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ORIGINAL PAPER

Exploring the Perceived Impact of Parental PTSD on Parents and Parenting Behaviours—A Qualitative Study

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Abstract

A considerable number of adults who are currently living with posttraumatic stress disorder (PTSD) are also parents caring for at least one biological child. Evidence suggests that parental PTSD can be associated with impairments to certain parenting behaviours, particularly increasing the use of more negative practices. However, most of the evidence to date has been collected using quantitative methodology, which gives limited insight into why such effects might occur. The current study qualitatively explored study the lived experiences of parents currently living with PTSD, within the United Kingdom. Interviews were conducted with 30 parents (16 mothers, 14 fathers) who were recruited via a PTSD research registry, and who had children living at home under the age of 18 years at the time they experienced their trauma. Three main themes were identified: key impacts of the trauma to the parent personally; negative changes to specific parenting outcomes; impact of these parenting changes on the parent's sense of parental efficacy; and recovery and coping. These findings provide novel insight into the experiences of both mothers and fathers with PTSD, and highlight the multiple challenges faced by parents living with PTSD that extend beyond impairments to themselves as individuals. Potential implications for the implementation of effective support for parents and their families following trauma exposure are considered.

Keywords Posttraumatic stress disorder · Trauma · Parenting · Parent-child relationship · Family

Highlights

- This study addressed gaps in the literature exploring the perceived impact of parental PTSD from a qualitative perspective.
- 30 parents were invited to take part in an interview about the day-to-day challenges of parenting following trauma.
- The current study offers a unique insight into the experiences of both mothers and fathers, as 47% of the sample were fathers.
- Three themes were identified perceived negative changes to specific parenting outcomes; impact of these parenting changes on the parent's sense of parental efficacy; and recovery and coping.
- The findings provide insight to the lived experiences of parents with PTSD, as well as highlighting several clinical implications for family well-being and effective functioning.

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Introduction

Posttraumatic stress disorder (PTSD) is a debilitating mental health problem with an estimated lifetime prevalence of 12.9% (Kessler et al., 2017). When it occurs in parents, PTSD has being linked to impaired parenting behaviours (Christie et al., 2019; McGaw et al., 2018). There is growing quantitative evidence that suggests trauma and parental PTSD are associated with decreased parent satisfaction (Galovski & Lyons, 2004); increased reactivity and aggressiveness towards children (Leen-Feldner et al., 2013); increased emotional numbing towards children; as well as an increase in negative perceptions of children and their behaviour, which in turn have been subsequently linked to increased potential of child maltreatment (Cross et al., 2018). Parenting difficulties in association with PTSD have also been linked to an increased risk for children developing both internalising and externalising disorders (Leen-Feldner et al., 2011).

Emerging qualitative evidence has begun to provide a more in-depth picture of the experiences of the impact of parental trauma in specific trauma populations, but to date this is limited to a small number of trauma samples (e.g., military or refugee). Research with military veterans (Sherman et al., 2015) found that parent PTSD impacted parent-child communication, whilst refugee mothers reported trauma-related challenges to child behaviour management and emotional regulation difficulties (El-Khani et al., 2016; van Ee et al., 2016). Through secondary data analysis of qualitative interviews, Cavanaugh et al. (2015) found mothers who had experienced childhood sexual abuse perceived a great need to protect their child from potential abuse, an inability to keep their child safe, and difficulties bonding with their child. Of these studies, only Sherman and colleagues (2015) specifically studied parents with a PTSD diagnosis. Further, in a recent systematic review of qualitative evidence, McGaw et al. (2019) highlight the impact military parental PTSD has on the veteran parent, but also on the wider family (including partners and children) and the home environment; which included family members walking on eggshells around the parent with PTSD and parents with PTSD withdrawing from family members.

While important, studies that focus on specific trauma populations are of limited generalisability. For example, in veteran populations long absences from home as well as trauma exposure are common, and refugees are coping with a range of extreme and ongoing stressors. Further, theoretical models such as Belsky's (1984) process model of the determinants of parenting would suggest it may not be about the trauma type, but rather a combination of several determinants that may influence parenting behaviours, including the parent's mental and physical wellbeing, their child's characteristics and the wider environment. The utilisation of more heterogeneous trauma samples may aid in the development of an understanding that cuts across different trauma experiences to illuminate the impacts of parental PTSD and increase the transferability of findings. Moreover, most existing qualitative studies of trauma exposed parents have not specifically examined parental PTSD. Therefore, we conducted a qualitative exploration of the lived experiences of parents with current PTSD, using a heterogeneous trauma sample, focusing on perspectives on their parenting role. The aim of the current project was to explore experiences of parents with PTSD, to understand more about perceived impacts trauma experiences and PTSD had on parenting behaviours; as well as exploring perceived impacts to children, partners and anyone else within the family home.

