Research article

Transformational change in parenting practices after child interpersonal trauma: A grounded theory examination of parental response

Jorden A. Cummings

Department of Psychology, University of Saskatchewan, 9 Campus Drive, Saskatoon, SK, Canada

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ABSTRACT

Child interpersonal trauma is associated with a host of negative outcomes, both concurrently and in adulthood. Parental responses following trauma can play an important role in modulating child responses, symptoms, and post-trauma functioning. However, parents themselves are also impacted after their child experiences trauma, reporting distress, psychopathology, concerns about the child’s safety, changes in discipline and protectiveness, and feelings of blame. Most of this previous research, however, suffers from methodological limitations such as focusing on description and correlations, providing static “one shot” assessments of parenting after trauma, and relying mainly on results related to child sexual abuse. This project developed a comprehensive, explanatory theory of the dynamic process by which parenting changes in response to a range of child trauma, using a sample of parents whose children had experienced a range of interpersonal trauma types. Grounded theory analyses revealed a three-phase dynamic model of discontinuous transformation, in which parents experienced destabilization, recalibration, and re-stabilization of parenting practices in response to child trauma. Parents were focused on Protecting and Healing the child victim, often at the expense of their own needs. Most parents reached a phase of posttraumatic growth, labelled Thriving Recovery, but processes that hindered this recovery are also discussed. This study provides the first evidence that dynamic systems of change as well as vicarious posttraumatic growth can apply to parents of child trauma victims. Generating an explanatory theory provides important avenues for future research as well as interventions and services aimed at families who have experienced child trauma.

1. Introduction

Child interpersonal trauma (i.e., trauma perpetuated by another human, such as sexual abuse, physical abuse, or witnessing domestic violence) occurs with concerning frequency (see Felitti et al., 1998). As demonstrated by a longstanding body of research, child victims of interpersonal trauma are at risk for many negative outcomes, both in childhood and adulthood (Green et al., 2010; Kessler et al., 2010), including poor physical health (Elkit & Shevlin, 2010), depression, suicidality, posttraumatic stress disorder (PTSD), academic difficulties, delinquency, and substance abuse (Burnam et al., 1988; Ford, Elhai, Connor, & Frueh, 2010; Greeson et al., 2014; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Nelson et al., 2002; Steinberg et al., 2014), as well as revictimization and intimate partner violence (Fletcher, 2003; Molnar et al., 2001; Noll, 2005). Early exposure to violence and childhood adversity is even associated with accelerated aging, chronic inflammation, and early mortality (Kiecolt-Glaser et al., 2011; Shaley et al., 2013).

Nonoffending parents1 can serve as important modulators of child responses and functioning (Charuvastra & Cloitre, 2008;

E-mail address: jorden.cummings@usask.ca.

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Fromuth, 1986; Johnson & Kenkel, 1991; Tremblay, Herbert, & Piche, 1999) and are an important predictor of child outcomes post-trauma (Alsic, Jongmans, van Wesel, & Kleber, 2011; Godbout, Briere, Sabourin, & Lussier, 2014; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Maternal support following child sexual abuse is associated with less child distress (Conte & Schuerman, 1987; Morrison & Clavenna-Valleroy, 1998) and fewer symptoms (Hazzard, Celano, Gould, Lawry, & Webb, 1995; Mannarino & Cohen, 1996), whereas parental rejection or guilt for the trauma has detrimental influences (Deblinger, Steer, & Lippman, 1999). Withdrawn, overprotective, and frightening parental responses can also exacerbate child symptoms (Scheeringa & Zeanah, 2001) and parental variables have been shown to significantly impact how children respond to therapy for interpersonal trauma (Yasinski, et al., 2016). Consistently, research has demonstrated that parents’ and children’s responses post-trauma are related. Specifically, parents of trauma victims report helplessness, frustration, depression, anxiety, and symptoms of PTSD, all of which influence the wellbeing of their children (for a review see Appleyard & Osofsky, 2003).

Furthermore, parenting is impacted and possibly changed by child trauma. In a comparison of mothers of sexually abused children and mothers of nontraumatized children, Kim, Noll, Putman, and Trickett (2007) reported that mothers of sexually abused children provided less structure and were more punitive. Up to 53% of mothers of sexually abused children, in one sample, reported that their feelings and behavior toward the victimized child changed after learning of the abuse (Leifer, Kibane, & Grossman, 2001). Parents of child trauma victims across multiple studies report negative emotions (e.g., guilt, anger, fear, and shock), distress, changes in protectivelessness, worries regarding safety, interpersonal changes, poorer family functioning, decreased satisfaction with parenting, and feeling blamed (Carter, 1993, 1999; Davies, 1995; Elliot & Carnes, 2001; Hiebert-Murphy, 2000; Manion & McIntyre, 1996; Regehr, 1990).

