary knowledge base by exploring childhood trauma experts' perspectives of resilience among trauma-exposed youth throughout the pediatric lifespan.

Problem Statement

An increased focus on resilience as a buffer against the negative health outcomes related to childhood adversity has resulted in a surge of research into resilience in trauma-exposed youth. However, in many ways, studies of resilience closely reflect the respective discipline of the researcher, which may contribute to the persistent variation in the definition, conceptualization, and measurement of resilience (Masten & Monn, 2015; Morse et al., 2021; Yoon et al., 2021). Additionally, as children progress from infancy through adolescence, they achieve various developmental milestones (cognitive, psychosocial, moral, etc.) along the way (Alderman et al., 2019; Allen & Waterman,

2019; Zubler et al., 2022). Therefore, it is reasonable to expect that pathways to and indicators of resilience following adversity may present differently across the pediatric lifespan; however, much resilience research lacks integration of developmental context and perspective (Yoon et al., 2021; Yoon, 2021).

A continued lack of multidisciplinary consensus on the definition, concept, measurement, and analysis of resilience, along with the lack of developmental perspective may impede the advancement of resilience research and knowledge and slow the integration of crucial findings into policy and practice (Masten & Monn, 2015; Yoon et al., 2021). Congruence across disciplines and exploration of resilience within the context of developmental age would be valuable contributions to childhood trauma and resilience research and informative to nursing and other disciplines aiming to identify, measure, and promote resilience in trauma-exposed youth across the pediatric life course (Yoon et al., 2021).

Purpose of the Study

This study aims to identify, analyze, organize, describe, and report themes related to trauma and resilience in trauma-exposed children across the pediatric life span within interviews with 15 nationally known childhood trauma experts. Through this study, I seek to address two problems: 1) the lack of consensus related to the meaning of resilience in trauma-exposed children, and 2) the lack of developmental perspective in the conceptualization and promotion of resilience across the pediatric lifespan.

The overarching research question for this study is “How do childhood trauma experts view trauma and resilience in children”, and specifically, how do childhood trauma experts describe: 1) the impacts of exposure to trauma in children of different

developmental ages; 2) resilience in trauma-exposed children; 3) ways in which trauma-exposed children of different developmental ages demonstrate resilience; and 4) modifiable factors that promote resilience in trauma-exposed children?

Significance

Considering the persistent incongruity as to the conceptualization of resilience, as well as lack of integration of developmental perspective in the extant literature, a qualitative approach to address the research aims of this study is an appropriate step in furthering understating of resilience in trauma-exposed youth. This approach will provide valuable insight into childhood trauma and resilience through the narratives from experts practicing within varied disciplines, diverse pediatric populations, and settings. Further, framing this research within a nursing theoretical model is important in advancing nursing knowledge in this area of research in which the voice of nursing has historically been underrepresented. Therefore, the findings of this study will have broad implications for nursing knowledge and science, will be instrumental in understanding, recognizing, and promoting resilience in youth impacted by trauma, and valuable in increasing interdisciplinary collaboration in child trauma research and practice initiatives.

Chapter Summary

In this chapter I have presented an overview of childhood trauma and resilience, including different types of childhood trauma, the impacts of trauma and ACEs, and various known protective factors that may lead to resilience in trauma-exposed youth. I have also presented a statement of the problem that led to the development of my research questions, as well as the significance of this research.

In Chapter Two, I will examine and synthesize the extant literature related to childhood trauma and resilience, as well as the theoretical perspectives that framed and guided the development of this study.

CHAPTER TWO

LITERATURE REVIEW

The purpose of this study was to analyze qualitative data, in the form of interviews with 15 multidisciplinary childhood trauma experts, to produce and report themes related to trauma and resilience in trauma-exposed youth across the pediatric life span. This chapter presents a brief overview of the perspectives on conducting a literature review through a qualitative lens, a discussion of the extant literature related to childhood trauma and resilience, and a review of the theoretical framework utilized to conceptualize and design this study. The chapter concludes with an illustrative presentation of the theoretical framework within the context of the topic of this research, resilience in trauma-exposed youth, followed by a chapter summary.

Perspectives on Reviewing the Literature

In qualitative inquiry, researchers often delay a thorough literature review until after the study is completed so as not to influence data collection, interpretation, or analysis processes (Charmaz, 2014; Creswell & Poth, 2018; Merriam & Tisdell, 2016; Streubert & Carpenter, 2011). Delayed literature reviews may also be completed to situate the research results in the context of the extant literature (Braun & Clarke, 2022; Streubert & Carpenter, 2011). However, it may be appropriate to conduct cursory or detailed review of the disciplinary research before, during, or after determining a research topic, depending on the researcher's knowledge and experience, the aims of the study, and the approach to data analysis (Braun & Clarke, 2022; Charmaz, 2014). For this study I determined it was prudent to reflect and expand upon my current knowledge and

perspective related to the phenomena of interest in order to properly align, structure, and guide the research process. Therefore, a literature review was conducted to identify, appraise, and synthesize the current evidence related to childhood trauma and adverse childhood experiences (ACEs); the conceptualization, definition, and application of the term "resilience;" protective factors that promote resilience in trauma-exposed children; and key theoretical and conceptual models that have provided the foundation for scholarly research related to trauma and resilience. This review was conducted over several months and subsequent literature searches were conducted to ensure the most recent and relevant research was included.

Review of Childhood Trauma and Resilience Literature

To explore what is known about resilience in children who have experienced trauma, a thorough search was performed by accessing the following electronic databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed (MEDLINE), and PsychINFO to identify peer-reviewed research related to the topic. Key search terms included trauma, childhood trauma, child maltreatment, child abuse, childhood adversity, adverse childhood experiences, ACEs, resilience, resilient, resiliency, adaptation, positive childhood experiences, and protective factors. The initial search results were extensive, therefore key search terms were combined to narrow the results (for example, "childhood trauma" AND "resilience"). Criteria for inclusion were that the article was in English ; the abstract included the key search terms; and the publication date was between 01/01/2010 and 12/31/2022. A title search of the results was conducted and duplicates, articles unavailable in English or from non-peer-reviewed journals, editorials, and sources without full-text availability were excluded. The

abstracts of the remaining articles were reviewed for relevance to the study. Landmark studies, older sources frequently cited in the literature, relevant textbooks, and pertinent government and administrative reports were also reviewed.

Types and Definitions of Trauma

Trauma can be experienced by individuals, families, groups, or communities regardless of demographics. Individual trauma stems from exposure to one or more harmful or threatening events or ongoing circumstances that may have long-term adverse impacts on one's capacity to function, as well as their psychosocial, emotional, physical, or spiritual well-being (SAMHSA, 2023). Community trauma impacts more than one individual and is associated with societal or structural implications (SAMHSA, 2023). Some examples of community trauma are cultural, racial, and historical trauma. SAMHSA (2023) defines cultural trauma as trauma "that occurs when a group that shares a culture or identity experiences an event that causes lasting effects on group consciousness" (p.3). Racial trauma occurs in response to acts of "conflict, hatred, injury, or threatened harm to an individual based on their race" (SAMHSA, 2023, p. 3). Historical trauma is defined by SAMHSA (2023) as "collective complex trauma inflicted on a group of people who share a specific identity or affiliation" (p. 3). The consequences of community trauma tend to be perpetual and can result in the intergenerational transmission of trauma from one generation to the next (Woods-Jaeger et al., 2018; Narayan et al., 2021; SAMHSA, 2023). Exposure to trauma is widespread in the United States, with nine out of ten adults endorsing at least one traumatic event in their lifetime (SAMHSA, 2023).

Biological Response to Trauma

Trauma occurs when an individual or group experiences an event or ongoing events or circumstances that are threatening or harmful. In response to the perception of threat, as in the case of childhood trauma, biological reactions in the body occur to prepare organ systems for survival (Bhushan et al., 2020; De Bellis & Zisk, 2014). This is often referred to as a fight or flight response. These biological reactions result in increased production of stress-related neurotransmitters, including noradrenalin, adrenalin, and cortisol, which have a cascading effect on various regulatory systems in the body (Bhushan et al., 2020; De Bellis & Zisk, 2014; van der Kolk, 2003, 2017). During the stress response, the body is focused on survival in a finely tuned adaptive response to threat. Heart rate and blood pressure increase; respiration, immune activity, and digestion slow down; and the parts of the brain associated with learning, memory, judgment, impulse control and executive function become less active (Bhushan et al., 2020; De Bellis & Zisk, 2014; Ioannidis et al., 2020; van der Kolk, 2003, 2017). In all humans, some level of stress is expected, and is essential in the processes of growth and development. However, when the stress response is continually activated, this can lead to prolonged disruption of several of the body's regulatory mechanisms, resulting in long-term negative impacts on health (Cohodes et al., 2021; Bhushan et al., 2020; De Bellis & Zisk, 2014; Ioannidis et al., 2020; NASEM, 2019).

Neurobiology of trauma (NBT) refers to the biological response to trauma and the specific impacts of trauma on the developing brain of infants and children as they adapt to trauma during critical periods of development. NBT assumes there are three

developmental pathways that are interrelated, and that the effects of trauma on children will vary depending on their stage of development when the trauma occurred (van der Kolk, 2003). Developmental stage is a central theme and there is some overlap with attachment theory and the impact of early parental bonds as factors in how trauma during childhood will impact the child (van der Kolk, 2003). In his work on the neurobiology of trauma, van der Kolk (2003) summarizes evidence from multiple studies that examine the specific impacts of trauma on brain development, the neuroendocrine system, the hypothalamic-pituitary-adrenal (HPA) axis, and "every conceivable neurotransmitter system" (pg. 298).

Perry (2009, 2014) and Hambrick, Brawner, & Perry (2019), studied the impacts of early life stress (ELS) on brain development in children during specific developmental stages, utilizing the framework of the Neurosequential Model of Therapeutics (NMT). The NMT is an approach to therapeutic work with trauma-exposed youth in a variety of settings and is based on the foundational principles of neurodevelopment (Perry, 2009; Hambrick, Brawner, & Perry, 2019). The model asserts that events, such as maternal substance use during pregnancy and trauma occurring in early childhood, are disruptive to the complex developmental processes taking place, and this disruption impacts brain development (Hambrick, Brawner, & Perry, 2019; Perry, 2014). The severity of functional and developmental consequences of trauma are dependent on the timing, severity, type, and pattern of the trauma (Perry, 2014). In practice, NMT metrics are utilized to capture information from clinical encounters related to a child's development and functioning following exposure to trauma at specific developmental periods. NBT and NMT have provided the framework for numerous studies examining the impacts of

trauma and the process of adaptation following trauma in children and adults (Traub & Boynton-Jarrett, 2017; van der Kolk, 2003; van der Kolk et al., 2005; Hambrick et al., 2019; Hambrick, Brawner & Perry, 2019; Perry, 2009, 2014).

Toxic Stress

In children, continued exposure to trauma and adversity can result in toxic stress (Bhushan et al., 2020; CDC, 2022; Jones et al., 2020). Toxic stress refers to the prolonged activation of the stress response system, which can disrupt brain development, impact heart rate variability, and dysregulate the neuroendocrine and numerous other body systems (Bhushan et al., 2020; CDC, 2022; Jones et al., 2020; NASEM, 2019; Teicher & Samson, 2016; van der Kolk, 2003, 2016). Research also indicates that the neurobiological impacts vary according to the type of adversity experienced and the developmental periods during which adversity occurs (Andersen, 2022; van der Kolk, 2003; Webster, 2022; Yoon et al., 2021).

Critical Periods of Development

During childhood, there are sensitive and critical periods of development, during which the child is particularly influenced by their environment and relationships with those caring for them, and when certain experiences may result in diminished or enhanced responsiveness of the brain, or permanent neurobiological changes (Andersen, 2022; Bhushan et al., 2020; van der Kolk, 2003; Yoon et al., 2021). Critical developmental periods of childhood are defined in the NMT as: “Perinatal period (birth to 2 months), Infancy (2-12 months), Early Childhood (13 months to 4 years), and Childhood (4-11 years)” (Hambrick et al., 2019, p. 3). Early childhood is crucial as the foundation for later development, and therefore experiencing adversity during this period

puts the child at increased risk for neuroendocrine, immune, and other physiologic system changes (Luby et al., 2020; Bhushan et al., 2020; Yoon et al., 2021).

Childhood Trauma and Adverse Childhood Experiences

Childhood trauma is a broad term referring to various types of traumatic events occurring during childhood that may result in long-lasting effects on physical and mental health, daily functioning, and overall well-being. As a form of childhood trauma, adverse childhood experiences (ACEs) are preventable, potentially traumatic events occurring during the period of birth through the age of 18, that are linked to long-term negative health outcomes (Bethell & Gombojav, 2019; CDC, 2019; Felitti et al., 1998; Jones et al., 2020; Mishra et al., 2023; Swedo et al., 2023). In the late 1990s, the landmark ACEs study (Felitti et al., 1998) marked a pivotal point in childhood trauma research with the discovery of a strong cumulative effect of ACEs on health risk behaviors and lifelong adverse health outcomes such as cancer, diabetes, heart disease, and early death (Bhushan et al., 2020; Felitti et al., 1998). The types of ACEs included in the original study are physical, sexual, or psychological abuse; emotional or physical neglect; and various environmental or family challenges impacting a child's perception of safety or stability such as mental illness, substance use, or interpersonal violence in the home; incarceration of a relative; and parental separation or divorce (CDC, 2022; Felitti et al., 1998; Lacey & Minnis, 2020; SAMHSA, 2023; Swedo et al., 2023; Yoon et al. 2021). In recent years, ACEs research has expanded to include other forms of childhood adversity as well as the implications of social determinants of health such as community violence, war, parental or caregiver stress, death of a parent or caregiver by suicide, bullying, living in foster care, residing in under-resourced or racially segregated neighborhoods, and experiencing

food insecurity or other instability (Bethell & Gombojav, 2019; CDC, 2019, 2022; Jones et al., 2020; Lacey & Minnis, 2020; Yoon et al., 2021). In their review of ACEs research, Lacey and Minnis (2020) describe childhood adversity as experiences during the developmental periods of childhood requiring substantial neurodevelopmental, social, and psychological adaptation.

Impacts of Childhood Trauma and Adversity

Neurobiological and other changes as a result of childhood adversity and toxic stress can have significant and widespread impacts. Children with trauma exposure may experience delays in reaching developmental milestones as well as difficulties with emotional regulation, concentration, sleep, executive functioning, and decision-making (Bhushan et al., 2020; CDC, 2019, 2022; Webster, 2022; Yoon et al., 2021). Trauma-exposed children and adolescents are at higher risk for attention-deficit hyperactivity disorder (ADHD), anxiety, depression, self-harm, learning disability, poor school performance, substance use disorders, impaired coping skills, aggressive behavior, social withdrawal, and increased peer rejection (Bethell et al., 2014; Bethell & Gombojav, 2019; CDC, 2019, 2022; Ioannidis et al., 2020; Lacey & Minnis, 2020; Webster, 2022). ACEs have also been linked to poor academic performance, learning difficulties, lower school attendance, decreased employment potential, and lack of insurance coverage (Bethell et al., 2014; Bethell et al, 2022; CDC, 2022; Jones et al., 2020; Webster, 2022). In adults, ACEs are linked to a higher rate of smoking and substance use disorders as well as increased risk for numerous chronic health conditions and several leading causes of morbidity and mortality (CDC, 2022; Felitti et al., 1998; Jones et al., 2020; Merrick et al., 2019). As compared to individuals with zero ACEs, those with exposure to four or

more types of ACEs have 12 times the risk of death by suicide and those with six or more have a reduced life expectancy of up to 20 years (Bowes & Jaffee, 2013; Felitti et al., 1998; Merrick et al., 2019). The economic burden of ACEs is also high, with annual costs associated with ACEs are estimated at hundreds of billions of dollars, most of which are healthcare-related (Jones et al., 2020; Klika et al., 2020; Peterson et al., 2018).

Prevalence of Childhood Adversity

The prevalence of childhood adversity, especially among younger children and those living in poverty, is high. An estimated 600,000 children were victims of maltreatment or neglect in 2021, and over 56% of victims were three years or younger (USDHHS, 2024; Yoon et al., 2021). Bethell and Gombojav (2019) report that 45% of all children in the United States (US) were exposed to at least one type of ACE by the time they reached the age of 17, and among children living in poverty, the rate of exposure rose to over 54%. Approximately 64% of adults in the United States reported experiencing at least one type of ACE before age 18, and greater than 17% reported exposure to four or more ACEs (Swedo et al., 2023). Additionally, some groups such as women; non-Hispanic American Indian or Alaskan Native and multiracial adults; members of the lesbian, gay, bisexual, transgender, plus (LGBT+) and black, indigenous, and people of color (BIPOC) communities; as well as low income and ethnic minority groups are exposed to ACEs and experience the associated impacts at disproportionately higher rates (Flagg et al., 2023; Jonas et al., 2022; SAMHSA, 2023; Swedo et al., 2023).