Method

Participants

Participants were 16 mothers and 14 fathers, aged between 35–66 years (see Table 1). Just over half of parents still had their children living at home with them. For the remainder of the sample, children were in the home growing up during the time of the trauma, which was the focus of the interview, but had now left home. Over half of participants were married or co-habiting and the majority were not working either due to unemployment or retirement.

Using the PDS, parents reported experiencing between one and nine traumatic incidents ($Mdn = 2$; see Table 2 for trauma exposure details). Where multiple traumas were reported, participants were asked to identify a focal trauma (i.e., the event that caused them the most distress) to discuss. The majority of participants experienced their focal trauma more than 5 years prior to the interview. All parents had a confirmed clinical history of a diagnosis of PTSD, with 83% ($n = 25$) of the sample still reporting moderate to severe symptom severity scores ($M = 36.1$, $SD = 15.4$).

Procedure

Following providing informed consent, participants completed the PDS before participating in the interview. The development of the semi-structured interview was informed by the available evidence relating to parenting in the context of PTSD (Christie et al., 2019), as well as key papers in the wider parenting field, and was piloted with a small sample of parents to ensure appropriateness of the questions. During the interview participants were asked to identify and discuss their most significant trauma. Participants were then invited to discuss (i) their parenting and broader

Table 1 Sample demographics ($N = 30$)

Demographic characteristics	Statistic
Parent demographics	
Age in years, *M* (*SD*)	52.4 (9.12)
Proportion of mothers, *N* (%)	16 (53%)
Proportion married or cohabiting, *N* (%)	18 (60%)
Proportion with children still living at home, *N* (%)	17 (57%)
Ethnicity	
White, *N* (%)	28 (93%)
Other, *N* (%)	2 (7%)
Child demographics	
Number of children, range (median)	1–5 (2)
Age in years, range (median)	4–46 (23)
Length of time since index trauma	
3–5 years, *N* (%)	4 (13%)
More than 5 years, *N* (%)	26 (87%)

Table 2 Summary of trauma types experienced as measured by the posttraumatic diagnostic scale

Trauma type	Focal ($N = 30$)		Experienced ($N = 30$)	
	n	%	*n*	%
Serious accident	6	20	13	43
Natural disaster	1	3	1	3
Non-sexual assault by stranger	0	0	6	20
Non-sexual assault by family member	0	0	5	17
Sexual assault by family member	4	13	10	33
Sexual assault by stranger	1	3	4	13
Military combat*	8	27	9	30
Sexual contact younger than 18	0	0	10	33
Torture	0	0	3	10
Life threatening illness	2	7	8	27
Other**	8	27	16	53

*Military trauma was experienced by men only

**Other traumas reported included 'sudden unplanned incidents' or 'a sudden, unexpected bereavement'

relationships *prior* to the event, (ii) the focal trauma, (iii) parenting and relationships following the trauma, and (iv) coping and support seeking behaviours. For a subset of parents ($n = 5$) their focal trauma comprised some of the earliest memories they had from their own childhood, which meant they were unable to reflect on their pre-trauma life in any capacity. However, parents were still invited to reflect on perceived impacts of their trauma/PTSD.

Interviews were conducted by phone, were audio-recorded and later transcribed. Participants were offered the option to participate in the interview via a video call; however, all chose to participate via phone for various reasons including internet signal difficulties in their area, or uncertainty using technology. Recordings were deleted following transcription. Following their participation, parents were compensated for their time, debriefed and given the opportunity to discuss their experience. While it can be thought that telephone interviews are lesser to face-to-face interviewing, there is a growing body of evidence that suggest, especially regarding sensitive topics, that telephone interviews can offer several advantages to both the participant and interviewer (Drabble et al., 2016). These include, providing anonymity for the participant, offering the participant the opportunity to take part in the interview in a safe space, as well as offering increased privacy for participants (Drabble et al., 2016; Mealer & Jones, 2014).