Qualitative research has provided further evidence of distressed parental reactions following child trauma. Parental responses after the Beslan, Russia school siege of 2004 indicated that they felt increased concern for their children and worry regarding the well-being of their children (for a review see Appleyard & Osofsky, 2003). Concerns regarding their role as parents and experienced particular difficulty imposing rules and discipline. A more recent thematic analysis of parental experiences following disclosure of child sexual abuse by Bux, Cartwright, and Collings (2015) sorted caregivers’ experiences into five core themes: distress, concern for the child, alienation from community and family, coping styles, and grief. Similar thematic work reported that being aware of the child’s needs and acting upon those needs were crucial components of responsive parenting after trauma (Alsic, Boeije, Jongmans, & Kleber, 2012).

Despite this array of consistent results, covering decades of studies, research on parenting and child trauma suffers from a number of limitations. First, most previous research has been primarily descriptive of common parental reactions, giving a static one-time account of these reactions. Second, much of this research focuses on correlations between parent and child symptoms (e.g., depression, anxiety, PTSD) only, rather than a fuller range of experiences, such as changes in parenting strategies. As noted by Alsic et al. (2012) much of this previous research has only studied parental negative responses. Fourth, most previous research focuses solely on child sexual abuse victims and it is unclear if these results can be generalized to other types of child interpersonal trauma. Fifth, and perhaps most importantly, this area is substantially hindered by the lack of a unifying theory of parenting responses to child interpersonal trauma.

This lack of comprehensive theory generates substantial problems for both researchers and clinicians. First, a lack of unifying theoretical framework stifles the ability for research advances in this area. Whereas description “tells us about an event or happening,” theory, in contrast, “offers explanations for why events or happenings occur.” (Corbin & Strauss, 2015, p. 12). Whereas description and theory both involve examining common aspects of a phenomenon across participants, theory also establishes linkages explaining how these aspects relate to one another and how they are experienced as phases over time (Corbin & Strauss, 2015). Second, this lack of a cohesive model results in an inability to develop empirically informed, theoretically-based interventions and support services aimed at parents. That is, theory allows one to test hypotheses and evaluate an ensuing intervention for effectiveness. Last, this represents a lost opportunity to maximize health outcomes for child trauma victims, by supporting and leveraging parent response in an empirically based manner.

2. Current study: grounded theory approach to parenting after trauma

The purpose of this project was to address these concerns and develop a cohesive theory of how parenting strategies change following child trauma, using grounded theory (GT), a qualitative approach to generating a theory of a human experience (Charmaz, 2003; Corbin & Strauss, 2015; Glaser & Strauss, 1967). Grounded theories are inductive (i.e., “grounded in the data”) instead of deductive (i.e., applying already known results and theories to a set of data). GT is an iterative process, where researchers analyze and collect data simultaneously (Charmaz, 2006). Early coding is used to separate, sort, and synthesize the data as well as generate hypotheses for further data collection, a process known as theoretical sampling. During coding, constant comparison is used to repeatedly check ideas against data (Schwandt, 2001) in order to avoid confirmation bias. This cycle of coding, constant comparison, and theoretical sampling (i.e., recruiting new participants or re-interviewing previous participants) continues in an iterative, non-linear fashion until no new concepts, categories, or ideas are generated (i.e., saturation is reached).

GT was considered most appropriate for this project for multiple reasons. First, GT approaches are helpful when little previous research exists from which to generate a theory, consistent with the lack of previous models for parental adjustment following child trauma. A deductive approach to generating a theory of parenting after trauma is not possible given the lack of previous models in this area. Second, as mentioned, GT is designed to develop an explanatory theory of a process, which was the purpose of this project. Development of a unified theory of how parents respond to child trauma (with a range of outcomes) has potential implications for both future research in this area as well as clinical work with families impacted by interpersonal trauma.
3. Method

3.1. Participants

Participants were recruited from letters of invitation posted throughout the community, local service providers, and using a professional survey company (www.probit.ca).1 Potential participants were considered eligible to participate if they were 1) a parent or guardian whose child was under the age of 16 when they experienced trauma; 2) not the accused perpetrator of that trauma; 3) English-speaking; and 4) willing to participate in an open-ended interview regarding their experiences. Thirty-eight participants were screened for the project, with 11 being unreachable following their initial contact call/email, 11 not meeting inclusion criteria, and 1 declining to participate.