Resilience

Childhood trauma is pervasive, and the impacts are multifaceted, disproportionately affecting populations already burdened by health disparities (CDC,

2019; Merrick et al., 2019). However, many trauma-exposed children do not go on to experience lifelong adverse outcomes, and research indicates that various protective factors, such as optimism, self-efficacy, and having supportive caregivers, can buffer the effects of adversity and promote resilience (Masten, 2011; Bhushan et al., 2020; Hamby et al., 2018; Bowes & Jaffee, 2013; Traub & Boynton-Jarrett, 2017; Martinelli et al., 2008; Yoon et al., 2021). Research related to resilience spans the last five decades, however interest in and use of this term in research, practice, and policy, specifically related to ACEs and childhood trauma, has increased significantly over the past several years. A search of the nursing, psychological, and social sciences literature found 538 peer-reviewed articles published in the past five years alone that paired "resilience" with "childhood adversity" or related terms—up significantly from just 197 articles between 2006 and 2016, and only 19 between 1977 and 2005. This growth reflects an increasing focus on the prevalence and impact of childhood trauma and strength-based approaches to understanding and promoting resilience (Masten et al., 2021; Morse et al., 2021).

Numerous studies of resilience are contextually situated within the realm of physical and/or psychological health, and although nurses are extensively responsible for the health and wellbeing of individuals and communities, nursing as compared to other disciplines such as the social and psychological sciences, is consistently underrepresented in resilience research (Morse et al., 2021). Most resilience scholars note the complexity of the concept, and resilience is conceptualized differently depending on the context in which it is studied. Throughout the literature, the concept is referred to as a personality trait (or set of traits), one's ability or capacity, a set of attitudes or behaviors, a dynamic process through which a result occurs, and an outcome (APA, 2018; Aburn et al., 2016;

Earvolino-Ramirez, 2007; Jean-Thorn et al., 2022; Masten et al., 2021; Morse et al., 2021; Rutter, 1985; Yoon et al., 2021). The APA (2018) defines resilience as ‘‘the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands” (para. 1). Consistent with this definition, some form of adversity, either a single occurrence or a consequence of continued exposure to a stressor, is associated with resilience in most research (Morse et al., 2021). Different types of adversity commonly associated with resilience are traumatic events, processes of disease or illness, and everyday stress (Rudzinski et al., 2017). When viewed as a static attribute, resilience is often assessed using scales that measure traits such as self-efficacy, personal skills (e.g., coping, problem solving, social, help seeking), intellectual ability, religiosity/spirituality, and optimism (Aburn et al., 2016; Garcia-Dia et al., 2013; Kobiske & Bekhet, 2018; Ponce-Garcia et al., 2015; Rudzinski et al., 2017). External factors associated with resilience are the consistent presence of a trusted adult figure, fair treatment by others, peer support, having a positive role model (Bhushan et al., 2020; Masten, 2011; Traub & Boynton-Jarrett, 2017; Yoon et al., 2021). In studies viewing resilience as a dynamic process, operationalization and measurement become less consistent and more complex (Rudzinski et al., 2017). What is clear from the literature is that there is no consistent definition of resilience, regardless of context, and that the indicators of resilience in children are inconsistent (Morse et al., 2021; Aburn et al., 2016; Yoon et al., 2021).

Theoretical Perspective

To gain perspective and background for this research, a search of the literature was conducted to identify theoretical models utilized to study childhood trauma and resilience. The promotion of resilience in all children, including those impacted by trauma, requires a multidisciplinary approach, and thus it was important to explore a wide range of theoretical literature representing diverse disciplinary perspectives that align with the aims of this study. Through this search, it was apparent that several models and theories have been utilized to study adaptation or resilience in the context of various forms of trauma or adversity, but most stem from medicine and the social sciences, and few studies of childhood trauma and resilience have utilized theory from the disciplinary perspective of nursing. Through the process of appraisal of the extant literature related to childhood trauma and resilience, some congruency was noted related to the etiology and impacts of childhood trauma, potential protective factors, and responses to adversity throughout the pediatric lifespan. As I sought theoretical support that would effectively guide this work, one nursing model stood out as a conceptually congruent and synergistically representative framework for this research; Roy's Adaptation Model (RAM) (Roy, 2009). Though, to my knowledge, RAM has not been used to study resilience in trauma exposed youth, it is exceptionally well-aligned to explore this topic. Thus, this model informed the conceptualization and design of this study and provided guidance in the development of the research process.

Roy's Adaptation Model

RAM is a conceptual model developed by Sister Callista Roy, a nurse, theorist, and scholar. Roy's experience as a pediatric nurse greatly influenced the development of

RAM (Patton, 2004). Roy was captivated by her observations of children who, amidst their experiences of illness, demonstrated remarkable adaptability to their circumstances. Moreover, Roy recognized nursing as a pivotal catalyst to fostering such adaptation (Patton, 2004). From these roots RAM was developed and has been utilized to create and advance nursing knowledge for decades.

The main philosophical assumptions of RAM are that human beings are adaptive and evolving systems in continuous interaction with the ever-changing environment (Frederickson, 2011; Patton, 2004; Roy, 2009; Roy & Andrews, 1999; Ursavaş & Karayurt, 2020). RAM stems from the metaparadigm of person, health, environment, and nursing that has been widely used as a theoretical framework to advance nursing science and practice across specialties and populations (Dobratz, 2008; Fawcett & DeSanto-Madeya, 2012; Frederickson, 2000; Jennings, 2017; Patton, 2004; Ursavaş & Karayurt, 2020; Willis et al., 2015; Woods & Isenberg, 2001; Wright et al., 1993). RAM views humans holistically as systems continuously interacting with the environment and asserts that the overarching goal of human systems is to promote and maintain adaptation in response to or within the context of internal or external stimuli (Dobratz, 2008; Fawcett & DeSanto-Madeya, 2012; Patton, 2004; Roy, 2009; Roy & Andrews, 1999; Ursavaş & Karayurt, 2020). Through coping mechanisms and adaptive processes, individuals respond to stimuli, and these responses impact the individual's physical and psychological health and overall well-being (Dobratz, 2008; Frederickson, 2000; Jennings, 2017; Roy, 2014). The goals of adaptation include stability, survival, growth,

and mastery (Roy, 2009, 2014; Roy & Andrews, 1999). The model asserts multiple scientific and philosophical assumptions, and those of import to this research are listed in Table 2.1.

Table 2.1

Assumptions of Roy's Adaptation Model

Philosophical Assumptions: • Persons use human creative abilities of awareness, enlightenment, and faith. Scientific Assumptions: • Awareness of self and environment is rooted in thinking and feeling. • Humans by their decisions are accountable for the integration of creative processes. • Thinking and feeling mediate human action. • System relationships include acceptance, protection, and fostering of interdependence. • Person and environment transformations are created in human consciousness. • Integration of human and environment meanings results in adaptation.

(Roy & Andrews, 1999, p. 35)

The constructs within this model are stimuli, coping processes, and adaptation, all of which are interrelated. Stimuli are factors influencing adaptation and are described as focal, contextual, and residual (Roy, 2014). Focal stimuli are internal and external components of the situation which result in the individual's immediate response. Contextual stimuli represent other situational factors that augment the impact of focal stimuli. Residual stimuli are environmental factors that have uncertain effects on a given situation (Frederickson, 2000; Jennings, 2017; Roy, 2009, 2014; Roy & Andrews, 1999). Coping processes are instinctive and learned strategies of interacting with the environment and include the regulator subsystem, which involves the automatic chemical and neuro-endocrine response to stimuli, and the cognator subsystem, which involves

information processing, learning, judgment, and emotional response (Fawcett & DeSanto-Madeya, 2012; Jennings, 2017; Roy, 2014; Ursavaş & Karayurt, 2020). The construct of adaptation is defined through four interrelated adaptation modes: physiologic, interdependence, role-function, and self-concept (Fawcett & DeSanto-Madeya, 2012). The adaptation modes along with the application of each to this study are presented in Table 2.2.

Table 2.2

Adaptation Modes in RAM

Adaptation mode	Description	Application to this study
Physiologic	Need: physiologic integrity Oxygenation, nutrition, elimination, activity and rest, protection, senses, fluid-electrolyte and acid-base balance, and neurological and endocrine functions	Physical and physiologic health/illness.
Interdependence	Need: relational integrity Behaviors related to affectional, developmental adequacy; support systems, significant others	Relationships with parents, caregivers, extended family, friends, significant other; support systems
Role Function	Need: social integrity Behaviors related to the role occupied in society	School, work, athletics, role in the family, daily functioning
Self-Concept	Need: psychological and spiritual integrity Behaviors related to feelings and beliefs about oneself; physical self, personal self, spiritual self	Self-esteem, psychological well-being, thoughts about self (positive/negative)

(Fawcett & DeSanto-Madeya, 2012; Ursavaş & Karayurt, 2020; Wright et al., 1993)

Utility of RAM to this Research

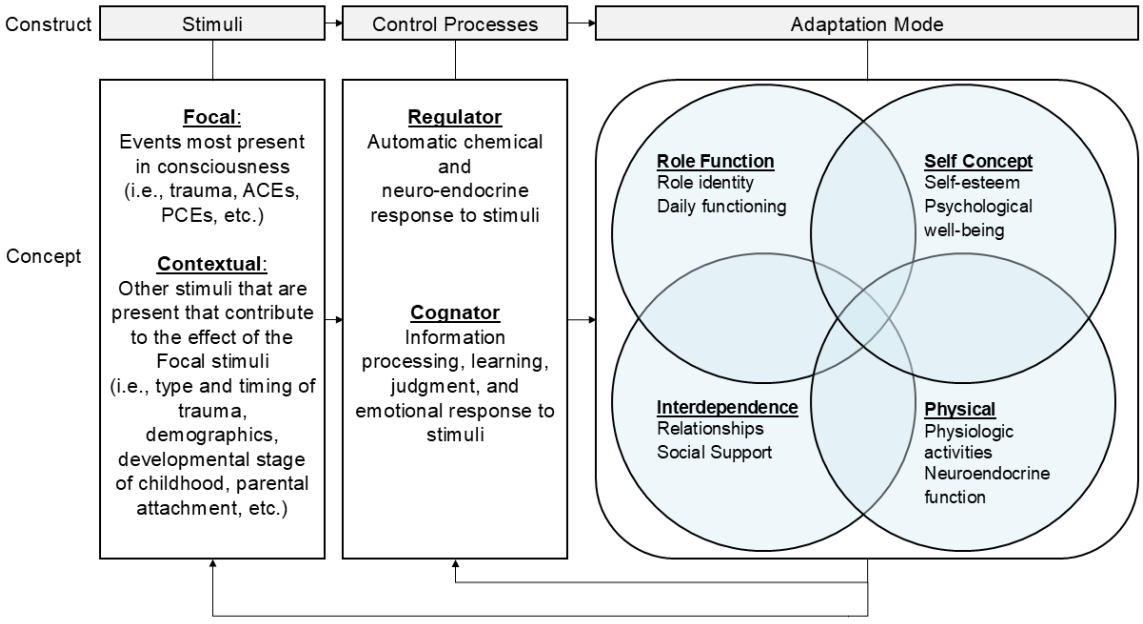
As a conceptual framework, RAM lacks specificity in terms of context, however it has been the basis for several nursing studies of trauma in adult populations. Specifically RAM has provided a theoretical framework for the study of spiritual healing in men who have experienced child maltreatment (Willis et al., 2015); moral injury, post-traumatic stress disorder (PTSD), and alcohol disorders in combat veterans (Cox et al., 2021; Hallihan et al., 2021; Nayback, 2009); intimate abuse and traumatic stress in women (Limandri, 1986; Woods & Isenberg, 2001); traumatic stress and caregiver adaptation in traumatically injured patients and survivors (Frank et al., 2017; Hudson et al., 2022); and shame as an obstacle for disclosing abuse in the healthcare setting (Cummings & Baumann, 2021). RAM has also been utilized as a framework for the development of a comprehensive sexual assault tool (Burgess & Fawcett, 1996).

Fewer studies have utilized RAM within the pediatric population; however, the model has been the basis for research related to adolescents with cancer (Ramini et al., 2008); emotional wellbeing of children in a Honduran orphanage (Debiasi et al., 2012); adaptation in girls with precocious puberty (Miral & Sahin, 2022); and anger in the adolescent population (Pullen et al., 2015). No studies of childhood trauma and resilience have utilized RAM as a theoretical framework, however regardless of whether resilience is viewed as a capacity, trait, outcome, or process, throughout the literature, descriptions of resilience consistently include the mention of adaptation following some form of insult or adversity (Masten, 2018). Furthermore, the concepts defined within RAM align exceptionally well with other models utilized in trauma research stemming from other disciplines, including NBT and NMT, which describe various mechanisms by which

exposure to trauma results in adaptive responses that can impact a child's development and functioning (Hambrick et al., 2019; Perry, 2009). Because of the congruence of RAM and what is known about the neurobiological, psychological, and social effects of childhood adversity on both children and adults, this model is an excellent framework for the study of childhood trauma and resilience and the advancement of nursing science. Figure 2.1 is a diagram of the conceptual model developed to frame this study which depicts the alignment of the constructs and concepts of Roy's Adaptation Model (Roy, 2009) to the study of childhood trauma and resilience.

Figure 2.1

Resilience in Trauma-Exposed Youth Framed within Roy's Adaptation Model



This model was utilized as the framework to explore the following research questions: How do childhood trauma experts view trauma and resilience in children; and specifically, how do experts describe: a) trauma in children (stimuli); b) manifestations of exposure to trauma in children of different developmental ages (adaptation mode), c)

resilience in trauma-exposed children (adaptation mode), and d) modifiable factors that promote resilience in trauma-exposed children (control processes)?

Chapter Summary

In this chapter I have discussed perspectives on qualitative literature review, synthesized the relevant extant literature in the areas of childhood trauma and resilience, and have presented the theoretical framework that provided structure and guidance for the development of this research. Chapter Three provides details related to the methodology for this study, including an explanation of my epistemological and ontological perspectives and assumptions, rationale for choosing both the qualitative methodology and the analytic method of reflexive thematic analysis to explore the study's research questions. The chapter also includes a discussion of the processes and procedures for the study, followed by a chapter summary.

CHAPTER THREE

METHODS

Research methodology refers to the framework that guides the research design, approach, and methods, and is determined by the researcher's philosophical assumptions about reality and knowledge, as well as their theoretical and paradigmatic perspectives (Braun & Clarke, 2021, 2022). Research based upon the quantitative methodology holds realist ontological and objectivist epistemological perspectives and stems from the positivist or post-positivist paradigms grounded in scientific inquiry (Cresswell & Cresswell, 2018). These paradigms assume that there is a single reality that is objective and can be discovered through researcher observation and measurement. Quantitative research is appropriate for studies with the aim of observing, studying, and analyzing phenomena without bias or subjectivity, to discover a truth that can be replicated (Cresswell & Cresswell, 2018).

In contrast, qualitative research is predominantly positioned within the interpretive/constructionist paradigm, holds relativist epistemological and subjectivist ontological perspectives, and is rooted in naturalistic inquiry (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guba & Lincoln, 1982). Within this methodology, reality is viewed as subjective, multiple realities can concurrently exist, and knowledge is contextual and co-constructed through interpersonal social interactions (Creswell & Poth, 2018; Guba & Lincoln, 1982; Lincoln & Guba, 1985). Qualitative research is concerned with the study of human phenomena such as values, beliefs, culture, relationships, and processes, which are difficult to explore through quantitative methodologies situated

within the positivist and post-positivist paradigms (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guba & Lincoln, 1982; Merriam & Tisdell, 2016; Streubert & Carpenter, 2011). Because the overall analytic orientation of the qualitative researcher is to capture and interpret meaning, qualitative methods are particularly well-suited for research questions with a focus on understanding the views and perceptions that people or groups may have about a particular phenomenon situated within a specific context (Braun & Clarke, 2021, 2022; Creswell & Poth, 2018; Merriam & Tisdell, 2016; Streubert & Carpenter, 2011).

This study aims to explore the ways in which childhood trauma experts view, understand, and explain childhood trauma and resilience. The primary research question for this study is "How do childhood trauma experts view trauma and resilience in children?", and sub questions are focused on how childhood trauma experts describe: 1) the impacts of exposure to trauma in children of different developmental ages; 2) resilience in trauma-exposed children; 3) ways in which trauma-exposed children of different developmental ages demonstrate resilience; and 4) modifiable factors that promote resilience in trauma-exposed children. This chapter presents an overview of the design of the study, a detailed discussion of the study's procedures, including the setting, data source, IRB and ethical considerations, methods of data management, and the phased approach of reflexive thematic analysis. The chapter further presents the delimitations and limitations of the study and a chapter summary.