Measures

Posttraumatic diagnostic scale (PDS; Foa et al. (1993))

The PDS is a 49-item self-report measure that indexes DSM-IV criteria for PTSD, including a 17 item PTSD symptom scale, with established reliability and validity ($alpha = 0.92$). Symptom scores were used for PTSS severity: scores of 21–35 are classed as moderate to severe, with scores over 36 classified as severe. There is no specific clinical cut off.

Study Design and Setting

Parents were recruited via a UK based registry of patients with PTSD that has been created and developed by JB and NP as part of a National Centre for Mental Health research initiative. Of the participants held on the registry, 201 had dependent children and were therefore eligible for the current study. No limits on the children's current age were applied, but parental trauma must have occurred before child age of 18 years. A total of 30 parents took part in the qualitative interview and also completed study questionnaires.

Parents were included in the study if they: (i) were the parent of at least one child; (ii) were in frequent contact with their children (defined as "living in the same house as, or having shared custody of your child(ren)". If the children were older and had moved out of the family home, seeing their children on a regular basis and communicating by phone were also viewed as frequent contact); (iii) had experienced a trauma over four weeks ago, prior to or during the period in which their children were growing up; (iv) had been diagnosed with or screened positive for PTSD, ascertained by their involvement in the UK based registry. Parents were excluded if: (i) they suffered from an organic brain injury or intellectual disability which inhibited their ability to understand the purpose of the study; or (ii) they had been diagnosed with any psychotic disorder (e.g., schizophrenia).

Ethical considerations and safeguarding

Ethical approval was granted by University of Bath (17-039), and the Southeast Wales Research Ethics Committee - Panel C (12/WA/0037). The protocol included safeguarding procedures, which were discussed with participants at the beginning of each interview. No risk events were identified. Participants were invited to discuss the trauma event in as much or as little detail as the participant wanted. For some participants their child was present, or learned about the focal event later (e.g., if parent was hospitalised as the result of their trauma) which came up during discussions. Further, previous research has indicated that although discussing sensitive, traumatic topics during research interviews can be upsetting, participants also report the experience as relieving and cathartic (Campbell et al., 2010).

Data Analysis

Transcripts were analysed using qualitative analysis software (Atlas.ti). We used inductive Thematic Analysis following Braun and Clarke's (2006) six-phase approach. Firstly, the first author initially read through the transcripts without coding, but noted down thoughts while reading to become fully immersed and familiarised with the data. Initial codes were then generated, and were iteratively re-visited as the analysis progressed. Preliminary themes were then developed and mapped, before being discussed with other co-authors. Themes were then reviewed and revised if necessary. Final themes were defined and named, and a thematic map was developed.

As qualitative analysis is subjective in nature, steps were taken to ensure limited assumptions, biases or premature interpretations of the data were made. The first author kept a reflexive journal, and a second coder [RM] blind coded 10% ($n = 3$) of the transcripts (Morrow, 2005). Following blind coding, authors met to discuss codes and themes to examine for agreement, coherence and accuracy. Further discussion of initial themes was held with the remaining co-authors to ensure participant views and experiences were represented accurately. The analysis process was made transparent through the study researcher's annotations and notes, from initial thoughts, to clusters of ideas, to themes (Shenton, 2004). The study design and its analysis were not pre-registered.

Regarding data saturation, Hennink et al. (2017) state that saturation falls into two stages, including code saturation (i.e., the point at which no additional codes are identified) and meaning saturation (i.e., the point at which no further dimensions, nuances, or insights of issues are identified). For the current sample, code saturation was achieved at around 14 interviews, whereas, meaning saturation was achieved at around 26 interviews.

Results

Qualitative Findings

Inductive thematic analysis revealed three main themes, which related to participants' experiences as parents with PTSD, as well as illustrating the daily challenges they faced. A summary of these main themes, their sub-themes and supporting quotations is provided in the supplementary material. The use if supplementary material has been done to ensure that all voices and points raised by participants are recognised in their entirety.

Theme one: Perceived impact on parenting of trauma related difficulties

Throughout the interview, parents discussed the personal impact they had experienced because of their trauma exposure and subsequent development of PTSD. These included changes to personality and behaviour, as well as key functional impairments. Parents discussed the perceived impact these trauma-related changes had on their parenting behaviours, or if the trauma occurred prior to their becoming a parent, considered any perceived impacts of their trauma on their parenting without focusing on change.