Fifteen parents (12 mothers, 3 fathers) of 22 victims of child interpersonal trauma (12 male, 10 female) participated in the study. The participants’ children had experienced a wide range of traumatic events (see Table 1 for demographics) including sexual abuse/sexual assault, witnessing domestic violence, physical abuse/assault, and bullying. Three participants were interviewed as negative cases, which can be defined as participants not meeting specific inclusion criteria or who are different from the remainder of the sample, and which allow researchers to assess the boundaries of developed categories and confirm hypotheses regarding interpersonal trauma (Booth, Carroll, Ilott, Low, & Cooper, 2013; Creswell & Miller, 2000).

Participants were purposefully sampled for heterogeneity, in order to maximize generalizability of the resulting GT (Robinson, 2014). First, no limit was placed on type of interpersonal trauma experienced by participant’s children. This is consistent with current empirically-supported treatment approaches to child interpersonal trauma, such as TF-CBT, which apply the same treatment package to victims of all interpersonal traumas (e.g., Cohen, Mannarino, & Deblinger, 2012). Second, participants had substantial geographical heterogeneity, representing eight of 13 Canadian provinces. Last, no limit was placed on parent gender, parent age, or on time since the trauma occurred, which allowed for collection of experiences of parents who were new to the experience of parenting after child trauma (minimum = 8 months) as well as parents who had a vantage point with more temporal distance (maximum = > 25 years).

3.2. Procedure

Informed consent procedures were reviewed with all participants, who then explicitly provided verbal consent to continue the interview. A small number of local interviews (but not all local interviews) were conducted face to face. The remaining interviews were conducted via phone.2 Participants were provided with an open-ended prompt to begin the unstructured interview: “Please tell me what this experience has been like for you, from the beginning. Tell me whatever you can about how this has been for you.” An open-ended interview was used in order to maximize the depth of data generated, minimize potential pre-existing bias arising from the interviewer (Homewood et al., 2009), and expedite saturation (Morse, 2015). This open-ended format only was used in the first eight interviews. This format was retained for all subsequent interviews but augmented with semi-structured probes designed to assess codes and categories that had arisen in the earlier eight interviews, consistent with theoretical sampling. Prior to ending our conversation, participants were asked to discuss their experience of the interview, debriefed, and thanked for their participation.

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1 From this point forward, the term “parents” is used to refer to nonoffending parents
2 In order to ensure maximum confidentiality given the size of the community where local participants were recruited, no information differentiating local from non-local participants is provided, including the number of participants in each recruitment group or number of participants completing phone versus in-person interviews (Allen & Wiles, 2016).
Participants were provided with a $50 honorarium. All interviews lasted between 60–90 min and were audio-recorded. Interviews were transcribed by research assistants. The author then reviewed all transcripts for errors and omissions by reading them while listening to the audio-recording.

3.3. Grounded theory analysis

3.3.1. Initial coding

In the first stage of analysis transcripts from the open-ended interviews were reviewed line by line. Any segments of text broadly relevant to the research question were highlighted and assigned an initial code. Consistent with recommendations from Charmaz (2006), active codes were used in order to facilitate the identification of dynamic processes within the data, as per the focus of GT. Memo writing was used in all stages of analysis and assisted with the development of the final model narrative (Charmaz, 2006).

3.3.2. Focused coding

Initial active codes were reviewed and more abstract, focused codes were created by combining common initial codes that reflected similar themes and principles. An initial grounded theory emerged from the data. These focused codes were then used to code interviews from the second phase of sampling (i.e., new participants and re-interviews of previous participants). Constant comparison within and between participants, as well as increasing levels of abstraction in coding, led to a more refined model. A saturation check was completed by reviewing each participants’ data for the presence of focused codes and saturation was confirmed (Morse, 2015).

3.3.3. Theoretical coding and model completion

The last phase of analysis focused on clarifying the relationships between categories/focused codes as well as testing the boundaries of those codes by analyzing negative cases and constant comparison. Overall, coding focused on understanding the purpose of each category and the sequential flow of participants through the model. This clarified the sub-processes involved in the full model and identified “exit points” whereby some participants did not experience the final phase of the model.

3.3.4. Verification strategies for reliability and validity

Morse, Barrett, Mayan, Olson, and Spiers (2002) argue that reliability and validity strategies are built into qualitative analysis, similar to quantitative research, by applying verification and self-correction strategies. Specifically, methodological coherence (i.e., match between research question and research method), sample appropriateness (i.e., interviewing participants who best represent the research question as well as saturation in categories), concurrent data collection and analysis, theoretical thinking (i.e., ideas emerging from the data are reconfirmed with new data), and theory development (i.e., reviewing results in context of current knowledge) should all be used to ensure rigor of qualitative projects (Morse et al., 2002).