Design Overview

To best address the research questions guiding this study, a qualitative methodology was chosen, as I aimed to identify, analyze, organize, describe, and report

themes related to trauma and resilience in trauma-exposed children across the pediatric life span within interviews with 15 nationally known childhood trauma experts. The general approach of thematic analysis (TA) was explored as the method for data analysis. Generally, TA is considered a flexible method of data analysis and has been utilized across multiple research methodologies (qualitative, quantitative, and mixed methods) to code and analyze participants' contextually positioned perceptions, behaviors, practices, social processes, and experiences related to a particular phenomenon (Braun & Clarke, 2006, 2021, 2022; Byrne, 2021). TA is described as a group of theoretically flexible data analysis methods with utility within a wide range of ontological and epistemological positions (Braun & Clarke, 2006). Before beginning TA research, Braun and Clarke (2021) urge researchers to participate in "conceptual and design thinking" (p. 2). Through conceptual and design thinking, the researcher must first understand the features and assumptions of each approach to TA to determine which best addresses the research problem and aligns with the researcher's philosophical perspective (Braun & Clarke, 2021). During this process, deep consideration is given to the orientation of the approach (experiential-constructionist, inductive-deductive, semantic-latent); the philosophical underpinnings of the research; any theoretical frameworks that may shape the analytic process, the research questions; and the methods and procedures for the study (Braun & Clarke, 2006, 2021; Byrne, 2021).

Reflexive Thematic Analysis

For this research, as I participated in the process of conceptual and design thinking, it became clear that, among the approaches to TA described by Braun & Clarke in their Guide to Thematic Analysis (2022), reflexive TA (RTA) aligns best with my

underlying ontological and epistemological assumptions that knowledge is constructed through people's engagement in particular experiences, and that meaning is subjectively created through individuals' experiences and interactions with others (Braun & Clarke, 2022; Merriam & Tisdell, 2016). According to Braun and Clarke (2022), RTA represents the true nature of qualitative inquiry by recognizing and valuing the researcher's role and subjectivity in analyzing, interpreting, and reflexively engaging with the data throughout the research process. In RTA, the goals of data analysis do not focus on achieving objectivity and reliability among multiple coders. Rather, RTA values the diversity in researcher interpretation throughout the analysis process (Braun & Clarke, 2022). The implications of RTA research are broad as RTA can be utilized across qualitative approaches. Nevertheless, the researcher must ensure the alignment of methods and procedures throughout the research process to achieve methodological integrity (Braun & Clarke, 2022).

Procedure

Setting

Following the onset of the COVID-19 pandemic in 2020, two psychologists and scholars collaborated to create Pandemic Parenting, a digital resource hub and 501(c)(3) nonprofit organization, which provided free and accessible science-based online resources for parents and caregivers navigating the COVID-19 pandemic (*Pandemic Parenting*, n.d.). Pandemic Parenting later partnered with the SAMHSA/NCTSN-funded Center for Developmental Trauma Disorders (CTDTD) at the University of Connecticut to create the Roadmap to Resilience Podcast (R2R) (*Roadmap to Resilience*, n.d.). This podcast project emerged from an ad hoc task force comprised of child trauma experts

from around the world that represented more than five trauma-focused professional organizations. R2R is a free and publicly available collection of audio podcast episodes, brief video clips, and infographics that provide listeners and viewers with insights from childhood trauma experts on what it means to provide trauma-informed support to children in their schools, homes, primary care settings, extracurricular activities, and communities (*Roadmap to Resilience*, n.d.). R2R was developed for the non-research purpose of public and professional knowledge translation and dissemination.

The R2R content was developed from raw recorded interviews that were conducted with many of the multidisciplinary childhood trauma experts serving on the child trauma task force. Semi-structured interview guides were developed by the R2R project leads, who also co-facilitated the interviews. CTDTD and Pandemic Parenting co-developed and share ownership of the recorded interviews and subsequent digital resources and produced content. Once the interviews were completed, the excerpts from the raw interview recordings were edited together to produce the publicly available R2R educational podcast episodes and supplementary materials.

Sample and Data Source

The sample for this study is a convenience sample of interviews with the multidisciplinary and internationally renowned childhood trauma experts who voluntarily participated in the R2R project. The interviewed experts are affiliated with several of the leading national and global trauma organizations, including the International Society for Traumatic Stress Studies (ISSTS), Division 56 of the American Psychological Society (Trauma Psychology), the American Professional Society on the Abuse of Children (APSAC), and the International Society for the Study of Trauma and Dissociation

(ISSTD) (*Roadmap to Resilience*, n.d.). The interviewed experts represent a variety of disciplines, including clinical psychology, nursing, pediatric medicine, psychiatry, social work, child welfare, education, research, community organizing, and law. They are located throughout the United States and internationally (e.g., Canada, Australia, Argentina) and work with diverse pediatric populations and settings. Each expert voluntarily participated in a recorded interview for the purposes of the R2R project. This study utilized preexisting qualitative data in the form of the individual raw (unedited) recorded interviews originally conducted for the R2R project, to explore the study's research questions, noting that this data has not previously been the basis for research.

Data Collection

The original data for this study was collected through recorded interviews with child trauma experts conducted by the R2R project leads via the Zoom video communications platform (Zoom Video Communications, Inc.). The interviews were conducted using semi-structured interview guides that varied by discipline, which allowed for maximum variation and rich data. Each interview was approximately 60-80 minutes long, and the interviews took place between April 2021 and September 2021. Excerpts from the interviews were then edited together and produced into audio podcast episodes, as well as a collection of short video highlight clips and infographics. These materials are publicly accessible on the R2R website at https://www.roadmaptoresilience.org and the R2R YouTube playlist at https://www.youtube.com/playlist?list=PLustfivIlmdEYz1-WK51iIKvECoA7E7JI. This

utilized only the raw recorded interviews, not the materials that are publicly available. Because the interviews were previously recorded, this study did not require further data collection.

IRB Approval

The study was submitted to the Oakland University Institutional Review Board and was approved (OU IRB #2022-205) under the following expedited categories: 5) research involving materials that have been collected solely for non-research purposes, and 7) research employing interview methodologies (see Appendix A).

Ethical Considerations

The members of my dissertation committee and I completed training on conducting human subjects research through the Collaborative Institutional Training Initiative (CITI Program). The interviews were used for the non-research purposes of public and professional education and portions of the interviews are publicly available. However, in order to utilize the unedited recorded interviews for this research study, I subsequently sought and received consent from 15 of the 16 experts for the specific purposes of this study. The study's research aims, purpose, and implications were detailed and provided to the participants in the information sheet (see Appendix B). Participants were informed through the consent process that participation in this study was voluntary, and they could decline to participate or withdraw their interview data from the study at any time without consequence. The participants were informed that no further interviews would be required for the purposes of the study, but that I may contact them for clarification purposes if necessary.

The experts' information was kept confidential, and experts were de-identified by replacing identifying information in each transcript with a pseudonym comprised of four random capital letters. A unique identifier key was created and housed on my secure laptop to which only I have access. All quotes and themes reported in the results section utilize pseudonyms to protect the privacy of the expert interviewees.

The experts are well known for their expertise in childhood trauma and resilience. Therefore, there was a minimal risk that individuals outside of the research team who are familiar with the Roadmap to Resilience project and associated publicly available content, or individuals who are deeply engaged in resilience and childhood trauma research and practice, may be able to deductively link statements presented in the study results to one or more individuals who participated in the study. Participant names, images, or other identifying information will not be used in the publication or presentation of findings from this study.

Data Management

The recorded raw interviews were shared with me via a secure cloud data storage platform. Only the interviews for which consent was received were shared (i.e., 15 of the 16 recorded interview files). All consented interviews were named with a unique identifier and transcribed using the software QSR NVivo (QSR International Americas, Inc.). The transcriptions were then rechecked for accuracy by listening to the interviews while reading the transcripts and making corrections as needed. All study documents including consent forms, interviews, memos, etc. were housed on a secure laptop accessible only by me or the IRB upon request.

Data Analysis

Reflexive Thematic Analysis

Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2006, 2022) was chosen as the method for data analysis for this study. This approach provided perspective and context for the reading, coding, grouping, and interpretation of data and themes related to childhood trauma and resilience (Braun & Clarke, 2021, 2022). RTA is a six phased approach to analysis that values researcher subjectivity, interpretation, and position within the topic of interest (Braun & Clarke, 2022). The six phases of RTA are data familiarization, coding, development of candidate themes, revision and refinement of themes, developing final themes, and producing the report (Braun & Clarke, 2022). Although Braun & Clarke (2021, 2022) present six phases of RTA, they intentionally avoid the use of the term "steps" and emphasize that the process of RTA is not linear or unidirectional. The researcher may return to an earlier phase or move back and forth between phases as their interpretation of the data evolves (Braun & Clarke, 2022).

Data Familiarization

In RTA, the phase of data familiarization allows the researcher to build a robust foundation for data analysis (Braun & Clarke, 2022). Through deep engagement with the data, the researcher gains knowledge and high-level understanding of the overall dataset while also practicing reflexivity which provides time and distance for reflection, and to note thoughts, ideas, and noticeable patterns of meaning that are, or may be, relevant to the research aims (Braun & Clarke, 2022).

Coding

I utilized NVivo throughout the coding phase of analysis. In RTA, coding is an evolving, systematic, and iterative process by which the researcher engages with the data through an analytic lens and applies codes to data segments that reflect units of meaning across the dataset. Codes represent small, singular units of meaning that may be more explicit or more abstract (Braun & Clarke, 2022). In RTA, the researcher is often the single coder, gaining perspective into the diversity of meaning as well as units of shared meaning throughout the coding phase. The goal of coding in RTA is meaning making as opposed to finding the truth within the data (Braun & Clarke, 2022). During the coding phase of RTA, researchers may utilize inductive or deductive approaches, or a combination of these, depending on the research aims, theoretical framework, and the researcher's philosophical orientation to analysis. When the aims of research focus on understanding the views and perspectives related to how one experiences a phenomenon, the approach to initial coding is often inductive, wherein codes are more latent and stem from and stay close to the data (Braun & Clarke, 2021, 2022; Byrne, 2021). However, the researcher's experiences, views, perspectives, and disciplinary worldview shape and influence the research process, therefore some deductive coding is inevitable (Braun & Clarke, 2022). Further, it is not uncommon in RTA for codes to evolve as the researcher's insight into the data is enhanced through continued analytic engagement with and reflection upon the data (Braun & Clarke, 2022).

Researchers utilizing RTA code the entire data set systematically and then repeat the process at least once, taking time away from the data to reflect, form interpretations of the dataset, and gain inspiration (Braun & Clarke, 2021, 2022). Following initial

coding, which takes place over multiple iterations and often extended periods of time during which the researcher participates in reflection, the initial codes are reviewed, revised, and grouped into categories of similar meaning. Braun & Clarke (2022) assert that in RTA, frequency of information does not necessarily imply importance in terms of coding. In this way, the researcher's prior knowledge and subjectivity is vital in understanding the relevance of the data to the research question (Braun & Clarke, 2021, 2022).

Generating, Revising, and Naming Themes

Following coding, and the creation of categories, themes and subthemes are developed by organizing the categories, subcategories, and concepts produced from the data. Through researcher reflexivity, themes and subthemes are developed, revised, and refined until the researcher is satisfied that the themes are meaningful to and address the research questions. In RTA, themes are outputs of the analytic process of coding and are produced by organizing codes around a central concept or concepts that the researcher interprets through prolonged engagement with the data and the development of patterns of meaning across the data (Byrne, 2021; Braun & Clarke, 2021, 2022).

Producing the Report

To produce the analytic report, which is the sixth phase of RTA, the researcher presents the themes to collectively construct a comprehensive representation of the data and sequences themes in a manner that ensures the reader is presented with a coherent and integrated “overall story” (Braun & Clarke, 2006, p. 94) about the phenomenon of interest. Braun & Clarke (2022) recommend including two to six multifaceted themes, and any related subthemes, in the analytic report, each with a distinct central organizing

concept. The study's implications then stem from the themes and subthemes produced through the analysis and the lens of the researcher's own discipline (Braun & Clarke, 2022).

Strategies to Address Integrity, Credibility, and Quality

The Role of the Researcher and Reflexivity

The researcher plays a key role in data collection and analysis in qualitative research and is often referred to as the "primary instrument" in these processes (Braun & Clarke, 2021, 2022; Merriam & Tisdell, 2016, p. 16). In RTA, researcher reflexivity is essential for ensuring quality, as it represents the researcher's intentional and repeated reflection throughout the research process to ensure alignment of the researcher's philosophical and theoretical assumptions, decision-making, and approach to research (Braun & Clarke, 2022). The reflexive processes of journaling, memoing, and note-taking in RTA provide an audit trail and capture the researcher's thoughts, reflections, interactions with the data, and decision-making from initial transcription through theme development (Braun & Clarke, 2022). Throughout analysis, the researcher must strive to recognize and hold true to their perspectives, identity, experiences, disciplinary and topical knowledge, and positionality, valuing these as integral in shaping their research practice and analytic process, and ensuring quality analysis and findings (Braun & Clarke, 2021, 2022, 2023). Although the process of data collection was complete for this study and preexisting recorded interviews were used, it was important for me to acknowledge my own experience and position within the research topic (Braun & Clarke, 2022). As a mother of three, a pediatric nurse, and a family nurse practitioner with a personal history of childhood adversity, I recognize that my experiences and perspectives

have shaped both my interest in this topic and the ways in which I designed and conducted this research. Throughout the study, I engaged in ongoing reflexivity regarding my positionality related to childhood trauma and resilience, remaining cognizant of the ways in which my subjectivity and lived experiences might influence the processes of coding and interpretation of the data. During the iterative phases of RTA, I was deliberate in my efforts to deeply contemplate the statements and narratives shared by the experts, to honor their voices, and to interpret the dataset with care and integrity. Through this approach my goal was to produce a nuanced and meaningful account of the data that is both compelling and relevant.

Delimitations and Limitations

Delimitations in qualitative research relate to decisions made by the researcher, such as the study's design, methodology, research focus, and other factors that create boundaries or parameters within which the research is constrained. This study is delimited by my chosen focus on the exploration of resilience in the context of trauma-exposed youth. The study is further delimited by the choice of dataset, which consists of pre-recorded interviews with 15 childhood trauma experts previously collected for the purposes of the R2R project. A limitation of this study is that I did not develop the interview guides, nor were they specifically designed to address the research aims for this study. A second limitation is that the study utilized preexisting data, and I did not have the opportunity to conduct further interviews with additional childhood trauma experts to gain further perspective on resilience in trauma-exposed youth. Finally, with the use of preexisting data, there was the possibility that the data may not address the research questions for this study upon analysis.

Chapter Summary

Chapter Three presented an overview of the design for this study, a discussion of the study's procedures, and a detailed discussion of the chosen analytic method of Braun & Clarke's reflexive thematic analysis. Further presented in this chapter were strategies to address integrity, credibility, and quality of data analysis, as well as the delimitations and limitations of this research. Chapter Four presents a detailed discussion of the data analysis process and the study's findings.

CHAPTER FOUR

DATA ANALYSIS AND RESULTS

The purpose of this qualitative study was to explore the perceptions, thoughts, ideas and perspectives of child trauma experts related to trauma and resilience in trauma-exposed children across the pediatric life span. Childhood trauma is ubiquitous in the United States and globally (Debiasi, 2012; CDC, 2022; Bethel et al., 2022; Hamby et al., 2021), and among the professional disciplines serving children such as psychology, social work, juvenile justice, medicine, and nursing, there is significant focus on factors which demonstrate and promote resilience in youth exposed to trauma (Hamby et al., 2021). However, the conceptualization of resilience often remains siloed within a researcher's discipline, which is a factor contributing to the continued variation in the interpretation and application of resilience science to interdisciplinary practice and collaboration (Masten & Monn, 2015; Morse et al., 2021; Yoon et al., 2021). Furthermore, throughout the pediatric lifespan, children progress through various stages of physical, cognitive, psychosocial, moral, and language development, with each corresponding to their developmental age (Hambrick et al., 2019; Alderman et al., 2019; Allen & Waterman, 2019; Zubler et al., 2022). As a child develops through each stage, the ways in which resilience may be promoted and demonstrated will parallel developmental changes; however, there is a paucity of resilience research that integrates developmental context and perspective related to recognizing and promoting resilience (Yoon et al., 2021).

This study aimed to address these gaps through an exploration of how child trauma experts describe trauma and resilience based on their experiences working with

trauma-exposed youth. The overarching research question (RQ) for this study is "how do childhood trauma experts view trauma and resilience in children", and specifically, how do childhood trauma experts describe: 1) the impacts of exposure to trauma in children of different developmental ages; 2) resilience in trauma-exposed children; 3) ways in which trauma-exposed children of different developmental ages demonstrate resilience; and 4) modifiable factors that promote resilience in trauma-exposed children?