Sub-theme one: Anger and reactivity meant having a short fuse with their children A number of parents discussed their trauma-related reactivity and anger feeding into their parenting, which meant that they became easily irritable with their children. Most parents talked about getting angry and yelling at their children for no reason other than the children were "just being children". Recalling the fact they had done this was upsetting, as these reactions were perceived to be inappropriate. Fathers described recurrent episodes of explosive anger directed at their children or occurring in their children's presence. With one exception, fathers stated that they were not physically violent towards their children, but they acknowledged that their children sometimes witnessed violent outbursts. Again, this realisation made them feel guilty and upset. In contrast, mothers never reported that their reactivity led to their children being exposed to physical violence.

> I'd smash my house up, I smashed up the house and the house was smashed to pieces…I was yelling in the house and she [daughter] couldn't understand. I strangled my wife and nearly killed her. It was hard for them [family] and I felt guilty. It's not nice having flashbacks or panic attacks in front of your daughter you know? She didn't know what's wrong with me. It was hard, it was hard for me. I wanna say never, ever laid a finger on my daughter but X, my wife I did

> strangle and hurt her and she put up with a lot from me. (PID 009, father).

While the discussion of aggression and reactivity was commonly discussed by fathers, some mothers did also discuss feeling very irritable and angry towards their children for no reason. While father's anger tended to manifest physically, mothers were more verbal with their anger as they discussed yelling at their child(ren) and partner.

> And I'd take it out on him [husband] and I'd be shouting at him and my son. I would be exploding on them even more then, and then I take myself off and then they'd be worrying about me and then I'd be upstairs crying and they'd be down here and then one of them would come upstairs then and I would be like "what the f'ing hell do you want, just leave me alone." (PID 012, mother).

Sub-theme two: Overprotective and strict parenting Parents noted that their hypervigilance fed considerably into overprotective behaviours with their children. While the majority expressed great concern for the safety and well-being of their children, those at the more extreme end of overprotective behaviour were predominately mothers. Mothers often described wanting to maximise their time around their child in order to keep them safe, in contrast to fathers who were more likely to withdraw from family life. At the time of the interview some parents had children who were growing into teenagers, meaning they were becoming increasingly independent. Parents described this as extremely challenging, as they struggled to allow their child to have independence while still making sure they were safe. While this is commonplace for parents with teenagers, some parents discussed more excessive behaviours, such as asking their teenagers to text them every 30 min with an update of where they were and what they were doing.

Some parents also became distrusting of the capacity of others to care for their children (e.g., not leaving their child with nursery school employees).

> It was really difficult, I think because she wasn't going to be with me. And I was going to have to entrust her to another human being, and I didn't want to. She would have to be on her own with a person that I didn't know for hours, and she was toilet training. I was so worried something was going to happen…So, obviously I had the conversation with her to explain to her that these are her places and that people mustn't ever make you feel uncomfortable. (PID 020, mother).

Other parents described stopping after-school activities their child had previously taken part in after their trauma, as the thought of their child being harmed was too much to cope with. While parents described this coming from a place of love and concern, it was difficult to let go of their children, sometimes literally. One mother described her children commenting that she was hurting them because she used to hold onto them so tightly. Parents found it difficult to deal with these feelings and behaviours. While they understood that they could not keep their children safe at all times, the desire to do so made it extremely difficult to control their own behaviour and this reality often caused them considerable distress.

> Oh no, no. I didn't want him to become harmed in any way, so I wouldn't take him to ice hockey or things. I just wouldn't go. It was just sheer anxiety. I was so concerned for his [child] safety…I'd already had one accident and that was the only time I'd had an accident and I certainly didn't want to have another one. (PID 007, father).

Sub-theme 3: Withdrawal from children Fathers in particular talked about their withdrawal from others extending to their children. This was most often rooted in a perceived need to protect their children from outbursts of negative behaviours; when they could feel themselves becoming irritated or angered by their children's behaviour fathers described responding by removing themselves from that environment.

> I didn't show them [children] the affection I wanted. I never explained to them why I was in bed all the time. But I'd just go upstairs out of the way. I didn't stop them playing with their toys or anything like that. If it was a noisy toy, I would go to the other room, I would go away from it. (PID 014, father).

> I would get in moods. I mean, I've never, ever been… I always say would never take, never took it out on the children. But I did lock myself away or I become unresponsive, I used to go and sit in the room for hours and hours on end. Because it was I had to get rid of the frustration or I'd, there's times where I would get in the car and drive and I didn't want to be…and I'd go and sit in the countryside, away from everybody…The last thing I want to do is start, you know, upsetting people and shouting things and saying this, that…because it's nobody's fault. Nobody's fault. It's my fault, it's my fault. (PID 026, father).