Such rigor was ensured in the current study by choosing to use GT given its focus on developing an inductive theory of a process and helpfulness in areas with little previous literature to inform a theory (i.e., methodological coherence), sampling parents of child interpersonal trauma victims and including negative cases to further explore the boundaries of the resulting model (i.e., sample appropriateness), using a phased, iterative approach to data generation and analysis (i.e., concurrent data collection and analysis), the use of constant comparison including reviewing previously collected interviews for any new concepts that emerged and asking newer participants about previously identified concepts with open-ended probes to avoid bias (i.e., theoretical thinking), and conducting a full literature review after GT analyses to check consistency between the model and current knowledge in the area (i.e., theory development).

4. Results

The theory was labelled Protecting and Healing, indicating that parents see themselves as responsible after trauma for protecting their child from the effects of trauma, avoiding further harm, and ensuring their child heals as quickly and easily as possible. The complete GT consists of a total of six subprocesses that can be separated into three phases (see Fig. 1). In Phase 1, Destabilization, the parent experiences violated expectations regarding the world, the self, and others. The parent’s attention becomes focused on the trauma and the chaotic experience of “trying to get back to normal.” In Phase 2, Recalibration, the parent has experienced some success with helping the child recover; attention broadens to focus on life beyond the trauma, and new parenting strategies emerge. Last, in Phase 3, Stabilization, the parent and child settle into post-trauma life, which is marked by movement beyond the alleviation of negative symptoms to benefits. This GT, in sum, explains why some families are able to experience positive recovery after trauma whereas some do not (for exemplar quotes see Table 2). Each subprocess is discussed, in order of movement through the model:

4.1. Violated expectations

Upon disclosure, parents’ beliefs and expectations about the world, themselves, and often their relationships with others are deeply challenged, contradicted, or shattered. These Violated Expectations relate to the very idea that something traumatic could

3 Three participants declined the honorarium and were not reimbursed
happen to their child, that they were unable to prevent the trauma, and that the perpetrator could commit such an act. This occurs almost instantaneously during the trauma disclosure. Violated Expectations are the crucial entry point into the GT. As will be discussed later, parents who do not experience Violated Expectations do not appear to reach the positive outcomes of the completed model. Violated Expectations provide the necessary energy for parents to move forward in this process of Protecting and Healing, much of which is demanding, emotionally difficult, and requires behaviors that are “above and beyond” what the participants ever expected to do as a parent.

4.2. Going into protective mode

Protective Mode is focused on “doing what needs to be done,” “stepping up” to heal the child, and fighting for the child’s post-trauma needs to be met. In Protective Mode life becomes exclusively focused on the child and trauma recovery. Some participants described Protective Mode as being accompanied by a different sense of time (“trauma time”), which is slower than “regular time” (e.g., it is focused on getting by one day at a time or even one hour at a time). Protective Mode includes two strategies: 1) subjugation of the parent’s own needs to focus on the child’s needs (e.g., giving up self-care activities, avoiding seeking assistance for their own reactions to the trauma); and 2) strategies to support the self and self-talk.

4.3. Making it better

Making It Better includes action-oriented steps and subsumes three additional subprocesses.

4.3.1. Searching for the right things to do

This subprocess is focused on figuring out the specific, necessary actions that must be taken to heal the child. Parents begin
generating ideas at time of disclosure; many parents begin by seeking professional assistance as they perceive child trauma as being “beyond their skill set.” These include professionals such as physicians, police, or therapists. Accompanying this request is often fear of doing the wrong thing (e.g., retraumatizing the child, contaminating a child’s recollection and undermining its legal utility, or upsetting the child) and/or being uncertain of what to do and hoping the professional will direct them. Other examples of possible Right Things to Do included moving out of the home shared with the perpetrator, reporting the trauma to the police, and allowing the child to switch schools. Searching for the Right Things to Do involves a trial and error process of brainstorming actions, trying those actions, and then evaluating their impact. No one strategy worked for all children, and the purpose of this subprocess is to find the unique combination of interventions that will work for each specific child.

4.3.2. Padding the child

Parents aim to place their child in a protective and safe space. This involves both a literal, physical placement (e.g., limiting the child’s activities, limiting access to certain situations/locations, or limiting the child’s time alone) as well as a psychological placement that is achieved by the parent’s actions (e.g., changing discipline habits so the child does not experience negative emotions, changing behavior in the home to avoid startle responses, insisting siblings be kinder to the trauma victim). The purpose of this padding is to provide space for the child to heal by eliminating their negative experiences in the world.

4.3.3. Being let down

This subprocess is similar to Violated Expectations, except for two distinctions: 1) Parents are unaware they hold these...
expectations until placed in the trauma situation, and thus these expectations are learned and violated via interactions with the post-trauma experience itself; and 2) These violated expectations relate primarily to the responses of others. For example, parents reported realizing that no one else would advocate for their child’s needs, that therapists were unprepared to work with them, that the legal system felt slow and unfair, or were left down by close others they expected to be supportive. Many of these beliefs are permanently changed and never repaired, directly influencing parenting choices even after recovery.