The following sections of this chapter address important updates to the original research questions and present the process of preparing the data for analysis, descriptive participant information, a statement about reflexivity in Braun & Clarke's (2022) reflexive thematic analysis (RTA), and the application of RTA to this research. The chapter further presents the final themes and subthemes produced from the transcripts of interviews with 15 child trauma experts, a discussion of the study's delimitations and limitations, and a chapter summary.

Updates to Original Research Questions

In qualitative research, analysis of the dataset should be closely aligned with the overall research aims. However, Braun and Clarke (2022) assert that, at the onset of qualitative data analysis, and particularly when beginning the reflexive process of RTA, a study's research questions are not necessarily finalized, and that, through deep engagement with the data over time, research questions may evolve or shift as new analytic insights emerge. This is not only acceptable in RTA but anticipated, as the iterative nature of the approach allows for both analytical and conceptual flexibility (Braun & Clarke, 2022).

Additionally, in preparing for this research, I recognized that by analyzing data that had already been collected, there was a possibility my research questions may need some revision, though I was confident that the overall research aims would be addressed in the dataset. As I progressed through the analysis, I recognized a distinction between two similar but separate ideas, one of which was reflected in research question one, (RQ1) and one that was equally as important but not specifically addressed in the original research questions. The first was related to a child's development as being *impacted by* exposure to trauma, which was reflected in the original RQ1. The second was related to a child's developmental age or phase as *influencing* the response to trauma, the nuances of which were not captured in the original questions. Therefore, my first research question was split into two questions as follows: how do childhood trauma experts describe 1) the influence of developmental age on responses to trauma in children; and 2) the developmental impacts of exposure to trauma during childhood?

These distinct yet interrelated questions enabled me to discern profound meaning related to the multilevel and dynamic interplay between the concepts of trauma, physical development (i.e., brain development), and developmental age as it relates to the anticipated stages of language, cognitive, moral, and psychosocial development. Additionally, as I progressed through data analysis, I discovered that it was challenging to distinguish between original research questions two (RQ2) and three (RQ3) in terms of the applicability of data segments to one versus the other. Through further reflection and engagement with the data, it became clear that RQ2 was more conducive to capturing broad patterns of meaning across the dataset. Since RQ1 addressed developmental influences related to the response to trauma, the original RQ3 related to the ways in

which trauma-exposed children of different developmental ages demonstrate resilience, was discarded. The original and revised research questions are presented Table 4.1. The overall aim of this research was not impacted by the revisions to the original research questions, and all research questions were addressed through the data analysis.

Table 4.1

Original and Revised Research Questions (RQs) and Rational for Revision

Original RQs	Revised RQs	Rationale for revision
How do childhood trauma experts describe:	How do childhood trauma experts describe:	
1) the impacts of exposure to trauma in children of different developmental ages?	1) the influence of developmental age on responses to trauma in children? 2) the developmental impacts of exposure to trauma during childhood?	The original RQ1 did not specifically distinguish between the ideas that 1) responses to trauma may be different in children of different developmental ages or phases, and 2) that exposure to trauma can impact a child's development. This distinction was present in the data and is important in telling the story of the data.
2) resilience in trauma-exposed children? 3) ways in which trauma-exposed children of different developmental ages demonstrate resilience?	3) resilience in trauma-exposed children?	Original RQ2 and RQ3 were similar; determined the broader question was more conducive to interpretation of the dataset. Revised RQ1 addresses development.
4) modifiable factors that promote resilience in trauma-exposed children?	4) modifiable factors that promote resilience in trauma-exposed children?	No revisions.

Preparation of the Raw Data for Analysis

The dataset for this study was a collection of unedited MP4 videos of pre-recorded interviews with 15 multidisciplinary childhood trauma experts, previously collected for the purposes of the R2R project. The interviews flowed similarly and were focused on various aspects of resilience in trauma-exposed youth, yet the facilitators also included questions that were relevant to the expert's own discipline, role, and experience working with trauma-exposed youth. Topics addressed in the interviews included child sexual abuse, children witnessing interpersonal homicide, trauma and dissociation, advancing trauma-informed approaches in healthcare settings, nursing care of trauma-exposed youth, trauma implications related to immigration, and legal considerations of child trauma.

To prepare the data for analysis, I transcribed the interview videos using QSR NVivo (QSR International Americas, Inc.) transcription software. The transcripts were then exported from NVivo so they could be edited in Microsoft Word (Microsoft® Word for Microsoft 365 MSO, Version 2506) to better facilitate the process of deidentification using the search and replace features. The interview MP4 and transcript files were renamed with a pseudonym comprised of a unique combination of four capital letters. Each transcript was then imported back into NVivo, linked with the corresponding video, and carefully reviewed while watching the interview to correct any spelling and punctuation errors and to ensure that the transcripts accurately captured what was stated in the expert videos. The NVivo files as well as backups of the videos and transcripts were stored on a secure cloud platform and on my password protected laptop. Through the process of preparing the data, I was able to develop an initial, high-level

understanding of the data while transcribing, correcting, and deidentifying the transcripts.

Trustworthiness

Assumptions of reality in qualitative research vary from quantitative research, as do the standards and criterion for establishing rigor (Merriam & Tisdell, 2015). Where quantitative research assumes a single reality and truth can be discovered through observation and measurement, qualitative research assumes multiple realities exist, that truth is subjective and contextual, and that knowledge is constructed through interactions with others (Braun & Clarke, 2022; Creswell & Poth, 2018). According to Merriam and Tisdell, (2015), the concepts of reliability and validity in qualitative research are related to the design of the study and methodological alignment among the research aims, methods, analysis, and results. Cresswell and Poth (2018), assert that these the use of the terms "reality" and "validity" can position qualitative research nearer the positivist/post-positivist end of the paradigmatic spectrum with realist ontological and objectivist epistemological perspectives.

Trustworthiness in qualitative research can be achieved by employing several strategies similar to the quantitative criteria of internal and external validity, objectivity, and reliability (Lincoln & Guba, 1985; Nowell et al., 2017; Cresswell and Poth, 2018). Cresswell & Poth (2018) recommend the researcher utilize "accepted strategies" during the research process to reflect the "accuracy" of the study and quality research findings (p. 259). These accepted strategies may include member-checking, generating thick description, engaging in reflexivity, prolonged engagement with participants, using a code book, intercoder reliability (Cresswell & Poth, 2018). Some strategies, such as intercoder reliability, did not reflect the relativist, interpretivist approach to this study,

and since this was essentially a secondary data analysis, member checking did not apply to the analysis. Further, according to Braun & Clarke (2022), some strategies related to validity and reliability in qualitative research do not reflect the true nature of the qualitative methodology. Therefore, prior to beginning analysis, and as guided by Braun & Clarke (2022), the strategies chosen to ensure quality research and credibility of findings for this study were reflexivity through reflection and journaling, prolonged engagement with the data, and frequent review of the alignment of the study's aims, research questions, and my own philosophical assumptions.

Strategies for Quality RTA

Reflexivity is the key instrument in RTA in terms of ensuring quality. Through reflexivity, the researcher intentionally and iteratively engages in reflection throughout each step of the research process to achieve methodological integrity, or the alignment of the researcher's philosophical and theoretical assumptions, methods, design, and procedures (Braun & Clarke, 2022). According to the guidance of Braun & Clarke, researchers should recognize and stay true to their perspectives, identity, lived experiences, disciplinary knowledge, and position within the research topic, recognizing these as essential and influential to their research design and analysis (Braun & Clarke, 2021, 2022, 2024). Throughout analysis, I was deeply focused enhancing my understanding of the nuances of the method and conducting my analysis in such a way that would reflect sound RTA practice (Braun & Clarke, 2022). I routinely reflected on my research questions, theoretical and philosophical assumptions, my own experiences, and how I am situated within this research topic, while immersing myself in the data, consistently capturing thoughts and ideas in my reflexive journal, and, when I strayed off

the path, referring back to the guidance of Braun & Clarke (2021, 2022, 2024). Note taking and memoing were completed in my digital notebook and on paper reports produced in NVivo during the phases of coding and theme development as I interacted with and reflected upon the data. I reviewed my notes and memos throughout the phases of analysis and shared them during meetings with the qualitative expert on my dissertation committee to facilitate discussion and reflection on my experience and analytic process.

During initial engagement with the data, I periodically experienced strong responses to some of the interview content, which I believe were related to my situatedness within the topics being discussed. Over the course of analysis, there were several occasions when I needed to step away from the data for extended periods of time to allow myself the distance and space to reflect, spend time with family, and engage in self-care activities. As part of reflexive practice, I noted my responses in my journal with a spirit of curiosity and exploration and journaled often during these breaks. Following each period of reflection, I returned to the data with renewed focus and determination to produce high-quality and compelling analytic output. My commitment to methodological integrity, understanding and intentional application of the phased approach to RTA, deep and prolonged engagement with the data, and frequent reflexive practices were instrumental in ensuring the quality and credibility of this research.

Data Saturation

In qualitative research methodologies, it is often the aim of the researcher to achieve data saturation, which is considered the standard criterion evident of an adequate sample size (Braun & Clarke, 2024). Braun & Clarke assert that the aim to reach data

saturation in RTA comes with challenges that may be difficult to address, as the concept of reaching a point where no new information can be gleaned from the dataset does not align with a relativist approach to analysis. A truly relativist approach implies that every time the researcher engages with the data, there could be a new interpretation of meaning (Braun & Clarke, 2022). Instead, Braun & Clarke encourage RTA researchers to focus on the power or richness of the data and how well the dataset addresses the study's aims and research questions (Braun & Clarke, 2022). To ensure the highest quality analytic output, I intently focused on each transcript and the dataset as a whole throughout the analytic process and repeatedly engaged in the phases of RTA over a period of several months during which I gained deep familiarity with the data. Although I was working with interviews that had been pre-recorded for another purpose, the recordings included rich narratives on concepts that were highly relevant to the research topic, addressed the research questions, and provided meaningful insight into this area of research.

Reflexive Thematic Analysis

Reflexive thematic analysis (RTA) (Braun & Clarke, 2006, 2021, 2022) was chosen as the method for data analysis for this study. The goal of analysis in RTA is not to be objective or to find a single, agreed upon truth, but rather to engage deeply with the data and, through subjective interpretation, create rich meaning in a way that is compelling and is situated within the researcher's own philosophical, theoretical, and disciplinary perspectives (Braun & Clarke, 2022). I approached the analysis through a relativist, constructionist lens, which aligns with my philosophical assumptions and world view that multiple realities exist, subjectivity is valued, and knowledge is constructed through interactions with others (Lincoln & Guba, 1985; Cresswell & Poth, 2018). RTA

assumes there is no objective approach to generate knowledge. There can be no single accurate interpretation of data, and the outputs of the analytic process, codes and themes, do not *emerge* from the data. Themes are not inherently present within the dataset, waiting to be found or discovered by the researcher, but are *created* and *produced* by the researcher through a combination of the researcher's deep engagement with and inexorably subjective interpretation of the data (Braun & Clarke, 2021, 2022). Finally, the goal of RTA is not to simply describe the data. RTA aims to tell the story of the data in a way that fosters interest in the topic and offers new and relevant perspectives.

Braun & Clarke present six phases of RTA, to guide researchers in their analysis, emphasizing the importance of recursively moving through the phases as they fully engage with and evolve their interpretation of the data (Braun & Clarke, 2022). RTA offers the flexibility to approach data analysis inductively, deductively or, in many cases, both inductively and deductively based on the research aims and theoretical framework. The phases of RTA include data familiarization; coding; generating initial themes; developing and reviewing themes; refining, defining, and naming themes; and writing up the analysis to include a presentation of themes with data extracts (Braun & Clarke, 2006, 2021, 2022). The phased approach of RTA provided perspective and context for the reading, interpretation, coding, and categorization of data and the production of themes from the dataset related to the research aims of childhood trauma and resilience.

Phase 1: Data Familiarization

Coding in RTA is a systematic and reflexive process that begins with good familiarization with the data, which is vital to ensuring a solid foundation upon which to progress through analysis (Braun & Clarke, 2022). During the data familiarization phase

of RTA, the researcher engages with the data for the purposes of developing an understanding of and knowledge about the data while also allowing time and distance to absorb and critically reflect on the dataset. During this phase the researcher also makes notes of thoughts, ideas, and noticeable patterns in the dataset that are, or may be, meaningful to the research aims (Braun & Clarke, 2022). In this study, data familiarization began with preparation of the data for analysis. Descriptive data related to the child trauma experts was also collected through this phase. Following preparation of the data, I systematically read and reread the transcripts as I reflected on my thoughts and initial interpretations of the data. I took notes to capture ideas and insights related to the dataset. Data familiarization continued until I began to critically form opinions about and notice patterns of meaning, at which point I moved on to phase two, coding.

Phase 2: Coding

The second phase of RTA is coding, during which the researcher works through the dataset in a systematic and detailed manner, closely reviewing the data with an analytic eye and applying codes to data that appear to be meaningful or potentially meaningful to the research aims. Codes specific and can be used to capture a range of meaning, from explicit or semantic to more abstract or latent (Braun & Clarke, 2022). I began initial coding within NVivo, closely reading each transcript and coding data segments that were relevant to my research aims and overall topic. I followed an inductive approach, which allowed me to focus intently on the data without the expectation of creating and applying codes that fell within the constraints of my conceptual model. I applied mostly semantic codes, or codes that remained very close to the expert's words, while at times applying more latent codes that required more

conceptual thinking based on my subjective position within the data. At the conclusion of this first round of initial coding, I had created 437 codes referencing more than 900 segments of data. It is beneficial in RTA to systematically review the dataset more than once and engage with the data in a different order during each round of coding to ensure full attention is given to the whole of the data (Braun & Clarke, 2022). I followed this approach as I read through the transcripts a second time in reverse order and made notations as I revised, combined, and eliminated some of the initial codes and continued to code data excerpts from across the dataset that had significant or potential meaning to my research aims. Following the second round of coding I noted that I was making many revisions and therefore felt I should review the transcripts a third time. For this round of coding, I applied both inductive and deductive strategies, the latter reflecting my philosophical orientation and prioritization of data-derived meaning while also broadly positioning the data within my disciplinary and conceptual framework (Braun & Clarke, 2022). Deductively, I created and applied codes that aligned with the concepts within the theoretical model upon which this study was based, Roy's Adaptation Model (RAM) (Roy, 2009). Further, I coded thoughts and ideas that did not directly address my research questions, but that I felt were important in some way to my study based on my position within the dataset. For example, I noticed nearly all experts made comments about the role of professionals working with traumatized children and the associated responsibilities or obligations, such as the need for provider education and training and modifications to curricula in disciplines such as nursing, medicine, and psychology. Although I did not have a research question related to this concept exactly, I identify as a trauma survivor, nurse practitioner, trauma researcher, and trauma-informed nurse

educator. From those perspectives, I believed certain data were meaningful to my overall research topic, and therefore I captured related units of meaning with code labels such as "all providers need trauma education and training" and "trauma content is absent from curricula". During the coding phase, I met with the qualitative research expert on my dissertation committee to discuss codes, coding memos, and decisions, with a goal of ensuring that data have been interpreted and capture meaning, rather than reflecting straight description of the data (Braun & Clarke, 2022).

Following the third round of coding, I utilized NVivo to create and print a report that collated the codes and coded data excerpts so that I could review and reflect upon the outcome of the initial coding process. From there, I made notations directly on the report and revised, grouped, and categorized code labels over time, reflecting on my work during and between each engagement with the data. Throughout this iterative process, I returned to the data, the theoretical model, my notes, and my research questions repeatedly, and continued until I had grouped the code labels into meaningful categories representing my interpretation of the data, at which point I moved on to the next phase of RTA, generating initial themes.

Phase 3: Generating Initial Themes

In the third phase of RTA, the goal is to organize codes into clusters of shared meaning and gather clusters that appear to broadly reflect an idea, concept, or thought that is common across the dataset and relevant to one or more of the research questions (Braun & Clarke, 2022). These broad ideas or thoughts are viewed as initial or candidate themes. I worked through phase three by first reviewing the groupings and categories of codes I had developed in phase two. At this point, I used NVivo to download the codes

and data segments into an Excel spreadsheet, where I could more easily sort and group the codes into initial themes. I alternated between the Excel spreadsheet and a printed copy as I again reflected and put significant thought into the meaning of the initial themes and whether each addressed my research questions. When I felt confident that the initial themes addressed my research aims, I moved on to phase four of RTA, developing and reviewing themes.