Sub-theme 4: Communication with children—sharing but not sharing A number of parents spoke about their communication as a family in relation to their trauma, stating they felt it was important to have an open line of communication with their children. Parents spoke positively about the fact they felt their child could talk to them about anything and would come to them if something bad had happened. Parents encouraged their children to have no secrets from them, as they felt after what they had experienced there was nothing their child would say that could shock them. For example, *"I always made it safe for them if they ever wanted to tell me anything I was there. They could be open with me. Nothing they could have said would have offended me or shocked me or…because nothing…nothing could"* (PID 002, mother).

While most behaviours did not seem to be particularly linked to a type of trauma, parents who had experienced child maltreatment also discussed having very frank conversations with their child about their bodies and what they should do if they felt uncomfortable with how another adult interacted with them. Thus, some parents particularly encouraged discussion about subjects linked to their own trauma.

In contrast to the openness parents expected from their children, the majority of parents said they had not and would not talk to their children about what they experienced during their own trauma. Parents felt that their children did not need to know what happened in any detail, and that their role as a parent was not to traumatise their child by sharing this information. Some parents stated their child was aware that they experienced mental health difficulties or knew that they had PTSD, but that was as far as the discussion would go.

> And ever since then I've never really spoke about the accident to the boys, because again, I just felt it was inflicting all this sadness on them because it was a huge part of their lives. I just kept it to myself really. (PID 019, father).

Theme two: Perceived parenting self-efficacy

Parents in the study were very quick to criticise their own behaviours and efforts as parents. Parents' trauma experiences appeared to have an influence on these negative beliefs, which could include perceptions that they were letting their children down, damaging their children or, in some extreme cases, the belief that their children would be better off without them. While these reflections on negative behaviours were often retrospective, they also discussed a current sense of hopelessness and feeling they still were not getting it right.

Sub-theme 1: Concerns about potential negative impacts of parental trauma on children A number of parents discussed how they feared that their parenting behaviour had damaged their child. As their children grew up, parents noticed certain behaviours, such as their child worrying excessively, and questioned whether this was the result of their own behaviour following the trauma. This caused parents additional concern, as they did not want to be the source of their child's anxiety or damaging behaviour (e.g., self-harm or substance abuse), but feared that it was their PTSD that caused this ripple effect. At the more extreme end, a number of parents admitted to thinking perhaps their child would have been better off if they [the parent] had not been in the child's life.

> Yes. I find that quite hard but um, no. It, I think in the early years, yes, it, it has impacted…I see it because my oldest daughter, she is a worrier and I honestly feel that's because of my state of mental health and I've you know, children are a product of their environment…I think that is down to me, she is such a worrier. I am disappointed and sad about that, but I can't change what it…it is what it is now. Isn't it? (PID 015, mother).

> I do feel guilty because there are children put there who don't have a parent with this condition. Therefore… of course my PTSD affects them and affects my parenting. And so I do feel incredibly guilty and it is very hard when I have bad time, that they would be better off without me, because they would then be brought up by someone who doesn't have PTSD. (PID 025, mother).

Sub-theme 2: Parents struggled to identify what they had done well During the interviews, parents were invited to talk about what they felt they did well as a parent. For the majority of parents, this question was challenging. Most were quick to identify a number of examples that evidenced they were a 'poor parent', often stating that they could easily name a longer list of things they had done wrong. When prompted again to discuss what they had done well, examples provided were often vague and non-specific, or were inferred only due to good child outcomes (i.e., their children have done well and so there must be something they did right). Reflecting on changes over time, a number of parents emphasised perceived past parenting mistakes that they wished they could take back.

> I still find it very difficult… I am better at sort of listening to my eldest. But it's kind of difficult… but I

> just take it on board as what a bad parent that I am. That I never spotted it, or never did anything. I should have noticed and all these 'I should haves.'. (PID 025, mother).

Sub-theme 3: Perceptions of falling short meant parents felt the needed to compensate Parents spoke a lot about their efforts to maintain normal routines for their children post-trauma. This included still being the one to take children to activities, or continuing pre-trauma family routines. However, this was not always possible. For some, their symptoms of PTSD, or physical impairments as the result of the trauma, prevented them from doing the things they used to do, which made them feel like a "terrible parent."