4.4. Reaching the tipping point

The three proceeding subprocesses of Making It Better reciprocally influence one another over time. For example, as parents engage in the actions in Searching for the Right Things to Do, they encounter experiences of Being Let Down. This in turn influences the actions they take in Padding the Child. Eventually, as parents cycle back and forth through these subprocesses, they reach a tipping point where they move forward into the second phase of the model (i.e., Recalibration). The number of cycles or duration of these iterations through these subprocesses is idiosyncratic and might take months to years. Two specific indicators of reaching this tipping point emerged from the data: 1) Parents reported that child distress has decreased substantially; 2) the interventions applied in Searching for the Right Things to Do begin to have an effect. Once these indicators occur, the remainder of the model is available for parents to experience.

4.5. Regaining stability

Regaining Stability begins to counter the destabilization and uncertainty associated with Phase 1 of the model. Attention widens to include life beyond trauma. Three important steps occur within this subprocess: First, parents begin more actively supporting themselves and considering their own needs, which were previously subjugated by most. Parents also received support from close others. Through this experience of supporting themselves, many parents described themselves as finding their own strength and developing the confidence they could cope with both their child’s past trauma and any adversity in the future. Second, parents also begin to see their child’s strengths and note discernable signs of recovery, and, third, begin to reduce the padding they previously placed around the child. For example, parents who were previously not disciplining their child realized this is an unhelpful choice in the long-term and resumed consequences for poor behavior or desisted providing rewards without associated positive behavior.

4.6. Experiencing thriving recovery

Parents who progress past Regaining Stability reach the final stage of the model, Experiencing Thriving Recovery. Parents and children who reach this final stage not only experience recovery in the sense that negative symptoms have been alleviated, but that they have experienced post-trauma gains in wellness that were not accessible prior to the trauma. These benefits included increased and improved communication between family members, increased intimacy as a family, increased family emotional intelligence, and increased ability to support one another as a family. Parents describe themselves as learning what is “most important” in their life and becoming a more authentic version of themselves. In these descriptions, parents believed the trauma directly influenced these outcomes and that they would not have reached these outcomes without the trauma experience.

It is important to note that the influence of the trauma is still present in Thriving Recovery. This was expressed in two ways: 1) parents spent time looking forward to consider how the trauma might still impact their child’s long-term future; and 2) some aspects of Padding the Child are retained and expressed as explicit safety planning, focused on avoiding reactivation of the past trauma or avoiding retraumatization. Examples of safety planning included making plans to avoid seeing the perpetrator in public, how to report trauma if it occurs in the future, and providing children with cell phones to be in close contact with parents when needed.

4.7. “Exit points” or inability to progress to thriving recovery

As previously mentioned, this theory explains why some families reach positive recovery after trauma whereas some do not. Unfortunately, some parents “exit” the model at various transition points. First, as previously mentioned, parents who did not respond to trauma with Violated Expectations did not progress any further in this process. Two participants illustrated this experience: One mother who had longstanding (i.e., > 15 years) suspicions that her daughter was being sexually abused and a foster mother who was aware of her foster child’s trauma history prior to placement. Neither of these participants reported Violated Expectations nor did they progress forward in the model. This further emphasizes that Violated Expectations serve the purpose of propelling parents onward to Protective Mode and through the model.

Second, some parents cycled through Making It Better but were unable to reach the tipping point necessary to enter the second phase of the model, for two reasons: 1) Some parents seemed unable to identify or apply the Right Things to Do. This occurred primarily with older children or adolescents who, for example, refused to attend any counselling or related services as well as children who had comorbid psychiatric conditions that complicated their care, such as the trauma exacerbating a severe depressive episode that did not respond to treatment; and 2) In some families, additional negative events occurred that exacerbated the strain on the family or presented additional sources of adversity that undermined the parent’s ability to cope and maintain their protective stance. For example, one adolescent victim experienced an unplanned pregnancy. In another family, the child’s trauma prompted the parent to begin drinking heavily.

Third, a small minority of families who reached Regaining Stability did not reach Experiencing Thriving Recovery, again due to
additional negative events that occurred at this stage. For example, one parent who was Regaining Stability after choosing to homeschool her child following his school-based trauma experienced setbacks that required the child to return to public school, where he was experiencing triggers and additional negative events. At time of the interview they had not reached Thriving Recovery.