Phase 4: Developing and Reviewing Themes

In the fourth phase of RTA, the goal is to critically review the initial themes to determine whether they are a good fit to the data and therefore reflect a viable analysis by moving back to the larger dataset to check that the themes align with not only the coded segments of data, but also the dataset as a whole. During this phase, all notes and revisions written on the printed spreadsheet were integrated into the Excel spreadsheet and data segments were sorted based on the initial theme. Each initial theme was considered carefully in light of the dataset in its entirety, to determine if the theme truly captured an idea that was most important among the dataset. With the research questions in mind, I created several different thematic maps to organize my thoughts and ideas about how the data addressed the research questions. An example of an early thematic map is presented in Appendix B. In a recursive manner, the collated data was reviewed as I engaged in reflection and continued to refine the thematic maps, each time achieving a bit more clarity in my interpretation and organization of the data. I engaged in this process, revising and remapping the initial themes along with choosing exemplar segments from the dataset until I reached a point where I was no longer making substantial revisions or modifications to the themes and felt I could move on the phase

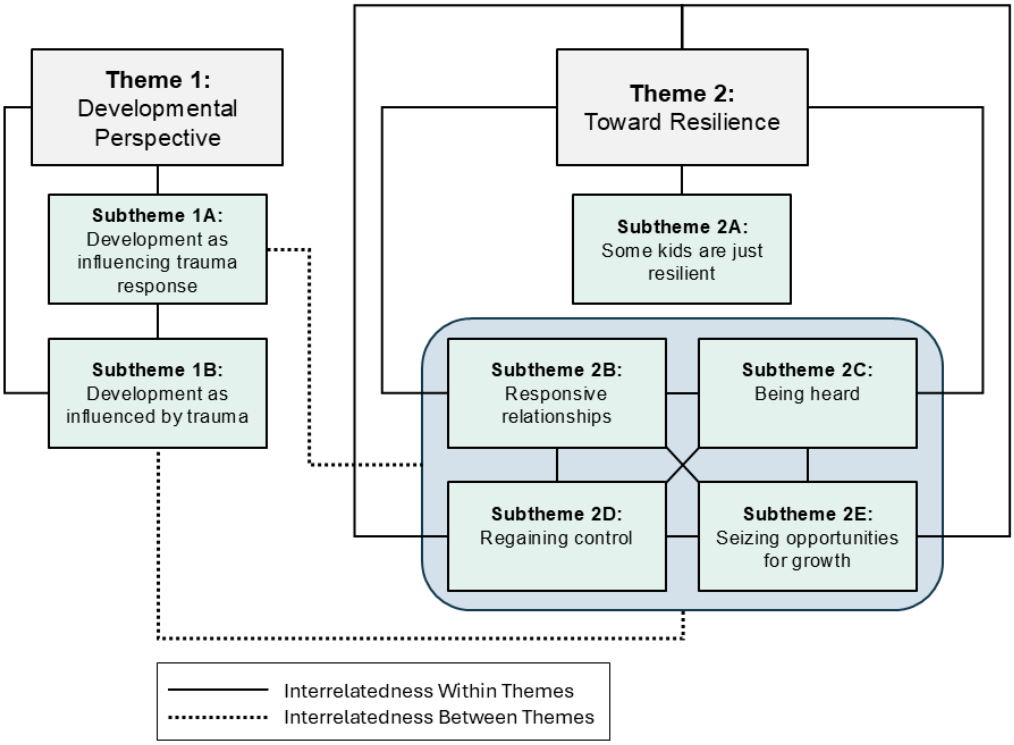
five (Braun & Clarke, 2022).

Phase 5: Refining, and Naming Final Themes

During phase five of RTA, the aim is to appraise the overall analysis by refining themes so that each is clearly generated around a robust central concept that reflects an important part of the data, and that the themes together tell a compelling overall story of the dataset. During this phase I developed names for each theme and wrote summaries that provided concise descriptions of the themes. I went through several cycles of naming and defining and reached a point where I felt the final themes needed no further development. In Figure 4.1, the primary themes and their subthemes are mapped to reflect the complex interplay within and between the themes.

Figure 4.1

Kennedy's Thematic Map of Resilience in Trauma-Exposed Youth



The final themes and subthemes along with descriptions of each are presented in Table 4.2. Appendix C lists the themes with examples of codes and data extracts.

Table 4.2

Final Theme Names and Descriptions

Themes and subthemes	Description
Theme 1: Developmental Perspective	
Subtheme 1A: Development as influencing trauma response	Depending on the child's developmental age and stage, the ability of the child to recognize, understand, and express experiences of trauma, violence, and maltreatment may be limited.
Subtheme 1B: Development as influenced by trauma	The timing of trauma, especially if it occurs during key periods of a child's development, can impact brain development, neuroendocrine, and other biologic or physiologic responses to trauma.
Theme 2: Toward Resilience	
Subtheme 2A: Some kids are just resilient	Children are naturally resilient; there are some predispositions or inborn attributes, such as temperament, which make some kids more likely to be resilient following trauma.
Subtheme 2B: Responsive relationships	Identifying and regularly engaging with one or more trusted adults who provide consistent, stable, and responsive relational support (for example, parents, caregivers, extended family members, teachers, healthcare providers, and spiritual leaders).

Table 4.2 - Continued

Final Theme Names and Descriptions

Themes and subthemes	Description
Subtheme 2C: Being heard	Identifying and interacting with supportive adults who show genuine interest, listen intently, and validate feelings and experiences; centering youth voice in problem-solving.
Subtheme 2D: Regaining control	Regaining a sense of control, empowerment, and voice following trauma.
Subtheme 2E: Seizing opportunities for growth	Building assets and participating in activities that promote growth and build autonomy such as learning new skills, helping others, and engaging in activism.

Phase 6: Producing the Report

In the sixth phase of RTA, the objective is to produce an analytic report presenting a cohesive narrative integrating the final themes with meaningful data excerpts to tell the story of the dataset related to the study's research questions (Braun & Clarke, 2022). The following sections present descriptive participant information, a thematic mapping illustrating the relationship among the two main themes and seven subthemes. and a detailed presentation of the themes interwoven with exemplar data segments from the expert narratives.

Analytic Report of Findings

Descriptive Participant Information

Because the data for this study was in the form of prerecorded interviews for the purposes of a non-research project, demographic information about the child trauma experts was not collected. The interview recordings did include information about the discipline and role of the experts, which is presented in Table 4.3.

Table 4.3

Descriptive Participant Information

Participant	Role and Discipline
ASPN	Associate Professor, Graduate School of Professional Psychology
CDAR	Bilingual and bicultural Clinical Psychologist
CPRS	Licensed Clinical Psychologist
ERMB	Clinical Psychologist; Instructor of Child and Adolescent Psychology; Research Scientist
REBD	Professor of Pediatrics; Director of Forensic Services
SGID	Managing Director of a national advocacy organization
RWCN	Founder and CEO of a technology and media company
JNPR	Clinical Associate Professor of Social Work
LRUL	Child abuse pediatrician; child psychiatrist; Associate Professor of Pediatrics
OCEN	Graduate student in Clinical Psychology
RVNR	Associate Professor of Criminology
NDGO	Clinical Psychologist
LRKA	Registered Nurse
BRHC	Associate Professor of Social Work; forensic and licensed clinical social worker
WLNO	Licensed Independent Clinical Social Worker

Theme One: Developmental Perspective

The first theme, *developmental perspective,* explores the experts' narratives around the topic of child development as it relates to trauma. Two subthemes were produced related to the main theme of *developmental perspective: development as influencing trauma response, and development as influenced by trauma.* Specifically, these themes describe the experts' perceptions of how a child's development may influence or be influenced by trauma, and address research questions 1) how do childhood trauma experts describe the influence of developmental age on responses to trauma in children; and 2) how do childhood trauma experts describe the developmental impacts of exposure to trauma during childhood?

Subtheme 1A: Development as Influencing Trauma Response

Experts shared insights on how a child's developmental stage influences their ability to comprehend and communicate traumatic experiences. The first subtheme, *development as influencing trauma response*, captures the understanding that a child's capacity to recognize and articulate traumatic experiences relates to their developmental age. Since the experts did not necessarily define developmental age or provide parameters for stages of development, to provide context for subthemes 1A and 1B, an example from the childhood trauma literature is provided.

Experts emphasized that younger children may not have reached a level of cognitive maturity allowing them to recognize that what they are experiencing is wrong, nor the language skills to disclose these experiences to a caregiver or professional. When discussing developmental age in context, some experts referred to specific age groups, such as "four- and five-year-olds" (NDGO), while most used general terms like "younger

children" (BHRC) or "younger kiddos" (JNPR) to describe children at early developmental stages. Experts BHRC, CPRS, and JNPR similarly expressed that young children may not comprehend that what they are experiencing is harmful or understand why it is happening. BHRC explained:

> I think one of the things that's really hard for people to understand is why children don't tell, why they don't disclose right away. And I think that it's important for them to understand that for younger children, oftentimes they don't really realize that they are experiencing sexual abuse.

CPRS and JNPR also emphasized the developmental factors that influence a child's ability to express traumatic experiences. JNPR noted that in the absence of language to describe what is happening, children may instead exhibit concerning symptoms or behaviors that prompt parents and caregivers to seek care:

> And so, it's really complex with younger kiddos who don't have the, may not have the capacity, because of their developmental stage, to really express or articulate what's going on for them […] we might see struggles with the intrusive memories, the avoidance, the numbing, you know, psychosomatic symptoms. So, you know, kids who aren't able to necessarily explain why they're feeling the way they do, but we recognize it through their behavior.

CPRS similarly reflected, "for many children, they spend quite a lot of time before they can understand that something is wrong about this". Further, CPRS asserts that children who have lived with chronic exposure to trauma may also adapt to anticipate traumatic experiences as normal in their everyday environment, as described in this statement:

> When they come to the world without trauma, their brain is waiting for more trauma to happen. And what we see is the tip of the iceberg, the behavior, and we punish the behavior, because we don't see the other part, which is what is under the line of water. So, the most powerful message is to understand that, is that what have been labeled as misbehaviors have been adaptations to something that shouldn't have happened, and the child is now showing us with his behaviors, with his affect, his regulation.

Subtheme 1A, *development as influencing trauma response*, captures the narratives of experts around how developmental age impacts the way in which children, particularly young children from infancy through age 3, respond to trauma. Children of different developmental ages exhibit variation in terms of cognitive and emotional maturity as well as language acquisition and expression, and therefore the response to trauma will vary as well. This subtheme is important to healthcare and other professionals working with or providing care to children. By gaining insight into the influence of development on trauma responses, providers and clinicians may be able to recognize certain behaviors or somatic symptoms possible responses to chronic stress or trauma. This may in turn result in early identification of potential adverse experiences or circumstances and allow the opportunity for early intervention to address modifiable factors that may improve health outcomes.

Subtheme 1B: Development as Influenced by Trauma

In contrast to subtheme 1A, which focused on how a child's development, specifically developmental age, impacts the response to trauma, another significant narrative reflected in the expert interviews was focused on how trauma itself influences

development, particularly during the period of "early childhood" (ERMB). The second subtheme, *development as influenced by trauma*, captures these ideas. Consider ERMB's statement:

> Early childhood […]and particularly up until about age three, is one of the most important periods for the development of the brain architecture. And […] even though we know that genes provide the roadmap or blueprint for the development of brain circuits, we also know that neurons fire together and wire together based on the experiences that babies and children have in early life. […] Severe stress and trauma […] can change chemistry, and ultimately genetic signaling and, you know, brain development.

Other experts shared similar insight on this topic. For example, REBD commented:

> Exposure to major stressors and traumas like are included in the ten ACEs and others, translates biologically through our immune systems […] through our changes in the brain, in our hypothalamic-pituitary axis, and […] in our circulating hormones, […] demonstrated actual changes in the neural anatomy.

Also related to trauma and development, LRKA expressed concern that professionals working with children may underemphasize the impact of parental or caregiver mental health on a child's development.

> Maybe we see that a parent is really struggling with a mental health concern. And I think we downplay how much that can actually be affecting the child and their development. And so, I think I think that the family dynamics and those relational disruption pieces, it could be even a sibling who is ill, domestic violence at home,

these pieces can often go missed when assessing and looking at a child or a family.

In summary, subtheme 1B, *development as influenced by trauma*, reflects the experts' narratives related to the impacts of trauma on children, and much emphasis was placed on adverse experiences during periods of rapid brain development, specifically in early childhood.

Summary of Theme One

Theme One and its subthemes capture ideas related to the bidirectional relationship between development and trauma, and specifically how various aspects of development during the time in which trauma occurs may both influence the child's responses to trauma and how developmental trajectory may also be impacted through the complex biopsychosocial responses to trauma.

Theme Two: Toward Resilience

The second main theme developed was *toward resilience*. This theme reflects the experts' views, perspectives, and ideas about resilience, such as what it is, how it is demonstrated, and how it can be promoted in trauma-exposed youth. Specifically, this theme addresses two primary research questions 3) how do childhood trauma experts describe resilience in trauma-exposed children, and 4) how do childhood trauma experts describe modifiable factors that promote resilience in trauma-exposed children? Within this theme, five subthemes were developed: 1) *some kids are just resilient;* 2) *responsive relationships*; 3) *regaining control*; 4) *being heard*; and 5) *seizing opportunities for growth*. Subtheme 2A focuses on the experts' perspectives on innate factors that may predispose a child to be resilient. The remaining subthemes reflect the experts' views

about protective factors (PFs) and positive childhood experiences (PCEs) which play a role in the mitigation of negative health outcomes of childhood adversity and the promotion of resilience (Bowling et al., 2022; Masten et al., 2021; Morse et al., 2021; Yoon et al., 2021).

Subtheme 2A: Some Kids are Just Resilient

The subtheme *some kids are just resilient* captures meaning related to the experts' perceptions that resilience following adversity may be inherently more likely in some children than others. Several experts stressed that certain innate attributes or characteristics, such as temperament and coping skills, may predispose some children to resilience following trauma. For instance, NDGO expressed, "I've treated two kids from the same family with the same trauma and one dissociated and the other didn't. So, I've thought about it a lot. And I think that there are actually some inborn predispositions." Similarly, BHRC noted the complex interplay between innate characteristics and environmental factors in this statement: "And that becomes this age-old question of nature versus nurture. It's really biopsychosocial; biological, psychological, and social-cultural. Some children just have an inherent ability to be resilient, and it's based on their temperament."

Further, JNPR emphasized that possessing and utilizing coping mechanisms is important to resilience, as noted here:

> Individual and collective coping that the youth themselves and the family are…their capacity to cope and…not only their capacity, but do they have the skills to cope, and do they utilize those coping skills consistently, both on an individual level and a collective level in terms of the family system.

BRHC warned of possible misconceptions among parents about childhood trauma, particularly that some people may perceive that children completely overcome trauma upon reaching adulthood. BRHC noted:

> Yes, children can be extremely resilient. I love talking about resilience, but what I worry sometimes when we talk about resilience is that parents will swing the other direction. Just from history, we've often treated children as if things that happened to them in childhood had no impact on adulthood. Like that, somehow there's this light switch that when they turn 18 that anything happened prior to 18 just kind of washes away.

Subtheme 2A, *some kids are just resilient*, captures expert perspectives on resilience as a predisposed attribute, or characteristic, such as temperament, as well as having and utilizing coping mechanisms. Also important is the perspective that professionals must understand that resilience is complex and multifaceted, and although some children adapt following trauma and are seen as resilient, it is important to practice with the understanding that in some individuals, exposure to childhood trauma can and does continue to influence health outcomes well into adulthood (Masten et al., 2021; Yoon et al., 2021). This is an important implication for nursing and other professional practice.

Subtheme 2B: Responsive Relationships

Experts in this study emphasized the value of responsive relationships, highlighting the significance of identifying and engaging with supportive adults, particularly for trauma-exposed youth who might otherwise lack sufficient emotional or social support. For example, OCEN stressed that the professional therapeutic relationship

itself can be an important resilience factor, especially for youth who have limited external support:

> Something else that I've learned is just how the therapeutic relationship itself can be a resiliency factor, it seems, in some of these kids in adolescence. So maybe where they're coming from in their context, they really don't have that many support people. You might be more important than you think […] and so also remembering that, you know, you know a lot more about mental health and trauma and how the body responds, how the mind can respond than the typical person and possibly your clients. So even just going back to some basic psychoeducation and just working with the family.

ERMB echoed the importance of supportive relationships and resilience for parents and caregivers as well, stating that "supporting kids is about building the resilience of the parents and the consistent caregivers, the people who care for kids, especially for young kids. So responsive relationships build resilience".

Furthermore, BRHC emphasized that supportive primary caregivers (i.e., parents, guardians, or other adults responsible for the day-to-day care of the child) facilitate recovery, particularly after experiences such as sexual abuse:

> But I think over time we're realizing it is whoever that and a primary caregiver being supportive and allowing them to receive whatever services might be needed is what really contributes to their ability to recover from sexual abuse experiences (BRHC).

The foundational role of relationships was further underscored by LRKA, who highlighted the restorative nature of reciprocal supportive relational experiences:

> And I think an important part of healing from trauma, from…from big trauma, from small trauma, from our world-wide culture of trauma, is to continue to engage in safe and supportive relationships, to support others, to receive support from others, and to bring us back to that natural tendency of looking towards relationships for supports and entrusting others to having a worldview of trusting and receiving.