> Well as I say, normal children who have normal parents are able to go out; they go to the park or for walks, they go to the movies. I can't even do a simple thing like go to the movies. I can't tolerate being in crowds. I can't tolerate being locked in a room. And I just feel guilty. I will buy them that movie they want to see when it comes out on DVD and we'll sit here at home as a family and watch it. But that's kind of the life that we have to have and I feel inadequate as a parent. Because as a parent, I should be able to do all these normal things that normal parents do, but I can't do because of my condition. And from that perspective I feel as though that I am a bad parent. (PID 025, mother).

Some fathers, but more particularly mothers, also discussed trying to compensate for these issues or to make up for past behaviour. Parents described this compensation manifesting in several different ways (e.g., spending more on their child, "spoiling" them in other ways). However, even when it involved spending time with their child, parents were incredibly critical that it still just 'wasn't good enough'. This was typically because it was not what they used to do or what other parents would do.

> Well things like their birthdays, the accident was on September 12th, and [son's] birthday was November 17th, and I went to my savings and I gave him £1000. And I gave him loads of money for passing his exams…I did it because I knew, or I felt, as a mother I was letting them down elsewhere. (PID 023, mother).

Theme three: Recovery, coping and support

At the time of interview, the majority of parents were several years post-trauma and post-treatment, which had allowed them time to reflect. Discussions around recovery were varied and included both positive and negative coping strategies. Despite this variation, the underlying tone around the topic of recovery was similar for the majority of parents: parents' views of their own recovery for themselves as individuals versus recovery for their parenting outcomes were seen as two separate elements.

Sub-theme 1: Treatment for PTSD brought improvements, but did not turn back the clock All participating parents had received some form of clinical treatment for PTSD. Treatments included Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), or counselling, with most parents also taking psychoactive medication. Parents reported that therapy or support from relevant services (with $n = 29$ parents describing receiving psychological interventions in their interview) brought significant improvements in functioning relative to when their PTSD was at its worst. However, they still felt a level of damage had been done that was irreparable, resulting in them not ever being able to return to the person they were before the trauma.

> I never say I'm cured. I live with PTSD now. It [treatment] has helped with that acceptance. I have the skillset that allows me to be partly in control of what happens now. If I have a panic attack when I'm out in my car I know I can work through that really easily just by doing breathing exercises or grounding myself in the moment and whatever. That gives me a bit of that control back which means I can live with this now…I go for coffee now, I go into town, I can change coffee shops and everything. I can go to the cinema now. I couldn't do any of these things when I was in the grip of the worst part of PTSD. (PID 035, father).

Sub-theme 2: Ongoing impacts of PTSD on parenting There appeared to be a dichotomy in how parents viewed their recovery. For most parents it was evident that while they acknowledged they would never be the same again, they were adjusting to their 'new normal' and that they were at least better than they were before. However, when it came to discussing their parenting, they did not view this in the same way. Parents seemed to see their parenting as a separate entity that was stuck in the past and unable to recover. In their view, the damage had been done and their parenting behaviours would not recover from this, despite the fact they, as an individual, could.

> It's still quite restricting going anywhere, but it has got me to the stage now, nearly a decade later, where I

> can actually go on short trips away, if there's not too many people around. It's sort of expanded my world a bit. However, for the kids' birthdays and stuff, I still can't. That's absolutely impossible, I couldn't possibly get into a crowd like that…Just reminds me of all the things I can't do and I felt pretty useless. (PID 010, mother).

Sub-theme 3: Children as a key motivating factor for coping Parents also discussed their own ways of coping, which incorporated both positive (e.g., exercise, starting a new hobby) and negative strategies (e.g., misuse of drugs and/or alcohol) and showed little consistency across participants. However, one thing that was agreed upon by most parents was that their children had helped with their coping and recovery. All acknowledged that it was extremely challenging to be a parent while coping with PTSD. However, their children were a constant and often provided a distraction for them when they themselves were feeling overwhelmed. Thus, while some parents described feeling that their families would be better off without them (Theme 3), they could simultaneously feel that if it was not for their child, they would no longer be here - having their child provided them with a reason to keep getting up in the morning.

