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Supporting children after single-incident trauma: Parents' views

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ABSTRACT

Objective: To strengthen trauma-informed health care by exploring parents' experiences of assisting their child after single-incident trauma (e.g., violence, accidents, sudden loss).

Method: Semi-structured interviews with parents (N=33) of 25 exposed children (8 -12 years).

Results: Responsive parenting after trauma emerged as a core theme, consisting of a) being aware of a child's needs and b) acting upon these needs. We identified 14 strategies, such as comparing behavior with siblings' behavior and providing opportunities to talk. Parents felt that their capacity to be responsive was influenced by their own level of distress.

Conclusion: We propose a model of Relational PTSD and Recovery to assist health care professionals working with children exposed to trauma. The results also point to the need to recognize parents' challenge to support a child after traumatic exposure and to align more with parents about procedures that may cause the child to be reminded of the event.

Key terms: children; parenting; parents; posttraumatic stress; recovery; semi-structured interviews; trauma; trauma-informed health care

INTRODUCTION

Pediatric health care professionals see many children who have been exposed to traumatic events and serve crucial roles in helping these youngsters.[1;2] Traumatic events are characterized by an overwhelming confrontation with death, serious injury, or other threat to physical integrity.[3] Examples include natural disasters, serious accidents, violence, and the sudden loss of a loved one. Exposure to these events is fairly common in children, with prevalence rates ranging from 14%[4] to over 65%[5;6] in peace-time general population studies. Traumatic exposure puts both mental and physical health at risk in children.[2;7-9] For example, they may develop posttraumatic stress disorder (PTSD[3]), encounter problems in academic functioning, and show increased rates of various physical disorders.

The care of pediatric providers is essential for children confronted with severe stressors. These professionals are often the first to see a child after exposure. They are trusted adults to whom children can disclose experiences, who can screen for functional impairments caused by an experience, who can provide education about normal reactions to trauma, who can monitor whether exposed children show psychiatric symptoms, and who can encourage parents to seek specialized mental health care for their child when needed. They can promote parents' optimal assistance to their child.[2;10]

Parents influence children's recovery.[11-13] Particularly, researchers have found parental distress to be a significant predictor of posttraumatic stress reactions in children.[14-16] Moreover, in a model of 'Relational PTSD', Scheeringa and Zeanah have described three parenting styles that exacerbate symptoms of young children.[17] The first is the withdrawn parent, who is not available to the child because of his/her own distress. The second is the overprotective parent, who is constrictive due to a strong fear that the child may be victimized again. The third style refers to the frightening parent, who may repeatedly ask about horrific details of the experience of the child or put the child in danger again.

Although this model is very informative, it would be valuable to complement it with healthy parent-child interactions after trauma. This would enable professionals to assess and promote parental assistance. Very little is known about parental strategies to support children after traumatic exposure, even though research in other domains regards positive parental behavior such as sensitivity and responsiveness[18]. In addition, most research is looking at correlations between symptom scores. While this focus provides broad insights regarding associations between, for example, parental PTSD and child PTSD, it does not lead to detailed knowledge of parent-child interactions after trauma or of parents' views on the help they receive from professionals in this regard. In order to assist parents in helping their children recover, a more detailed understanding is necessary.

The purpose of the current study is to strengthen trauma-informed health care[19] by exploring parents' strategies to promote the psychological recovery of their children after single-incident[20] trauma. Since qualitative methods enable the exploration of complex and dynamic processes and we wanted to study commonalities across different types of experiences, we conducted semi-structured interviews with parents of children who had been confronted with a wide range of traumatic events.

METHOD

Participants

Primary caregivers (referred to as parents) were recruited as part of a study on children's recovery after traumatic exposure. This study focused on children aged between eight and twelve and its methods and findings are reported in a separate article.[21] Children registered at the [large health care institution] as having experienced a single-incident trauma were eligible, provided they were not or no longer receiving mental health care, and the event had occurred at least six months previously. The traumatic events fitted the A1 exposure criterion for PTSD

in the DSM-IV[3]. Written informed consent and verbal assent were obtained from the parents and the children respectively. Inclusion in the study was continuous and carried out according to purposive sampling[22] to achieve maximum diversity in demographic characteristics, types of trauma, time since trauma, and degree of mental health care. We stopped including families when no significant new themes emerged from the interviews. The study protocol was approved by the Medical Ethics Committee of the [health care institution].