Similarly, RVNR, in discussing the impacts of online child sexual exploitation, emphasized the healing and protective powers of affirming and validating relationships, and children having someone in their lives that believes in them.

> What ameliorates the impact of child sexual exploitation? It's people, it's relationships. You know, having someone as a child that believed in you, that believed you, you know, if what happened was detected in childhood, then having someone that stepped in and was protective and was affirming and validating and destigmatizing.

From a higher-level perspective, the consistency and strength of a child's broader support network were emphasized by JNPR and WLNO as they shared thoughts about healing following trauma. Both experts expressed similar ideas about collective support and coming together as a community following trauma as powerful resilience-promoting factors. For example, JNPR notes:

> You know their support system certainly is, that ties into that, but also thinking about how robust is their support system, how consistent are those individuals within their support system. So certainly, looking at what their circle of influence or their families, friends, other adults in their communities, community providers,

right. All of us can really promote and be…have the positive impact on…on resilience occurring.

And WLNO comments:

The other thing I think communities can do is that we can think about resilience and help and social support on a community level. And we come together when we come together as a community to grieve, express what's happened in a communal way rather than an individual way is very, very powerful […] there's validation, there's action, there's the expression of feelings that are being validated. There's making sense of what's happened to you and what's happened to your community. And there's something about it being joint that I think is very powerful.

Expressing another perspective related to the meaning captured in Subtheme 1B, *development as influenced by trauma*, ERMB further noted that when a child experiences responsive relationships and positive interactions during the critical developmental periods of early childhood, even if adversity is concurrently present, these factors can have a deeply positive influence on child health and development. These factors are often referred to as positive childhood experiences (PCEs) which, in contrast to ACEs, are experiences during childhood that are protective and can mitigate the effects of adversity and promote resilience. The below comment from ERMB not only supports prior statements related to the impacts of trauma on the developing brain but provides a more encouraging perspective that other experiences during critical periods of development, such as a caregiver being responsive and attuned to the child can be protective and promote positive health outcomes.

> When we think about severe stress and trauma, for example, we can think about this as a sort of high-risk, high-reward period when, because our brain is so open to experiential inputs, positive experiences can be profoundly enriching and shape very positive health trajectories and developmental trajectories […] so, this period is really, really valuable in terms of interventions and emotional development.

REBD, when discussing initiatives aimed at prevention of ACEs and childhood trauma, also discussed positive childhood experiences (PCEs), stating that, conceptually, PCEs are more easily understood by others, such as stakeholders and legislators, than the complex concept of resilience.

> You can think about what kind of prevention programs and what kinds of things can you do to reduce the load of adversity, while you also focus on increasing the resilience of your childhood population and your general population, and positive childhood experiences is actually a very nice frame because it's specific enough to make intuitive sense to everyone.

Subtheme 2B, *responsive relationships*, captures meaning from expert perspectives related to the protective power of consistent and supportive relationships in the lives of trauma-exposed youth. Responsive relationships may occur within the context of family, such as parents, caregivers, and extended family; or within other settings such as with healthcare providers, teachers, or spiritual leaders. Further, experts emphasized that having a sense of belonging to and being part of your community are also very powerful resilience factors.

Subtheme 2C: Regaining Control

The subtheme *regaining control* captures the experts' views related to how trauma diminishes a child's sense of control, and that regaining a sense of autonomy and purpose following trauma are important protective factors that may mitigate the adverse effects of trauma. WLNO emphasized the importance of these factors in the statement: "Trauma takes away your sense of control over life, the world, the sense that disaster could happen at any moment. Things that give you a sense of control or purpose are really, really powerful antidotes to that."

Another expert, NDGO, noted the impact of trauma on autonomy, self-determination, and choice, while also making a connection to Subtheme 1A, *development as influencing trauma response*:

> If you are experiencing severe trauma […] one thing that is being lost is that self-determination because the brain becomes almost automatic in its adaptation because it's being signaled by the part of the brain that mediates automatic responses, the amygdala, which is heavily involved in trauma and memory of how to respond to trauma. So, there's less choice.

This subtheme *regaining control* reflects NDGO and WLNO's perspectives that trauma disrupts a child's autonomy and minimizes opportunities for self-determination. By having opportunities to regain control, youth impacted by trauma can begin to reestablish autonomy and empowerment, factors which are also protective and are important to the promotion of resilience (Hamby et al., 2020). This is a significant nursing and practice implication for other disciplines serving youth impacted by trauma. Pediatric healthcare settings, and particularly inpatient facilities, can diminish a child's

sense of control through disruption of the child's routine and family processes, limited interaction with friends, absence from school, and therapeutic interventions such as timed administration of medications, activity restrictions or being confined to a hospital room, having a specified diet, and more (Hockenberry & Wilson, 2021). By providing developmentally appropriate opportunities for youth to make choices, participate in decision-making, and collaborate in their care, nurses and other providers can promote agency, autonomy, self-efficacy, and resilience (Hamby et al., 2018).

Subtheme 2D: Being Heard

The subtheme, *being heard*, captures experts' thoughts about how actively listening to and taking a genuine interest in a child's life are powerful buffers against the negative outcomes of childhood adversity. Several experts emphasized the impact of actively listening to youth, centering youth voices, showing genuine interest, and integrating youth perspectives and insights into healthcare encounters. ASPN described how the power of listening to youth and demonstrating respect and genuine interest can foster authentic therapeutic relationships:

> […] and in listening, especially to young people, I've found that that very often they're not all that interested in what I have to say until they see that I'm interested in what they have to say, and not just interested, but until I actually show that I respect the fact that they are the experts they know more about their lives and what are potential solutions to the challenges they face than I will ever know […] our work can't be without youth voice.

Similarly, RWCN emphasized the therapeutic value of listening to youth as foundational in mental health care settings:

> So, as much as we can listen to young people and really, really listen, create the opportunity for them to actually say what is on their minds and on their hearts, I think that's going to take us so much further when it comes to this mental health work as well.

RVNR elaborated further on how genuine interest and open-ended curiosity create a safe space for youth to share their difficult experiences:

> I think how adults should relate to children generally is (having) genuine interest. And it's kind of it's an open-ended curiosity […]. And what's interesting about kids […] when they're starting to talk about things that they find difficult to talk about, it's just how carefully they test the waters, you know […] kids don't tell you things that they don't think you can handle. And […] genuine interest […] creates a milieu in which the child feels confident, and that you can handle what they want to talk about […].

Aligning with these insights, CPRS asserted that listening and validating are crucial to supporting children's trauma narratives when stating, "when children find a way to explain what happened to them, the only thing they need is someone who is able to listen to and understand". WLNO also notes below that validating experiences and specifically expressing to trauma-exposed youth that what they experienced is not their fault, can significantly relieve the emotional burden of trauma.

> First of all, we have to acknowledge them, and we have to acknowledge that they're, it's not their fault because […] we know that validating somebody's position and not blaming them is incredibly helpful and helps them get a clearer picture. It takes that extra emotional load off.

Further commenting on validation, NDGO provided perspective by emphasizing that listening and validation can empower youth speaking to their inherent desire for wellness.

> And when they feel that from me, they feel a lot of validation. And I tell them, I say, how did I become an expert? I said, I didn't know a thing. I just listened to kids like you. So please teach me. Teach me more. I really do. I think that that helps, too, to know that the kids do have a driving force towards wellness.

JNPR notes the significance of listening with the goal of incorporating the child's perspective in decision-making processes, and OCEN comments that listening during therapeutic interactions fosters professional learning. For example, JNPR states, "I think another important piece is that the child's perspective, their voice should be heard to help inform decision making", while OCEN notes, I've learned way more than my clients from my clients than I think they've learned from me".

The subtheme *being heard* emphasizes expert perspectives that actively listening to and validating youth experiences are essential components of fostering resilience. These supportive interactions strengthen trust, reinforce self-worth, and significantly contribute to positive developmental outcomes while also addressing the importance of incorporating youth voices into trauma-informed interventions in healthcare and other settings (Hamby et al., 2020; SAMHSA, 2023).

Subtheme 2E: Seizing opportunities for growth

The subtheme, *seizing opportunities for growth*, captures the experts' ideas around how skill development, asset building, finding purpose, and participating in

opportunities to be successful are significant in promoting resilience in trauma-exposed youth.

JNPR emphasizes the critical role developmental asset building plays in promoting resilience:

> And I also just think a lot about, you know, developmental asset building, which ties into all of these really thinking about those internal assets that that child or adolescent can develop in terms of skills. They're developing those values and self-perceptions that really promote resilience.

Moving beyond internal assets, JNPR makes a connection to subtheme 2B, *responsive relationships*, when discussing the importance of external support systems, and access to meaningful growth opportunities:

> And then those external assets, which I was mentioning around the support systems and those really solid relationships and just, you know, opportunities for growth… those opportunities to be successful in ways that are important to them. And I think all of that really promotes resilience.

ASPN expands this concept further by describing the value of getting involved in community activism and advocacy:

> That when you're getting involved in advocacy and activism, you're being involved with community and other people who are facing the same struggles and also trying to find solutions. So that is improving the negative mental health consequences of against systemic racism and systemic oppression. So, I think that is especially important for youth to find those ways to tap in and get connected because it also supports positive mental health outcomes.

In summary, the subtheme *seizing opportunities for growth* highlights the importance of trauma-exposed youth having access to and participating in opportunities to develop both internal and external assets. Building competencies and engaging in meaningful community involvement can collectively promote resilience, enhance self-efficacy, and support positive developmental outcomes (Gardner et al., 2023; Hamby et al., 2020; Morris et al., 2020; Ungar & Theron, 2020).

Summary of Theme Two

Theme Two, *toward resilience*, presents a comprehensive narrative, as expressed by the experts, of resilience in trauma-exposed youth and ways in which it can be promoted. The subthemes collectively emphasize that resilience is influenced by inherent predispositions, responsive and supportive relationships, regaining control and agency, validation through being heard, and by having opportunities for personal growth.

Summary of Themes

Through the analytic phases of RTA, two primary themes were produced from the dataset of transcripts from interviews with 15 child trauma experts. The primary themes, 1) *developmental perspective* and 2) *toward resilience*, along with their subthemes, 1A) *development as influencing trauma response,* 1B) *development as influenced by trauma*, 2A) *some kids are just resilient,* 2B) *responsive relationships*, 2C) *regaining control*, 2D) *being heard*; and 2E) *seizing opportunities for growth*, collectively capture the experts' perspectives related to the complex relationship and interaction among developmental age, trauma, the concept of resilience, and factors that promote resilience in trauma-exposed youth. Theme One explicates the influence of developmental age on responses to trauma as well as the neurobiological and developmental consequences of

trauma, particularly when it occurs in early childhood. In contrast, Theme Two presents resilience from a strengths-based perspective as achievable and promotable through protective factors and positive childhood experiences, including consistent and supportive relationships, reestablishing a sense of control following trauma, being listened to and validated, and the development of skills and assets. Together these themes, as the analytic output of this research, provide important contributions to nursing knowledge and offer insight for multidisciplinary practice and research, the implications of which are discussed in Chapter Five.

Delimitations and Limitations

In qualitative research, delimitations refer to deliberate boundaries that are drawn based on the researcher's decisions about the study's design, chosen methodology, research questions, focus, and scope. These decisions delimit the study by providing specific parameters around how to conduct the research (Cresswell & Poth, 2018; Merriam & Tisdell, 2015). As indicated in Chapter Three, this study's anticipated delimitations included my choice to use previously recorded interviews as the dataset for analysis, the scope and focus for the study, and the data analysis method of reflexive thematic analysis. The choice to use the previously recorded interviews from the R2R project was deliberate and reflected my enthusiasm and willingness to explore this data from a highly inductive analytic approach, recognizing the inherent value of gaining insight from internationally known child trauma experts across disciplines. Another delimitation of this study was my choice of theoretical framework, Roy's Adaptation Model, and the area of focus for this research, the exploration of how child trauma experts view and describe childhood trauma and resilience in trauma exposed youth.

Again, these were intentional choices based on several factors, including personal experience, strong interest in this topic, a desire to enhance multidisciplinary collaboration in child trauma and resilience research and practice, and to amplify the voice of nursing in these important areas.

Limitations of a study are factors that lie outside the researcher's control, such as sample size, time, and resources (Cresswell & Poth, 2018). The limitations of this study include the small sample size of 15 child trauma experts, the fact that I did not develop the interview guides used during the expert interviews, and that I did not participate in the interviews, as they were recorded prior to this study for non-research purposes. Another limitation is that, since the study utilized preexisting data, I did not have the opportunity to conduct further interviews with additional childhood trauma experts or reach out to them for clarification or member checking of their transcripts. Finally, with the use of preexisting data, there was the distinct possibility that, upon analysis, the analytic outputs from the dataset may not address the study's research questions. As was discussed earlier in this chapter, minimal modifications were made to the original research questions, and the overall aim of the research was not impacted by these revisions.

Chapter Summary

This research utilized pre-recorded interviews with 15 multidisciplinary child trauma experts, conducted as part of the Roadmap to Resilience Podcast (R2R). Braun and Clarke's (2022) six-phased approach to reflexive thematic analysis (RTA) was applied as the method for data analysis. The recorded interviews were transcribed using NVivo Transcription Services. The application of RTA to the interview transcripts provided the framework for analysis of the expert's perspectives and descriptions of

resilience in trauma-exposed youth and the revised research questions for this study which were: How do childhood trauma experts describe 1) how developmental age influences the response to trauma; 2) how development is impacted by exposure to trauma; 3) resilience in trauma-exposed children; 4) modifiable factors that promote resilience in trauma-exposed children? The resultant analytic outputs from RTA addressing these research questions include two overarching themes and seven subthemes that address the study's research aims. The subthemes related to the overarching theme of *developmental perspective*, which addresses research questions one and two, are *development as an influencer of trauma response* and *development as influenced by trauma.* The subthemes related to the overarching theme of *toward resilience*, which addresses research questions three and four, are *some kids are just resilient, responsive relationships, being heard, regaining control, and seizing opportunities for growth*. Chapter Five presents an overall review of the study's design and methods, a summary of the research findings, and theoretical implications. The chapter further presents implications for nursing and multidisciplinary practice, a summary of this study, and recommendations for future research.

CHAPTER FIVE

DISCUSSION

This qualitative study aimed to explore the views and perspectives on trauma and resilience among professionals from various disciplines, drawing from their experiences working with trauma-exposed youth. In the United States and globally, exposure to trauma during childhood is pervasive, with up to 64% of adults reporting that they experienced at least one form of trauma before the age of 18 (Flagg et al., 2023; Jonas et al., 2022; SAMHSA, 2023; Swedo et al., 2023). Adverse childhood experiences (ACEs) and other forms of childhood trauma have been linked to numerous negative physical and mental health outcomes (Felitti et al., 1998; Jones et al., 2020). Research across disciplines reflects an increasing focus on the promotion of resilience in trauma-exposed youth (Morse et al., 2021; Morris et al., 2020). However, there continues to be a lack of consensus across the helping disciplines such as psychology, social work, medicine, and nursing, as to what resilience is (process, attribute, characteristic, learned skill, etc.), how resilience is demonstrated and recognized, and strategies for promoting resilience (Masten & Monn, 2015; Morse et al., 2021; Yoon et al., 2021). Additionally, there is a gap in the evidence in terms of the integration of child developmental age and stage in resilience research; specifically, the exploration of how children of different ages respond to traumatic experiences to become resilient, and how resilience may be demonstrated and recognized in children of different ages (Yoon et al., 2021; Merrick et al., 2020; McLaughlin et al., 2019; Masten et al., 2021; Perry, 2014)

This study addressed these problems by employing a qualitative methodology and

an interpretive approach to analysis. Qualitative research is well-suited for the study of people's views, experiences, perceptions, beliefs, or understanding of a particular phenomenon, and is primarily situated within the interpretive/constructionist paradigm which aligns with my philosophical perspective that there is no one single truth, and that meaning is subjectively constructed through an individual's experiences with a particular phenomenon (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guba & Lincoln, 1982). The theoretical framework, Roy's Adaptation Model (RAM) (Roy, 2009), guided the design of the study and provided context for the research questions. The data for this study were pre-recorded video interviews with 15 multidisciplinary child trauma experts that were conducted for the non-research purposes of the Roadmap to Resilience Podcast project (R2R). R2R is a publicly available collection of audio and video clips, and other online resources created for professionals and parents with information about topics related to resilience in children impacted by trauma. Upon consent, the videos were shared with me by the project leader and were then transcribed using QSR NVivo (QSR International Americas, Inc.). I reviewed the transcripts, checked them for accuracy using the recordings for comparison, and made corrections to the transcripts as appropriate. Braun & Clarke's (2022) six-phased method of reflexive thematic analysis (RTA) was applied to the dataset to address the research aims. The data were inductively and deductively coded, first using NVivo and later by writing codes on a printed report I produced in NVivo. I engaged in reflexive journaling throughout the analytic process. Through recursive engagement with the data and the phases of RTA, initial, or candidate, themes were developed, reviewed, and refined to produce the final themes and subthemes, which address the following research questions:

How do childhood trauma experts describe:

RQ1: the influence of developmental age on responses to trauma in children?