5. Discussion

The purpose of GT is to develop an explanatory model of a human experience by grounding that theory within data generated with an appropriate sample (Morse et al., 2002). This resulting GT, Protecting and Healing, is the first comprehensive, explanatory theory that moves beyond description to explain how and why parents adjust their strategies following child trauma. Parents move through three phases of adjustment from destabilization to recalibration to stabilization, from initial disclosure of the trauma to, in positive cases, experiencing Thriving Recovery. Each stage is marked by changes in parenting designed to Protect and Heal the child. This model also included major exit points that explain why some families might not recover from interpersonal trauma.

Descriptively, several of the subprocesses of this model overlapped with categories identified in previous research. As discussed, however, the purpose of this project was to move beyond description. Thus, for the sake of brevity, categories consistent with previous correlational research are marked in Table 2, whereas here the model is discussed as a whole. In particular, parallels between Protecting and Healing, discontinuous transformation, and posttraumatic growth are noted. Differences between these theories, the unique challenges to separating parent and child experiences after child trauma, implications of these results and avenues for future research are also discussed.

5.1. Dynamic systems and discontinuous transformation

Dynamic systems are self-organizing systems of behavior that prefer states of homeostasis. As such, dynamic systems are organized around attractors that maintain the status quo in a system, although systems can demonstrate small and gradual changes in this state (Gelo & Salvatore, 2016). An individual human can be thought of as a dynamic system, maintaining patterns of behavior, affect, and personality with some flexibility for change. However, dynamic systems can also be victim to perturbations, where the system is thrown into a state of destabilization and the preferred system organization is no longer possible. The system experiences discombobulation as it reorganizes itself into a new dynamic in order to settle into a new form of homeostasis. In the psychology of change, such destabilization is seen as the birthplace of human growth and transformation (Gelo & Salvatore, 2016; Hayes, Laurenceau, Feldman, Strauss, & Cardaciotti, 2007) as humans reorganize their reality to match this challenge to their status quo (Miller & de Baca, 2001). The three phases of Protecting and Healing (i.e., Destabilization, Recalibration, and Stabilization) match these dynamic stages of perturbation, discombobulation, and new homeostasis.

As with my participants, deeply emotional and even traumatic events (Skalski & Hardy, 2013) can serve as perturbations prompting disorganization and reorganization. William James (James, 1958) noted this as early as 1958: “Emotional occasions, especially violent ones, are extremely potent in precipitating mental rearrangements” (p. 163). In models of discontinuous transformation, this perturbation triggers a period of disintegration (Skalski & Hardy, 2013) marked by overwhelming stress, relationship changes, and psychological turmoil, all of which are present in the Protecting and Healing model. This is followed by phases of new consciousness and integration, where individuals form a new reality, develop new insights, and integrate these insights into their views of the self and world, often involving a changing in values (Skalski & Hardy, 2013). Again, all of these are present in phases 2 and 3 of the Protecting and Healing model.

Within development, nonlinear change models have been frequently applied for studying developmental transitions, including families as they transition to adolescence (Granick, Hollenstein, Dishion, & Patterson, 2003). However, this study provides the first evidence that discontinuous transformation can apply to parenting development. That is, with severe perturbations parenting practices can be subject to deep, dynamic change.

5.2. Thriving recovery and models of posttraumatic growth

Participants also reached new levels of wellness (Thriving Recovery), consistent with models of posttraumatic growth (PTG). Calhoun and Tedeschi (2004, 2006) identify three necessary qualities for PTG: 1) significant challenges to schemas about the self and world; 2) stressor-induced distress; and 3) cognitive processing. All of these qualities are present in Protecting and Healing. Furthermore, having reached Thriving Recovery participants described experiencing levels of familial intimacy, support, honesty, and confidence in their own abilities as a parent to cope with adversity that were not available to them prior to their child’s interpersonal trauma.

Although models of PTG have been applied to vicarious trauma, research has previously focused on samples of professionals working with trauma victims. This has demonstrated that PTG can be applied vicariously (VTG) in populations such as trauma

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4 As described by Joseph and Linley (2005), posttraumatic growth has also been referred to as “stress-related growth (Park, Cohen, & Murch, 1996), perceived benefits (McMillen & Fisher, 1998), thriving (Abraido-Lanza, Guer, & Colon, 1998), positive changes in outlook (Joseph, Williams, & Yule, 1993), transformational coping (Aldwin, 1994), constructing benefits (Mileck & Tennen, 1996), heightened existential awareness (Yalom & Lieberman, 1991), quantum change (Miller & de Baca, 1994), positive by-products (McMillen & Cook, 2003), and flourishing (Byff & Singer, 1999). These terms have been used interchangeably within the literature...” (p. 263). Here I have chosen to use the label posttraumatic growth given that parents are discussing experiences specifically following a traumatizing experience.
workers and psychotherapists (Arnold, Calhoun, Tedeschi, & Cann, 2005; Cohen & Collins, 2013) as well as interpreters (Splevins, Cohen, Joseph, Murray, & Bowley, 2010). This GT shows that VITG can apply to other relationships, such as that of family members of the victim. This also lends support to previous research speculating that parents can experience traumatization as a result of their child’s trauma exposure (Manion & McIntyre, 1996; Scheeringa & Zeanah, 2001) and also provides evidence that child trauma is sufficient adversity to trigger destabilization and PTG processes for parents.