The parents of 34 children were approached for the study. The parents of seven children declined for various reasons including lack of time and concerns about exposing the child to the interview. In the case of two children we were unable to contact both divorced parents for informed consent. Participation of families was not significantly related to child age, child gender, or type of event ($p > 0.10$; other variables unknown for non-participants). Twenty-five families participated, with 33 parents involved in the interviews (see Table 1). The experiences of the children (15 boys and 10 girls, mean age 10.7 years) were categorized under sudden loss (six children, e.g., losing a sibling due to drowning), violence (eight children, e.g., sexual assault, witnessing a suicide), and accidents with injury (eleven children, e.g., sustaining complex fractures in a road traffic accident).

- Please, insert Table 1 about here -

Interviews

The topics in the interview guide (see Table 2) related to the characteristics of the trauma, reactions of the child, changes in the child's outlook on the world, and factors that assisted or impeded the child's recovery, including parents' role in the child's recovery. The wording of the questions was as open as possible. An experienced, trained interviewer [A1] carried out the interviews. [A2] monitored the wording and openness of the questions based on the transcripts. The body of the interviews lasted 37 minutes on average (ranging from 15 to 72

minutes, audio taped). Additional mental health care was offered after the interview and was accepted by one family.

- Please, insert Table 2 about here -

Analysis

The analysis was carried out according to the 'constant comparison' method. [22] Interviews were transcribed verbatim except for names, dates, and locations, which were substituted with functional codes to ensure confidentiality. The data were imported in MAXQDA 2007.[23] The study's approach was inductive. Each potentially meaningful fragment in the first four transcripts was coded independently by [A1] and [A2] and the differences were discussed until consensus was reached. Subsequent interviews were initially coded by [A1] and checked by [A2]. [A3] and [A4] reviewed the codes to avoid potential researcher bias. New interviews were compared with existing codes to identify similarities and differences. The codes were grouped into conceptual categories and the interrelationships were continuously discussed by the research team. Categories became saturated (i.e., no new themes came up) with 22 interviews, which was confirmed with three subsequent interviews. A clinical child psychologist and a social worker, both independent to the study, reviewed and approved the analysis.

RESULTS

Although the interviews covered a range of topics, parenting strategies to promote children's psychological recovery after traumatic exposure were prominent in participants' narratives. They often started to talk about these practices before any questions were posed about them. We distinguished two aspects in the narratives: a) being aware of a child's needs and b) acting upon these needs. We elaborate on the two categories of practices in the following sections.

We will refer to the combination as ‘responsive parenting after trauma’, the central theme of our results. Being responsive was a challenge for parents. One father mentioned both aspects of responsive parenting while expressing this challenge:

> “But I wonder, does he really still think about it? I don't know. Yeah, anybody would want to know their kid so well that you know that 'it's done', or 'something is still bothering my child'. And if the latter is the case, that you take action.”

Being aware of a child’s needs

Parents tried to get a sense of how their child was doing after the event. They made use of five strategies (see Table 3). One was to directly ask the child how he or she was doing. A second was to compare the child’s behavior before and after the trauma. Another was to determine whether the behavior of children was in line with their character. For example, a mother told that her son was rather introvert and that his reluctance to talk about the event was rather in line with his character instead of a potential stress reaction she was worried about. A fourth way to find a point of reference for the seriousness of children’s posttraumatic reactions was by comparing them with siblings:

> “I have another son, who is younger by two years. Now he *did* cry a lot…(My oldest son) did not cry as much as the youngest but he shows his tears.”

Some parents mentioned that they tried to monitor the child’s reactions but found it difficult to come to conclusions. In order not to miss possibly important cues, parents checked other people’s impressions of the child, such as a mental health care professional or a school teacher:

> "At school you talk about it a bit more with the teacher. And yeah, the teacher didn't really see that he ran behind or couldn't concentrate as well. No, it's going well at school."

Parents did not always succeed in being aware of their child's needs and functioning. One mother had missed her child's signals that he was still suffering from stress reactions related to the violence the family had encountered. She thought that he was too young to be affected by the incident. She did have the feeling that something was not going well for the boy, but thought that his concentration problems at school had to do with dyslexia. Looking back, she felt that her child's malfunctioning had continued for years because she was unaware of his needs. Only after it was discovered that he suffered from posttraumatic stress an adequate intervention was provided and he recovered.

- Please, insert Table 3 about here –

Acting upon the child's needs

Parents not only tried to be aware of their child's functioning and needs, they also took action to facilitate their child's recovery (nine strategies; see Table 3). Their approach often incorporated an element of making sure that the child felt in control. For example, when parents explained that it was important to talk about the event (the first strategy that we identified), most of them went into more depth and said that they actually provided an atmosphere in which the child felt free but not obliged to talk. Part of being able to provide such an atmosphere was knowing the child very well. Some parents pinpointed in which situations their child would talk about distressing thoughts or feelings and made sure they provided the opportunity:

> "He hardly talks about it. He does talk about it with me when we're taking a bath. Then the two of us take our time and he won't stop talking."