RQ2: the developmental impacts of exposure to trauma during childhood?

RQ3: resilience in trauma-exposed children?

RQ4: modifiable factors that promote resilience in trauma-exposed children?

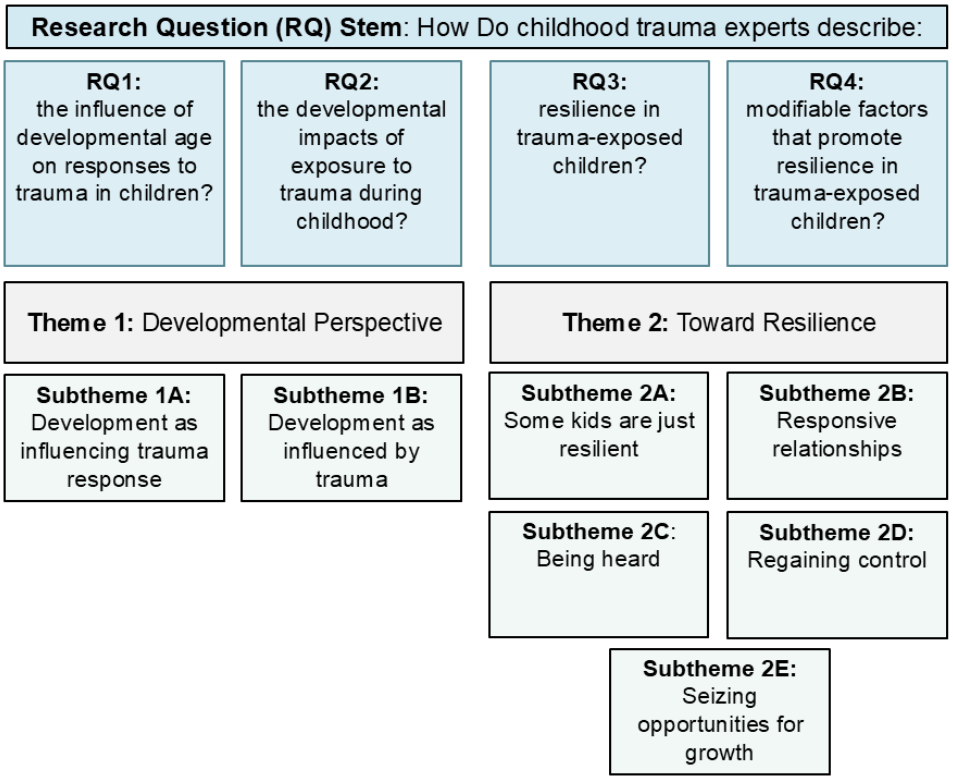
The findings of this research offer important contributions to nursing knowledge and provide relevant information and insight pertinent to multidisciplinary professional practice and future research. The following sections of this chapter provide a summary of the research findings and a detailed exploration of the theoretical implications of this research. The chapter further discusses implications for nursing and multidisciplinary practice and presents recommendations for future research.

Summary of Research Findings

Two main themes and seven subthemes were produced through the application of RTA, with guidance from the theoretical framework of Roy's Adaptation Model (RAM). The final themes, along with definitions, were presented in Chapter Four, Table 4.2. The themes, as they align with the study's research questions, are presented in Figure 5.1.

Figure 5.1

Alignment of Final Themes with Research Questions



The themes generated through this research address the primary aim of this study, to identify, analyze, organize, describe, and report themes related to trauma and resilience in trauma-exposed children across the pediatric life span within interviews with 15 nationally known childhood trauma experts. Theme One, *developmental perspective*, illuminated the experts' perceptions of the intricate, interactive relationship between a child's developmental age and their experiences of and responses to trauma. The subthemes, *development as influencing trauma response* and *development as influenced by trauma*, demonstrated how a child's developmental age influences their adaptive responses to trauma, including their ability to communicate distress and manage emotional responses. Further, these themes provide multidisciplinary perspective related

to how a child's development is impacted by trauma, particularly when the trauma occurs in early childhood during which critical and rapid periods of development take place. Theme Two, *toward resilience*, further addressed the study's aims by exploring key factors that contribute to resilience in trauma-exposed youth. Through the subthemes—*some kids are just resilient, responsive relationships, regaining control, being heard,* and *seizing opportunities for growth*—the findings present resilience as a dynamic process that encompasses innate and modifiable factors.

Theoretical Implications

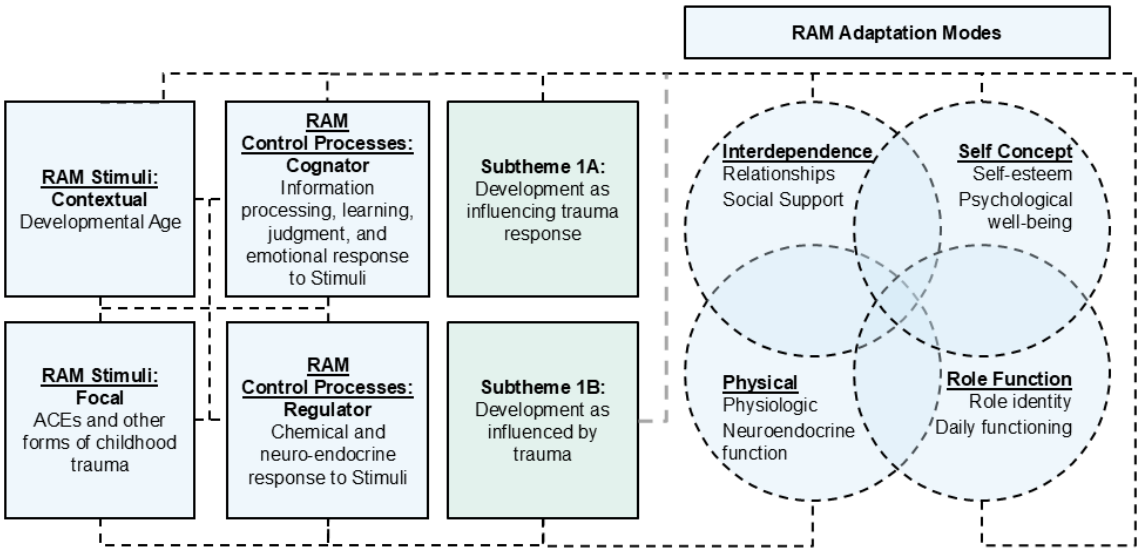
Roy's Adaptation Model (RAM) provided the scaffolding to align the study's findings, produced through reflexive thematic analysis, with the model's assumption that children, as humans, are systems that, through complex intrinsic and extrinsic processes, engage in constant interactions with their environment; and based on these interactions, children respond through one or more adaptation modalities; physical, role function, self-concept, and interconnectedness. In children who have experienced trauma, the collective experiences of focal and contextual stimuli, cognitive and regulatory processes, and adaptation modes, can result in a dynamic state of resilience, which may be promoted through modification of one or more stimuli.

Theme 1: Developmental Perspective

Utilizing RAM as the framework for this study and situating the theme *developmental perspective* within the model provided a valuable theoretical lens for understanding trauma responses and their developmental implications within nursing and other healthcare disciplines. Figure 5.2 presents Theme One and its subthemes in the context of the theoretical framework of RAM.

Figure 5.2

Theme One "Developmental Perspective" Aligned with RAM



Subtheme 1A: Development as Influencing Trauma Response

Within the RAM framework, Subtheme 1A, *development as influencing trauma response*, aligns with the concept that children's adaptive responses to trauma are shaped by their developmental age. Younger children may not have achieved the cognitive, language, and emotional maturity to fully comprehend or verbally communicate traumatic experiences (Hambrick et al., 2019; Hockenberry & Wilson, 2021). A child's developmental age can be conceptualized within RAM's concept of contextual stimuli, which interact with focal stimuli, such as trauma, to influence the trauma response. Developmental age determines the child's cognitive ability to process information, learn from experiences, regulate emotions, and apply coping mechanisms in response to trauma, all of which align with RAMs Cognator control processes.

Subtheme 1B: Development as Influenced by Trauma

Subtheme 1B, *development as influenced by trauma*, also connects deeply with RAM, in that trauma, the focal stimuli, results in a response by the Regulator coping processes, which include physiologic alterations in the body's neuro-endocrine and chemical regulatory systems. Acting as a focal stimulus, trauma exposure in childhood, especially chronic or severe trauma occurring during critical periods of development, can lead to enduring physiological and neurobiological changes, compromising the child's developmental trajectory (Shonkoff et al., 2021). This in turn influences the child's adaptive processes, conceptualized within RAM's Adaptation Modes of physiological, role-function, self-concept, and interdependence. Subtheme 1B is consistent with the extensive body of evidence linking adverse childhood experiences (ACEs), including parental or caregiver substance use in the home and mental health disorders, are linked to the disruption of neuro-endocrine function and hormone balance; alterations in areas of the brain responsible for emotional regulation and executive functioning; and long-lasting impacts on children's overall mental, behavioral, and physical health (van der Kolk, 2006; Perry, 2009; Webster, 2022).

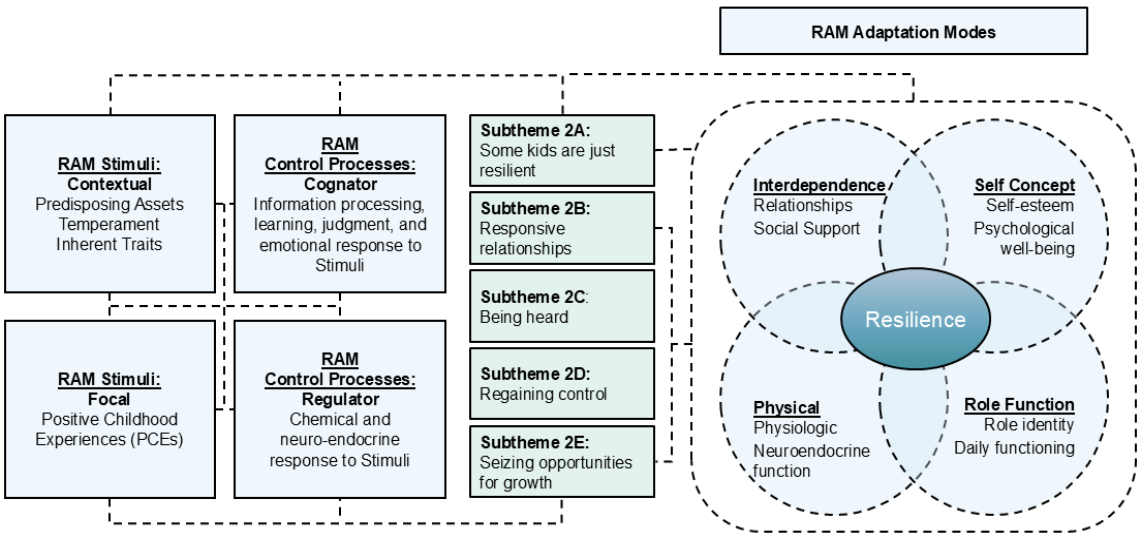
Theme Two: Toward Resilience

RAM also provides a robust framework for understanding and promoting resilience in trauma-exposed youth, particularly through its four adaptive modes: physical, self-concept, role function, and interdependence (Roy, 2009; Roy & Andrews, 1999). Theme Two, *toward resilience*, reflects both the innate and modifiable factors that promote resilience in trauma-exposed youth. The subthemes within Theme Two – *some kids are just resilient, responsive relationships, regaining control, being heard,* and

seizing opportunities for growth – are conceptualized in RAM as both influencing and being influenced by the constructs of Stimuli, Control Processes, and Adaptation Modes as illustrated in Figure 5.3. As stated in earlier chapters, one of the gaps identified in previous research was that the definition of resilience varied greatly in the literature. Some scholars describe factors that lead to resilience as being something a child is born with, such as a capacity, quality, trait, or attribute (Masten, 2015; Heard-Garris, 2018), which is consistent with meaning from the experts' narratives that formed subtheme 2A. The complexity of the concept reflected in the expert narratives as captured in subtheme 2B and supports the extant literature that resilience-promoting factors exist and resilience is a dynamic process that can be promoted by both internal and external influences (Fritz et al., 2018; Heard-Garris, 2018; Masten & Obradovik, 2006; Masten 2015; Gartland et al., 2019).

Figure 5.3

Theme Two "Toward Resilience" Aligned with RAM



Implications for Nursing, Practice, and Future Research

As was anticipated with the analysis of pre-existing data, there were numerous examples of shared meaning among the expert narratives that did not speak directly to the study's research aims or questions. However, many of these examples were powerful, relevant, and held implications for nursing, multidisciplinary professional practice, and recommendations for future research. Therefore, I felt it important to include these examples, including select data segments, in the following sections in which I discuss further implications of this research.

Nursing Implications

Although the majority of childhood trauma and resilience research has historically stemmed from disciplines other than nursing, nurses have the unique opportunity and privilege of spending significant time and building relationships with patients during encounters across healthcare settings (Morse et al., 2021). LRKA commented that "nursing at its heart is a profession that is dedicated to the holistic care of patients, families, and communities", and that nurses "provide a safe forum for communication and relationship building" and can "be advocates for their patients and families". Further, LRKA stressed that "nurses have the "opportunity to create the framework for care." Adding to LRKA's comments, nurses are ubiquitously present across a variety of settings that provide services to children and have strong and trusting relationships with patients and clients. Nursing is often cited as the "most trusted profession" (Morse et al., 2021), and nurses often establish enduring, trust-driven relationships with communities, families, and individuals. Therefore, nurses are in a unique position to champion initiatives to increase awareness among the profession, enhance nursing practice, and

advance the nursing knowledge base in the areas of childhood trauma, associated health impacts, and the promotion of resilience to improve physical and mental health outcomes and overall wellbeing.

Multidisciplinary Implications

Multidisciplinary Collaboration in Practice

This research was also a vital step in collectively exploring multidisciplinary perspectives on trauma and resilience in children. It is crucial for disciplines to work together to address childhood trauma, promote resilience in all children, and ultimately work collaboratively on initiatives to prevent childhood trauma from occurring in the first place. Several experts discussed a need for improvement in communication and collaboration among disciplines that participate in the care of children who have experienced trauma and note that much of this work is done in "silos" (LRUL, ASPN, and WLNO) which adds complexity to an already complicated system of accessing care. For example, consider the comments from LRUL and ASPN related to how medicine and mental health disciplines could work together to streamline access to pediatric mental health services.

> And so, I think having these conversations and talking across silos is so critical […] the more that we can be talking and problem solving together, I think the more we can undo some of the faulty design […] in terms of how medicine and healthcare and mental health (were) intended to be set up originally. (LRUL)

> So, I think over the years, I've just seen the necessity for multidisciplinary supports for families. How can we build that infrastructure there? […] Well, one of the things we need to improve upon is multidisciplinary systems of care. So, a

> lot of times we're not talking to each other […] a lot of our systems are very siloed and isolated and not communicating with each other on how to provide the supports to this individual and family (ASPN).

And WLNO also mentions that services for children and families needing support following trauma are "siloed" and "not necessarily integrated", making it complicated for families with multiple needs to access appropriate care.

Multidisciplinary Collaboration in Research

The findings from this study also highlight the critical need for professionals across disciplines to work collaboratively on future research to further elucidate the concept of resilience in children who have experienced trauma, particularly focusing on the developmental considerations of early childhood, during which exposure to not only *adverse* childhood experiences (ACEs), but more importantly from a strengths-based perspective, *positive* childhood experiences (PCEs) have heightened opportunity to protect from and mitigate the negative impacts of ACEs and other trauma (Shonkoff, Slopen, & Williams, 2021; Hamby et al., 2021).

Multidisciplinary Trauma-informed Education and Training for Providers

Experts emphasized the need for trauma-informed continuing education and professional development for providers and clinicians working in pediatric physical and mental health settings. REBD urges pediatric providers to "get educated" about trauma and trauma-informed care and advises "as you learn more, begin to integrate it into your practice." REBD shares further recommendations for providers on integrating trauma-informed care into practice:

> Ask the question. Make it clear to your patients that you understand and care

about the things that have happened to them in their lives. Or may be happening in their life now and in the lives of their children that have important health ramifications, and that you're open to addressing those.

Trauma Informed Content in Curriculum Across Disciplines

Another example of shared meaning across the dataset relates to multiple experts' ideas around and recommendations for the inclusion of trauma-informed content in nursing, healthcare, and mental health curricula. For example, LRKA states:

> I think that it's important for nurses to receive training related to child trauma. What I advocate for is that that training be an integral part of the nursing curriculum […] I would hope that down the road that would become an integral component of nursing training.