> Summing it up, I think my son got me through all of it. I don't think I'd be alive today having taken that overdose, every time I've contemplated it, I think about my son and how upset he would be and I don't want him to have that with him for the rest of his life. He's my anchor, that's what I'd say he was. He keeps my feet on the ground. (PID 007, father)

Discussion

This study provides insight into the lived experiences of parents with PTSD, by exploring parents' own perceptions of how their disorder may have impacted their parenting and others within the household (namely children and partners). Three main themes were identified, which included the noticeable changes parents perceived to themselves following their trauma and the associated changes to their parenting, parental perceptions of their own efficacy as a parent, and their experiences with treatment and recovery.

In line with the wider literature (Bisson et al., 2015) parents in the current study were able to describe temporal trauma-related changes in their personality and behaviour, with most stating they were no longer the person they were before their trauma had taken place. Furthermore, most of the changes that parents described affected specific parenting behaviours. For example, parents noted the emergence of hypervigilant behaviours, which often led to more overprotective parenting and increased concern for their child's safety. This is in line with previous research, suggesting parents' hyperawareness of their environment (e.g., how unsafe it may be), can lead to more protective behaviours (El-Khani et al., 2016). Parents also discussed how posttrauma anger, emotional reactivity and increased aggression gave rise to aggressive outbursts that their children experienced or witnessed. This supports previous research findings that suggest parents with PTSD are more likely to endorse more harsh parenting practices, including yelling and hitting (Leen-Feldner et al., 2011).

Although there were many areas of overlap in terms of the difficulties highlighted by mothers and fathers, there were apparent sex differences with certain parenting behaviour, which was interesting to note. Specifically, fathers (particularly those who had experienced military trauma) reported being more persistently angry and physically aggressive, sometimes uncontrollably so by their own description, which could result in violence towards their spouse and severe displays of aggression in front of their children. In turn, this perception of being on a short fuse often led to withdrawal from their children, with fathers coping with their emotions by removing themselves from the situation. Previous literature has highlighted similar findings, with military fathers reporting a poor parent-child relationship, along with reports of being reactive and aggressive (Galovski & Lyons, 2004; McGaw et al., 2019). However, moving beyond previous research, our findings also highlight the significant distress and self-recrimination that accompanies these behaviours, and the shutting down of family relationships that was a primary way of coping for many fathers. These observations highlight the key importance for clinicians to take into consideration the wider family environment when a patient discusses aggressive outbursts as a consequence of PTSD.

By contrast, mothers did not describe such pervasive irritability/anger, and any displays of physical aggression were isolated. Nonetheless, displays of anger and aggression in mothers were equally associated with feelings of self-recrimination and distress. Contrary to the withdrawal reported by fathers, mothers described wanting to spend all their time around their child post-trauma in order to ensure child safety. These differences in response to the same feelings (e.g., anger and irritability) may be of interest to explore in future research, especially when considering the implementation of family support. Previous research has consistently highlighted potential for parents to become more protective of their children and less willing to grant autonomy following their own trauma or trauma involving their child (El-Khani et al., 2016; Williamson et al., 2016).

Such behaviours potentially could have implications for the child's feeling of mastery over their own environment, increasing the child's vulnerability to threat, which may subsequently lead to the development of child anxiety (Leen-Feldner et al., 2011).

Parents in our study also talked about trauma-related consequences for their communication with their child. On the one hand, children were encouraged to be open with their parents, yet conversely parents were reluctant to discuss any aspect of their trauma with their child, including what they experienced and how it had impacted on their mental health. Difficulty discussing the parent's PTSD is a growing theme in the literature (McGaw & Reupert, 2022; Sherman et al., 2015). Children note avoiding discussing their parent's PTSD as well as avoiding behaviours or activities they know may 'trigger' their parents (McGaw & Reupert, 2022). Further, parents may avoid discussing their PTSD with their child as a means of protecting them, or to preserve their authoritative role within the family hierarchy (Sherman et al., 2015). While some of the reasons provided by parents in the current study resonate with previous research around not discussing their PTSD, there was also a strong expression of desire to communicate with their child about the changes they had experienced, they were concerned about not having the 'right tools' to do so. Such tools should be considered when providing family-focused support (Reupert, Cuff & Maybery, 2015).

All parents in the current study had reported as been diagnosed with PTSD, and most at the time of interview had received treatment; with approximately half having accessed psychotherapy and a majority being prescribed psychoactive medication. Consequently, they could reflect on past behaviours and the extent of their recovery. Parents reported being able to function more positively as a result of therapy and perceived clear and important benefits of treatment, but still acknowledged they were not the same person as before the trauma. Of great interest was the distinction between parent's descriptions of themselves following treatment and their parenting following treatment. Despite acknowledging the positive outcomes of treatment for their recovery, parents did not share the same view about their parenting abilities. Such negative perceptions of themselves as parents further escalated parental distress. As has been suggested in previous studies (El-Khani et al., 2016), findings from the current study could be used to argue for a more family-centred approach to treatment of parental PTSD.