The children had many questions, for example about "right and wrong" after incidents of violence and about what happened exactly in a car accident. The second strategy that we identified regarded answering these questions. Again, parents tried to adjust to the child's pace, by saying that the child was free to ask, and that when he or she was ready, parents would provide information. Some parents felt that their approach differed from the one followed by police officers or doctors:

> "Sometimes doctors came barging in and they would start that whole conversation, whereas we were just easing her into it, like 'Whenever you're ready we'll tell you about it'."

Being sensitive to their child's pace stood central as well in parents' descriptions of stimulating their children to do things that they preferred to avoid after the traumatic event, such as going to school by bike after a traffic accident or being confronted with a changed body image. The way parents guided this confrontation with reminders appeared to be a combination of challenging the child and giving the child control over the situation. Under these conditions, several children finally made the step towards the confrontation:

> "[Removing] that band-aid [from his disfigured finger], yeah, that was very hard for him. So we took a photo while he didn't look. We put that photo at home 'When you think *I want to see it* you can go look at the photo. Then you know what your finger

> looks like, and you can say whether the band aid can go or not.' And eventually he said himself: 'Now I want to see the photo'."

Parents protected their children from cues that they thought would be unhelpful for recovery, such as exposure to news crews. Parents also hid their own emotions from their children when they judged them too intense. For example, they hid tears until they were out of sight of the child. However, children appeared very sensitive to signals of parents' distress. Several parents coincidentally learned that their child knew about gruesome details they thought they had only spoken about with other adults. In other cases, parents felt they were so overwhelmed by the event that they were not able to hide any feelings. A mother described that her son was heavily affected by his parents being "off-track" and drunk. When children needed more help to come to terms with the event or when parents felt that they couldn't adequately support their children, parents searched for help, for example by contacting a social worker at school or a psychologist at the hospital:

> "That [my daughter] just didn't want to go outside anymore, that was a reason for me to think 'Well, I don't know how to go about this, I want to get help because I can't do this myself'."

A further strategy that parents used to support their child (and themselves) was to undertake symbolic activities. Again, they attempted to make the child feel in control. For example, they had children choose the colors for a painting related to the event. Or they made a scrap book of all the postcards that the child had received.

Many parents, whether they saw distress in their child or not, paid attention to taking up normal routines again, thereby providing a daily structure to rely on. Clinicians also

supported parents in taking up a normal rhythm, which was valuable to parents. A mother told that the most important piece of advice the medical staff gave her was to pick up normal routines again and let her son go to school as soon as possible. Without the advice she would have kept him home for a much longer period of time. Finally, parents talked about their efforts to allow time for fun activities and enjoyable moments as a strategy to support their children.

Parents felt that their strategies helped their children recover or that they could have helped if they had been better aware of the needs. A father who felt confident about his and his wife's approach said:

> "I think it's really to our credit too... We really tried hard to keep things as normal as possible for them."

DISCUSSION

The purpose of the current study was to strengthen trauma-informed health care[19] by qualitatively exploring parents' strategies to promote the psychological recovery of their children after single-incident trauma. Responsive parenting was a core theme in the narratives. It consisted of being aware of a child's needs and acting upon these needs. We distinguished five parental tactics to estimate the seriousness of posttraumatic stress reactions in children (to be aware) and nine behavioral strategies to assist children (to act upon needs). Central to responsivity were parents' attempts to follow children's pace while providing structure and guidance when necessary, or seeking help to do this. Parents felt that their capacity to be responsive was influenced by their own level of well-being or distress.

When interpreting the results, the limitations of the study should be noted. First, we studied parents' perspectives. Although their views have important clinical implications, their

accounts may not directly translate to what actually happened, which requires further study. Second, we studied parents in a Western-European culture, from a Western-European perspective. Our findings cannot be generalized to other cultures without more research. Finally, we studied a sample of children exposed to single-incident trauma. Although this represents a large and sometimes under recognized group of children confronted with adversity,[20] our findings should not be generalized to parents of children who have been traumatized chronically.