However, two nuanced differences between Protecting and Healing and PTG should be noted. First, although both models emphasize shattering of worldviews (e.g., Violated Expectations), the Protecting and Healing model is more detailed in its explication of the purpose of these shattered views, which is to arm oneself, as a parent, with the necessary energy, outrage, and motivation to go into Protective Mode and work to heal the child. Such shattered worldviews are consistent with research with trauma victims themselves (Janoff-Bulman, 1989, 1992), who are often described as accommodating or assimilating these worldviews with the traumatic experience, which can lead to PTSD. Interestingly, no participants in this study described such accommodating or assimilating or the development of PTSD symptoms. In contrast, Violated Expectations were a necessary and thus ultimately positive (yet difficult) experience for participants. Second, meaning making is central to most models of PTG (Joseph & Linley, 2005) but did not emerge from the data in this project. It is possible that participants’ experienced meaning making but did not discuss it.

Holistically, the Protecting and Healing model also addresses some criticisms of other models of PTG, as outlined by Joseph and Linley (2005). First, PTG theories are criticized for being static and descriptive. In contrast, Protecting and Healing is dynamic and explanatory. Second, previous theories have been criticized for not being comprehensive enough. That is, Joseph and Linley argue that models of PTG must be able to explain individual variance in responses that encompasses both positive change and negative change. Protecting and Healing incorporates and explains experiences of parents reached the end stage of Thriving Recovery as well as those who did not. Third, even the most comprehensive theory of posttraumatic growth (i.e., Calhoun & Tedeschi, 2004, 2006) has been criticized for failing to account for why people might motivate toward growth (Joseph & Linley, 2005). GT again addresses this limitation: Protecting and Healing describes why parents move through each step of this model. That is, parents are motivated to heal their child from the effects of trauma by any means necessary.

5.3. Separating parent experience from child experience

This project aimed to examine the unique parental experience associated with child trauma, in order to address this gap in the current literature. However, it became clear early in data generation that separating the parent experience from the child experience is difficult. For example, when asked to describe their own experience of their child’s trauma many parents responded by sharing the details of their child’s experience. Most participants required prompting to discuss their own experience and several parents reported never having reflected upon or considered their own individual experience as separate from their child’s prior to participating in this study. Related, it was impossible to completely separate parent and child experience in several components of the model. That is, despite being a model of parental experience this GT is still oriented toward the child’s recovery. At first, most parents push aside any of their own needs and focus exclusively on their child. It is only in later subprocesses that parents begin to attend to their own coping needs. This yoking of parent recovery to child recovery is perhaps best illustrated with Reaching the Tipping Point. Both indicators of the tipping point (i.e., reduced child distress and success of interventions) relate to the child’s functioning. Stated more explicitly, no parent was able to progress to the positive, healing phases of the model without improvement in the child’s functioning. Although previous research has established the importance of parent functioning to child recovery after trauma, this model indicates a possible reciprocal relationship between parent and child recovery. The child’s improving adjustment is a required gateway to Phases 2 and 3 of the model (Recalibration and Stabilization, respectively).

5.4. Implications for applied work with parents of trauma victims

The Protecting and Healing model has a number of implications for service providers of all types working with families impacted by trauma. Broadly, this model confirms that parents have a unique experience of adjustment following child trauma that indicates they also have unique needs. The first implication is that such parents are deserving of services that target their own needs. Unfortunately, although parents of trauma victims report desiring such services, they also report substantial barriers to receiving them (van Toledo & Seymour, 2016). Researchers developing and improving treatments for child trauma should begin to incorporate parents in a manner that not only capitalizes on their involvement as a way of maximizing child gains but also meets parent’s specific needs as well. As discussed, previous research has established that parents play an important role in how children recover from trauma, but this model provides the first evidence that the child’s recovery influences parents’ recovery as well. This further speaks to the need for interventions to address both child and parent needs in order to maximize the recovery of both.