Clinical Implications

Our findings have several clinical implications. First, PTSD treatment was perceived to benefit parents as individuals, but appeared to fall short of providing parents necessary tools to help identify and deal with more negative or dysfunctional parenting behaviours. During the current study, it was discussed that when entering intake for PTSD treatment, parents were not asked about dependent children or parenting responsibilities during their treatment process. This may in part explain why parents themselves felt improvements as individuals, but perhaps felt little improvement around their parenting. Implications of this may be to ask individuals seeking treatment for trauma exposure whether or not they are parents, or have dependents in the home. Further, parent-child communication was reported to be a persistent issue, which may suggest the need for a more family-centred approach to treatment. Psychoeducation for the parent with PTSD, as well as family members, could also be factored into treatment options. While there is limited evidence around the effectiveness of PTSD psychoeducation programmes, family psychoeducation may offer the family unit the opportunity to gain a deeper understanding around the parent's PTSD and the implications this has (Sherman et al., 2015). Including the whole family in the therapeutic process would have added benefits to monitor the potential impact on children's emotional and psychological development. Parents in the current study reported a real concern about the potential negative impact to their children. Intervening early with PTSD may ensure maximum benefits not only for parents themselves, but importantly may also limit some of these wider perceived impacts on family relationships (Barawi, Lewis, Simon, & Bisson, 2020). These suggestions are echoed by recent developments of a family focused practice model, which would emphasise the importance of aids in family communication, practical support for families, family involvement in care and treatment planning (Reupert et al., 2018)

Limitations and Future Directions

The current paper offers in depth insight into the impact of parental PTSD from the perspective of the parent, using a heterogenous trauma sample, with nearly an equal number of mothers and fathers. However, limitations of the current study must also be acknowledged. The range of current ages of the parents' children in this study was large (4–46 years, with just under half of parents providing retrospective accounts of their parenting experiences. While the goal of a heterogenous trauma sample was achieved, it may be argued that the sample was perhaps too heterogenous including a variety of parents with different aged children, treatment experiences, and time since trauma experience. That being said, the descriptions of parenting problems were strikingly consistent across the range of experiences captured by our diverse trauma sample, but clearly there is the potential for biased recall. We also focused on parents who had received treatment for PTSD, with the focal trauma typically having occurred at least five years previously. Most participants considered themselves to be functioning better than they had been when their PTSD was more severe, which may have influenced responding. For example, parents may have had less insight into the consequences of their PTSD prior to receiving treatment. As such, our findings may provide more limited understanding of the challenges faced by parents while experiencing more extreme PTSD symptoms. Therefore, future studies focusing on participants with untreated PTSD are warranted. Lastly, it is of note that only experiences from the parent with PTSD were collected. As has been shown in other research, there is considerable benefit to gathering a more holistic view of the household by interviewing children and partners (McGaw et al., 2019; McGaw & Reupert, 2022; Vuković et al. 2015) and exploring their experiences in addition to the parent with PTSD.

Conclusion

Results from the current study emphasise the multiple challenges faced by parents currently living with PTSD, which included negative impact on themselves and their functioning, their parenting behaviours, and their perception of their parenting abilities. Parents in our study comprised both fathers and mothers, exposed to a range of different traumas, and at different stages post-trauma. Nonetheless, all reported pervasively low self-perception of their parenting role, which caused significant distress. Findings suggest that adopting a more 'family-centric' approach to PTSD treatment that involves parents, allowing for the parent's needs and parenting behaviours to be assessed and supported, could be beneficial. In addition, the safeguarding of other family members residing in the home, who may be witness to violent outbursts, or who may potentially be directly affected by this, needs to be considered. Moving forward, future research should continue to explore the specific, symptom-linked challenges to parenting faced by parents with PTSD, and potential consequences for child development.

Data availability

The data that support the findings of this study are available from the corresponding author, upon reasonable request. The data are not publicly available due to the sensitive content of the interviews and information that may compromise the privacy of research participants.

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Compliance with Ethical Standards

Conflict of Interest The authors declare no competing interests.

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