Despite these limitations, our findings provide the basis for an extended version of Scheeringa and Zeanah's model of Relational PTSD[17], including not only the withdrawn parent, the overprotective parent, and the frightening parent, but also the responsive parent and his or her specific strategies. Therefore, we propose a model of Relational PTSD and Recovery (see Figure 1). The model shows that trauma in children affects both the children themselves and their parents.[10] Subsequently, parents' own well-being influences their parenting style, which has an effect on the child's well-being. Because most children recover well and most parents do not develop clinical levels of PTSD after trauma[5;10], we have depicted the unresponsive parenting styles in smaller boxes than the responsive style (which includes both elements of being aware of the child's needs and acting upon these needs). Because parental behavior influences children also in other ways than through parenting alone (e.g., by modeling[11]), an additional direct arrow is shown between the parent's and the child's wellbeing.

- Please, insert Figure 1 about here -

This model may guide health care professionals when exploring which strategies parents are using at a certain moment and what their capacity is to promote their children's recovery after trauma. In addition, the model may be used to inform parents of helpful and

unhelpful behaviors and serve as a basis for training parenting skills. The model may also assist in identifying families that need specialized mental health care, when distress levels are high and parenting styles are less than optimal. For future use, the model will need to be further tested and instruments, such as questionnaires, interviews, and training manuals, can be developed to assist clinicians in using the model.

Meanwhile, our results point to several direct clinical implications. First, we found that parenting responsively after trauma was felt as a challenge to the parents. Health care providers need to be aware of this in order to be responsive themselves and give parents the opportunity to share worries or thoughts about parenting. Second, parents talked about instances in which their thoughtful strategies to help their child (e.g., regarding giving information about the event) were interrupted by professionals. Therefore, both health care and other professionals need to make sure that they are aligned with parents regarding the timing and content of information given to children about what happened exactly during the traumatic event or what is going to happen (e.g., in medical or judicial procedures). Finally, psychoeducation (e.g., regarding restoring normal routines) by health care professionals was regarded very favorably by parents. It appears valuable to explicitly include this information in discussions with parents.

To our knowledge, this study is the first in-depth examination of parents' views on children's recovery after a wide range of traumatic experiences, focusing on parental strategies to promote psychological recovery. Although studies regarding other pediatric health issues (e.g., spina bifida[24]; diabetes[25]) showed the importance of parental acceptation and warmth, the area of positive parent-child interactions after trauma was uncovered. It is our hope that the model of Relational PTSD and Recovery will improve trauma-informed health care and promote children's post trauma recovery.

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Figure 1. Model of Relational PTSD and Recovery

See the attached JPEG file “Figure 1 from Powerpoint for Supporting children after trauma”

Table 1. Parent, child, trauma, and care characteristics

Characteristic	*M* / *N*	*SD* / %
Demographics		
Age of interviewed parents (*N* = 33)	41.4	5.8
Number of interviewed fathers	9	27%
Age of children in the study (*N* = 25)	10.7	1.04
Number of boys	15	60%
Family situation:		
Child lives with both parents	18	72%
Child lives with single parent	3	12%
Child lives with parent & stepparent	3	12%
Child lives with foster parents	1	4%
Number of children in a family	2.4	0.87
Trauma and care characteristics		
Time since the event (in years)	2.8	1.74
Children admitted to hospital	12	48%
If hospitalized, number of days	15.7	28.65
Number of mental health care sessions	15.7	
for child/parents*:		
0 sessions	1 / 4	4% / 16%
1 session	4 / 3	16% / 12%
2-5 sessions	14 / 10	56% / 40%
6-10 sessions	5 / 5	20% / 20%
≥ 11 sessions	1 / 3	4% / 12%

* Mental health care sessions within [health care institution]. In two-parent families, parents are seen together during sessions.

Table 2. Interview guide: general overview

The event

Characteristics of the event

(e.g., what happened/ where did it happen/ who were there/ what did they do?)

Emotions and thoughts of the child during the event

(e.g., which emotions did the child show/ which feelings did the child report/ which thoughts did the child talk about?)

The worst aspect of the event

(e.g., what was the worst part of the event for the child/ what upset the child the most?)

Immediate reactions

Child's emotions, behavior and cognitions

(e.g., which emotions did the child show/ how did the child behave after the trauma/ which thoughts did the child talk about?)

Reactions of others

(e.g., how did the family react/ how did peers react?)

Reactions of parent

(e.g., how did you react/ what did you do/ how did you interact with your child?)

Changes in reactions

Presence of the event in daily life

(e.g., to what extent was the child preoccupied by the event/ what did the child do to feel better/ what changes did you see?)

Emotions

(e.g., which emotions did the child show most of the time/ which emotion was strongest/ did it change; how, when?)

Intrusion and avoidance

(e.g., to what extent did the child avoid reminders of the event/ to what extent was the child troubled by recollections?)

Milestones

(e.g., where there any special moments in the period after the event/ could you describe them?)