Second, it is important to acknowledge that while destabilization and suffering can precede PTG, clinicians “too routinely endeavour to ease client suffering” (Skalski & Hardy, 2013, p. 175), which undermine the individual’s ability to experience discontinuous transformation. If Destabilization is necessary for recovery, consistent with previous research on dynamic systems and change, then clinicians who ameliorate this discomfort might hinder the parent’s ability to reach Thriving Recovery. Service providers need education about this process so they can be adequately prepared and they need strategies to assist parents in this process. As Skalski and Hardy (2013) note, the PTG literature can assist clinicians in this challenging task. Calhoun and Tedeschi (2004) recommend PTG-oriented strategies such as listening for and labelling PTG when it is experienced, focusing on the client’s struggle rather than the trauma itself, opportunities for clients to meet with other survivors, and the use of narrative work to encourage PTG. More specifically to Protecting and Healing, service providers can assist parents with strategies for Making It Better but must
recognize that Reaching the Tipping Point is idiosyncratic and the result of multiple interventions, both formal and informal.

Service providers should be attuned to families who are at risk to “exit” the model and assist them with staying on track toward Thriving Recovery. Related, these results should be used to normalize this difficult experience for parents of child trauma victims, who would likely benefit from psychoeducation about Protecting and Healing. Specifically, parents should know that Destabilization is normative, that many iterations of Making it Better will likely be necessary, that parents will often feel uncertain about what to do but that many parents also naturalistically, with the right individualized amount of time, reach recovery.

Last, experiencing Being Let Down illustrates how difficult it is for families to navigate the systems and institutions they must interact with after child trauma. This is consistent with research showing that families experience such systems as frustrating, inadequate, insensitive, and unsupportive (e.g., Davies, 1995; Wells, 1994), sometimes labelled “system induced trauma” (Alaggia, Michalski, & Vine, 1999, p. 59). Such experiences of being let down applied to the legal system, physicians, schools and teachers, therapists, insurance providers, and even politicians. Professionals who interact with families who experience trauma need to be aware of the hurdles involved in such systems and be proactive about changing such systems. Such negative experiences are distressing and can even be retraumatizing for vulnerable families.

5.5. Limitations

This study was limited by a lack of ethnic diversity in the sample, despite diversity in terms of gender, trauma type, geographical location, and time since the trauma. All but one participant (who self-identified as First Nations) self-identified as Caucasian. Application of this model to culturally diverse samples should be done with caution until it has been assessed with such populations. Previous research on maternal response to child sexual abuse, for example, does indicate that cultural factors influence parents post-trauma (Alaggia, 2002). However, qualitative research by Bux et al. (2015) revealed themes similar to my results in a South African population. Further research in this area is warranted. Second, parent psychopathology, especially depression, anxiety, and PTSD, following child trauma has been shown to influence child recovery from trauma (for a review see Appleyard & Ososky, 2003). Parents’ self-reported psychopathology was not collected in this study. Future research should assess parent mental health and assess its influence on their ability to progress through the Protecting and Healing model. Last, it is important to be aware that individuals who volunteer to take part in interviews, particularly about sensitive topics, might be illustrating a self-selection bias (Robinson, 2014). For example, although previous research (Alaggia, 2002; Bolen & Lamb, 2004) has reported a range of parental responses to child trauma, most participants in this sample responded positively and immediately believed the child’s allegations. Unfortunately, however, it is not possible to know how such participants might differ from those who did not volunteer.

5.6. Future directions

This model generates many additional and important research questions, some of which have been previously mentioned such as understanding the contradictory positive nature of Violated Expectations, examining possible meaning making amongst parents of child trauma victims, evaluating how interventions can best accommodate parents into services, and understanding how PTG can be triggered by vicarious trauma. Two other research areas are imperative. First, additional research should test the translation of this model to intervention strategies for parents of child trauma victims in order to develop more tailored parent interventions, as discussed in the applied implications section. This GT provides a helpful map for developing interventions aimed at guiding parents through the naturalistic recovery process. Next steps must include evaluation of this map as an intervention tool. Related, further research is necessary to examine the identified exit points in more detail and to assess how service providers can best assist such families with “getting back on track” with Protecting and Healing by identifying and intervening as quickly and as effectively as possible. Second, it will be important for future research to replicate and verify this model, particularly to test it prospectively and longitudinally. Grounded theories are always flexible and open to adjustment in light of new research (Corbin & Strauss, 2015).

5.7. Conclusion

“Third generation” studies regarding child maltreatment have been described as those that move beyond documenting prevalence rates or linking trauma to negative outcomes to instead examine more complex processes (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). It is time for research on child trauma and parenting to do the same. This project developed the first theory of parental adjustment following child interpersonal trauma. It also represents the first evidence that dynamic systems and discontinuous transformation can apply to parenting strategies and that PTG can be applied to this population. Seminal grounded theorists Corbin and Strauss (2015) stated “[t]he knowledge gained through grounded theory methodology enables persons to explain and take action to alter, contain, and change situations” (p. 11). This model provides a framework for educating parents and service providers as well future researchers to assess how to intervene and assist parents.

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