And LRUL makes a similar argument for curricular updates to medical education programs:

> When it comes to training it is really in thinking about what do we want pediatricians to be doing in 10 or 20 years and then making sure that what's included in residencies and what's included in the foundational training for medical school is inclusive of that.

LRUL further states that pediatricians must also understand "how the social environment impacts children…in a healthy way", also commenting that this does not get enough attention in medicine. ERMB addresses this topic from the mental health perspective, stating that "mental health curriculum, particularly trauma informed ones, can actually be very important and are in fact critical for the training for all types of

health professionals, even if they are not focused on mental health". ERMB further comments:

> Their primary care provider or pediatrician or, you know, their OBGYN might be the first person that is actually screening for, asking about, or the first safe person that they can even talk to about some of their concerns. So, I guess I would say that there's a piece of training […] for all of us, which is that we need mental health awareness and training outside of mental health kind of professions themselves.

Summary of Implications

Throughout the expert narratives, there was much shared meaning that was relevant to nursing and other disciplines providing care and services to trauma-exposed youth. These perspectives provide much needed insight into the need for multidisciplinary collaboration and the revision of nursing, medical, and mental health program curricula to include content related to childhood trauma and trauma-informed care. This information is also relevant to future research related to enhancing access to and quality of care through multidisciplinary collaboration, as well as foundational research of various curricula to explore the extent to which trauma-informed topics are integrated, and if they are integrated, what are the impacts to child health outcomes.

Strengths and Limitations of this Research

To my knowledge, this is the first study to utilize Roy's Adaptation Model (RAM) as the theoretical framework for qualitative inquiry aimed to explore resilience in trauma-exposed youth, and the only study utilizing data from interviews with multidisciplinary child trauma experts as the basis for childhood trauma and resilience

research. Another strength of this study is the diversity of the experts who participated in the recorded interviews, in that they are geographically located in the United States, Canada, Australia, and Argentina; represent the disciplines of nursing, clinical psychology, pediatric medicine, psychiatry, social work, child welfare, education, research, community leadership, advocacy, and law; and work within diverse pediatric populations and settings. The findings addressed the overarching research aim of exploring how child trauma experts perceive and understand trauma and resilience in children across the pediatric life span, with a specific focus on the interplay between resilience, trauma, and developmental age. As discussed in Chapter Two, through a review of the extant literature, a research gap was identified in these areas. By applying a qualitative methodology and study design, approaching data analysis from an interpretive and experiential perspective, and choosing an analytic method reflecting my ontological and epistemological world views, this research was conducted with methodological integrity and alignment. Through reflexive thematic analysis, the themes produced from the interview data captured the experts' narratives in their own words as they discussed various topics related to trauma and resilience in children. These themes contribute to what is known about child trauma and resilience and provide context for scholars embarking on future research on this topic.

As discussed in Chapter Four, there were some limitations of this research, most of which are related to my deliberate choice to utilize pre-recorded interviews as the dataset for analysis. This choice meant that I did not participate in the selection of participants, development of the interview guides, or facilitation of the interviews, and did not have the opportunity to conduct further interviews with additional experts. And

by using preexisting data, there was no guarantee that, upon analysis, the analytic outputs would address the study's research questions. In light of these limitations, the analysis addressed the overall research aims and contributed relevant and detailed information on this topic.

Recommendations for Future Research

There continue to be important needs for future research related to the study of resilience in trauma-exposed youth. This study provided insight from child trauma experts but did not include perspectives of youth or adults who have had the lived experience of trauma during childhood. Qualitative research aimed at capturing the lived experiences of resilience among youth or young adults impacted by childhood trauma would be a powerful next step in advancing resilience science and could serve as a framework for quantitative research on resilience in these populations. Further, quantitative research using a fine-grained approach to studying resilience, in the context of specific and narrow developmental periods of early childhood, through the utilization or development of measurable and reliable tools, would provide additional insight into understanding, operationalizing, and promoting resilience in the earliest stages of development. Finally, additional research utilizing RAM, or possible theory substruction of RAM and well-utilized theoretical models from other disciplines, for the study of childhood trauma and resilience would advance nursing science and further empower nurses to lead and more prominently participate as members of multidisciplinary teams involved in child trauma research and practice.

Chapter Summary

This chapter presented a summary of this research, and themes produced from data in the form of transcripts of interviews with 15 child trauma experts across disciplines. Also presented were theoretical implications of this research and implications for nursing and professional practice. Finally, this chapter presented the strengths and limitations of this study and recommendations for future research.

Conclusion

This qualitative study contributes to nursing science by utilizing the framework of Roy's Adaptation Model (RAM), rooted in the discipline of nursing, and applying Braun & Clarke's (2022) reflexive thematic analysis (RTA), to the exploration of perspectives and views about trauma and resilience among experts working with trauma-exposed youth. Nurses are universal among a myriad of settings that serve and provide care to children, families, and communities, and as such they have a distinct opportunity to advocate for and lead initiatives to enhance awareness among the profession, advance nursing practice, and contribute to the body of evidence related to childhood trauma, its health impacts, and the promotion of resilience. Further, the findings from this study inform professionals across disciplines on the importance of working collaboratively on future research to further elucidate the concept of resilience in children who have experienced trauma, particularly focusing on the developmental considerations of early childhood, a period of rapid neurodevelopment, during which exposure to positive childhood experiences and other protective factors may have the most impact. Additionally, collaborative efforts toward advocacy, policy reform, and curricular revision among disciplines engaged with children and families would

contribute to improvement of health outcomes for all communities, including those disproportionately impacted by trauma. Finally, working to eliminate “silos” and foster multidisciplinary collaboration among providers and others serving children through roles in physical and mental health care, social science, education, juvenile justice, and other settings would add significant value to the advancement of initiatives and interventions aimed at preventing childhood trauma from occurring in the first place.

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APPENDIX A

IRB APPROVAL

OAKLAND UNIVERSITY

Institutional Review Board

Date: June 14, 2022

Study #: IRB-FY2022-205

Study Tile: Resilience in Trauma-Exposed Youth: A Qualitative Thematic Analysis of Interviews with Multidisciplinary Childhood Trauma Experts

Submission Type: Initial

IRB Decision: Approved

Research Team:
Peg Kennedy
Toni Glover

Based on applicable federal regulations, the above referenced study has been determined to involve no more than minimal risk to participants and to be Approved, with the following expedited categories:
5. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Letter and Consent Document:
This letter along with the IRB approved (date-stamped) consent document can be found in Cayuse in the Submission Details page under Letters and Attachments, respectively.

The IRB approved version of the consent document must be used in consenting participants. Federal regulations require that each participant receive a copy of the consent document unless a waiver is granted by the IRB. Signed consent forms must be retained for a minimum of three years after the completion of the project. Please remember that informed consent is a process that continues throughout the project, starting with recruitment and assurance of participant understanding of the project, and followed by a signed consent form when applicable.

Permission from Research Sites:
Please note the following:

- This IRB approval letter means that the research has met the federal criteria for approval per 45 CFR 46.111 Criteria for IRB Approval of Research.
- Before the research is initiated, permission to conduct research at a given site must be obtained from all research locations listed in the IRB submission. You must keep copies of all such permission letters for your records.
- It is the responsibility of each researcher to follow all applicable policies and procedures of any outside institution where the research will be conducted.

Modifications:
Any changes to the approved project must be approved by the IRB prior to initiation by submitting a MODIFICATION request. Do not collect data while the changes are being reviewed. Data collected during this time cannot be used in research.

Incidents:
All unanticipated problems involving risks to participants or others, serious and unexpected adverse events, non-compliance issues and/or serious complaints regarding this project must be reported promptly to the IRB by submitting an INCIDENT report.

You are approved to start the research. Please retain a copy of this notification for your records.

If you have any questions, please contact the IRB office.

Thank you.

The Oakland University IRB

OAKLAND UNIVERSITY

Institutional Review Board

Date: December 6, 2022

Study #: IRB-FY2022-205

Study Tile: Resilience in Trauma-Exposed Youth: A Qualitative Thematic Analysis of Interviews with Multidisciplinary Childhood Trauma Experts

Submission Type: Modification

IRB Decision: Approved

Research Team:
Peg Kennedy
Toni Glover

The IRB has reviewed the Modification submission for the above referenced study. The modified study with the changes listed below has been determined to involve no more than minimal risk to participants and is Approved through an expedited review per federal regulations.

The approved modifications are the following:

- Change to consent form: Edited to include information on how data can be withdrawn after providing consent.
- Addition of consent clarification: Email to already consented participants notifying them of their right to withdraw.
- Addition of edited recruitment document: Edited to inform participants of their right to withdraw after they provide consent.

The **revised IRB approved (date-stamped) consent document, version 12-6-2022** has been published under Attachments in the Submission Details page. Please make sure to use the most recent IRB approved version of the consent form in consenting participants.

You are approved to implement the aforementioned modifications. Please retain a copy of this notification for your records.

This letter can also be found in Cayuse under the Letters tab in the Submission Details page.

If you have any questions, please contact the IRB office.

Thank you.

The Oakland University IRB

APPENDIX B

INFORMED CONSENT

Informed Consent

Request for Permission for use of Roadmap to Resilience Raw Interviews

My name is Peg Kennedy, and I am a Ph.D. student in the School of Nursing at Oakland University in Rochester, Michigan. I have had the pleasure of working with Dr. Amanda Zelechoski through the completion of several Ph.D. cognate courses in the Trauma-Informed Certificate program at Valparaiso University.

Dr. Zelechoski and I have discussed the publicly available ***Roadmap to Resilience*** website and content, and the possibility of utilizing the raw interviews collected for the purposes of this project for my dissertation research.

As your recorded interview was originally collected for a purpose other than research, I am contacting you at this time to request your permission to utilize your pre-recorded raw interviews for the following research study - ***Resilience in Trauma-Exposed Youth: A Qualitative Thematic Analysis of Interviews with Multidisciplinary Childhood Trauma Experts***. This study aims to identify, analyze, organize, describe, and report themes found within transcripts of interviews with childhood trauma experts. The findings from this research will provide valuable insight related to resilience in trauma-exposed youth and will inform future research, practice, and policy in terms of understanding, recognizing, and promoting resilience in youth impacted by trauma.

Your decision to participate in this study is voluntary, and no further action or interview with you will be required. However, Dr. Zelechoski or I may contact you for clarification purposes if necessary. You can choose to withdraw your recorded interview from the study at any time. Your decision will not affect your present or future relationship with Oakland University or the researchers. If you wish to withdraw, you may inform me of your decision via my contact information below.

If you have any questions or would like to discuss the details related to this study, please feel free to contact me at 248-224-7219, or via email at mmkenned@oakland.edu. You may also contact my faculty advisor, Dr. Toni Glover at tglover@oakland.edu.

Thank you for your time!

Sincerely,
Peg Kennedy, MSN, RN, FNP-BC

Do you provide consent to use your interview for the purposes of this study?

Yes

No

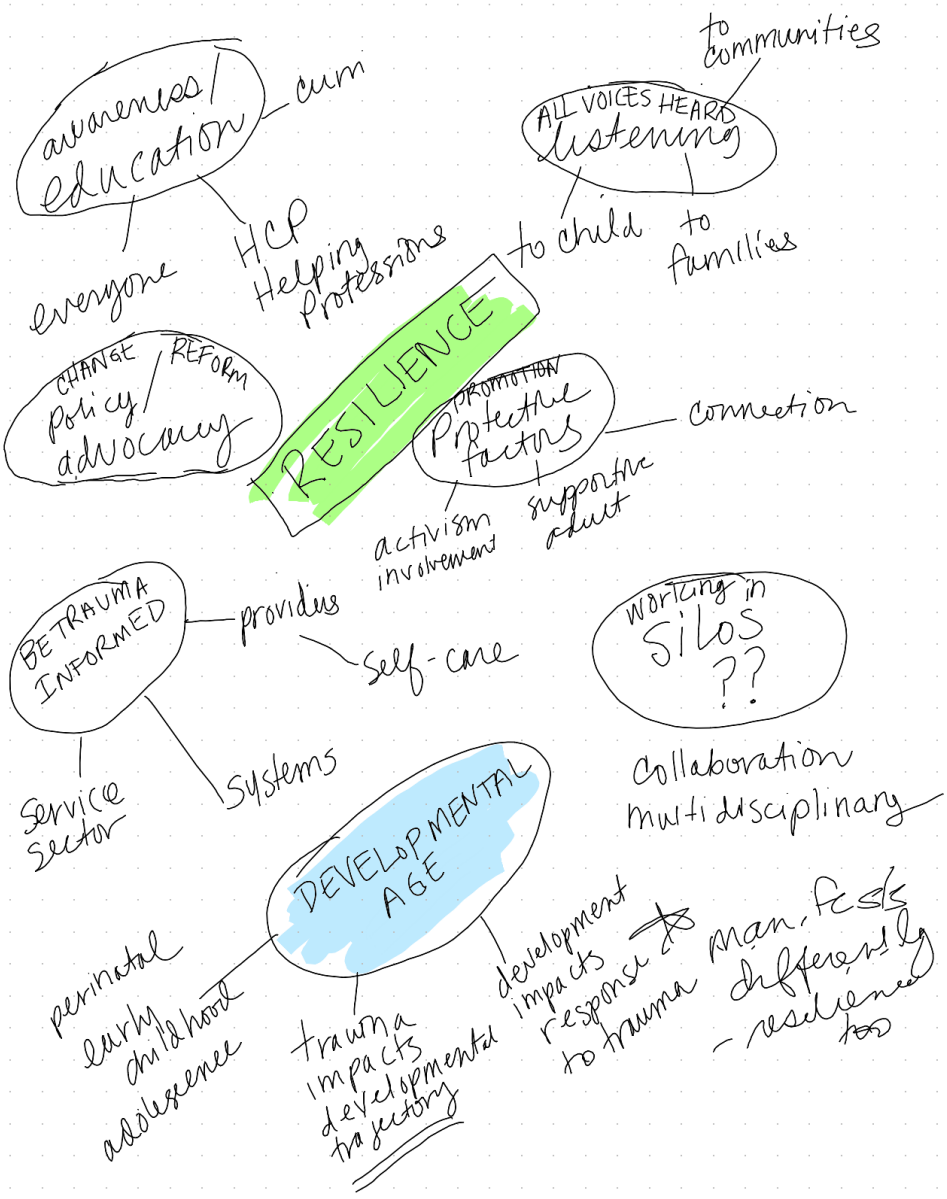
Electronic Signature (please type your first and last name)

Powered by Qualtrics

APPENDIX C

EARLY THEMATIC MAP EXAMPLE

Example of an early thematic map of the organizing concepts of resilience and developmental age.



APPENDIX D

THEMES, CODES, AND EXAMPLES OF DATA EXTRACTS

Themes and subthemes	Code examples	Data extract examples
1: Developmental Perspective		
1A: Development as an influencer of trauma response	Don't understand what is happening Can't express their feelings	"[…] so, it's really complex with younger kiddos who don't have the, may not have the capacity because of their developmental stage to really express or articulate what's going on for them" (JNPR)
1B: Development as influenced by trauma	Critical periods of development Brain development in early childhood	"And while we know that the brain obviously continues to develop, you know, well into our mid-twenties and beyond, early childhood, particularly up until about age three, is one of the most important periods for the development of the brain architecture" (ERMB)
2: Toward Resilience		
2A: Some kids are just resilient	Predispositions Resilient temperament	"Some children just have an inherent ability to be resilient, and it's based on their temperament" (BRHC)
2B: Responsive relationships	Validation Relational support Provider as therapeutic	"Something else that I've learned is just how the therapeutic relationship itself can be a resiliency factor" (OCEN)

Themes and subthemes	Code examples	Data extract examples
2C: Being heard	Listening with genuine interest All voices heard Youth voice Someone to listen	"But kids don't tell you things that they don't think you can handle. And the nice thing about kind of genuine interest is that it creates a milieu in which the child feels confident and that you can handle what they want to talk about" (RVNR) "So, when children find a way to explain what happened to them, the only thing they need is someone who is able to listen to and understand" (CPRS)
2D: Regaining control	Sense of control Trauma takes away choice Adaptation Bounce back Having a choice	"Trauma takes away your sense of control over life world, the sense that disaster could happen at any moment. Things that give you a sense of control of purpose are really, really powerful antidotes to that" (WLNO) "[…] the brain becomes almost automatic in its adaptation because it's being signaled by the part of the brain that mediates automatic responses, the amygdala, which is heavily involved in trauma and memory of how to respond to trauma. So, there's less choice." (NDGO)
2E: Seizing opportunities for growth	Participating in opportunities to be successful Development of assets and skills Self-concept	"[…] really thinking about those internal assets that that child or adolescent can develop in terms of skills. They're developing those values and self-perceptions that really promote resilience" (JNPR)