Outlook on the world

Shattered assumptions

(e.g., to what extent had the event changed the child's ideas about the world/life?)

Posttraumatic growth

(e.g., is there a positive side in the story for the child?)

Influences on dealing with trauma

Risk factors

(e.g., what/who made it difficult for the child to deal with the experience/ what made the child feel bad; how, when?)

Protective factors

(e.g., what/who helped the child to deal with the experience/ what made the child feel better; how, when?)

Child's behavior

(e.g., what did the child do to feel better?)

Parent's behavior

(e.g., what did you do to help your child feel better/ what was your role in the child's recovery?)

Other information

Other relevant information

(e.g., what else do you think is important for me to know?)

Table 3. Strategies used to parent responsively after trauma

A) Being aware of a child's needs
1.Asking a child about how he/she feels about the event
"Then I thought, "Gee, does he still think about it now and then?" But he sort of brushed it off, "No mom, not at all anymore really," but then he did mention two examples "If I fall really hard" and "Once in a while...". So I asked "Does it still make you sad or anything?" "No." He said it doesn't."
2. Comparing behavior before – after trauma
"But [my daughter] now has different problems at school, mostly social problems. Sometimes at home I've mentioned that I really wonder if those problems have something to do with the accident. After the accident, the fact that she has changed, you know, has become a little less happy."
3. Appraising reactions in the light of a child's character
"Yeah, they are two really great and active boys, always playing outside. Yeah, that was all gone for a little while."
4. Comparing behavior with siblings' behavior
"[My oldest daughter's first reaction was] calm. My other daughter got out of the car and went and stood between the barrier and the grass looking away from the car, she didn't want to see any of it. ...we had to wait in the ER and [my oldest daughter] sat there chatting happily with the nurse, telling her about her plans and where she went to school, and we kept looking at her and thinking, what on earth..."
5. Checking impression with other adults involved with the child
"Before school started I went to them [the teachers] and told what had happened, so they knew what kind of child they would have in class. That has been a good

thing…they also gave feedback, which we could use at home. We went to school for it … I am happy I did that."

B) Acting upon the child's needs

1. Providing opportunities to talk

"If they want to talk about it, you have to be there, but you can't be like a shrink, if you'll pardon the expression, and just keep pushing and coaxing, because that won't work. My oldest daughter ... knows that, too. The door is always open. I mean, you can keep repeating it, every month, you know: 'you need to talk about it,' no... you need to be there when she needs you, I think. Then you need to face up to it and not push it aside."

2. Answering questions at the child's pace

"If he had questions, then you try to answer them as clearly and completely as possible, and honestly, too. I feel that is really important."

4. Guiding confrontation with reminders

"And we deliberately did not watch it on TV, and we kept saying to her 'well, we have it,' we had put some things on DVD, and some things are still on the internet, you know, 'you can watch it if you want, but you don't have to.' And then all of a sudden she would want to watch it in the afternoon, when no one was around, you know."

5. Protecting from unnecessary harm

"And we told her and we let the school know, 'the hearing is scheduled for then-and-then so watch out for news crews' 'cause the network wanted to send cameras again. I did send an e-mail telling them that we didn't want any camera crews. In the end they didn't show up."

6. Hiding own distress

"The first time he played soccer, he was only allowed to kick the ball over the goal, I was there on the sideline and I put on my sunglasses and I sat there and cried and cried, thinking 'there he goes, please let it go well.' A kid can feel that, you don't need to say it. I went and sat somewhere else, far away."

6. Searching for help

"[The reason for finding a therapist was] that she really was sleeping poorly and she was frightened, didn't want to be alone. I had to be with her constantly, you know, she didn't want to be alone. She was like that in the hospital, too, but then I could be with her all the time. That was great... But back home it was the same story, you know, so she wanted me to be with her all night long, lying next to her. So that was, you know, I mean that needed to be looked into."

7. Undertaking symbolic activities

"We made sure they were really involved in [the funeral], they made drawings and [Child] drew some letters on the card, but what she doesn't know is that those letters will be engraved on the gravestone, so she's sure to recognize it as her own handwriting."

8. Taking up normal routines

"I went with him to his swimming lesson the day after the funeral. That was really pretty quick, but I think he had also already been back to school before the funeral. So that all happened really fast, we got him back into his regular routine since his house and all his things were gone. And that alone is so horrible that we thought 'Let's get him back into his normal routine as quickly as possible'."

9. Providing fun activities / enjoyable moments

“We really put a lot of time into them, so we didn’t have to hang around at home but could do fun things on Saturdays. They really appreciated it, you know, they thought it was a lot of fun. We did absolutely everything we could for them, you know.”
