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CLINICAL RESEARCH ARTICLE

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Understanding and supporting parenting in parents seeking PTSD treatment: a qualitative study

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ABSTRACT

Background: Parental post-traumatic stress disorder (PTSD) can impact parenting and child psychosocial wellbeing. Complementing trauma-focused psychotherapy with parenting interventions can thus have important preventive value. Understanding parents' lived experiences is necessary to tailor such interventions to their needs.

Objective: This study addressed the question: how can preventive parenting support be shaped to the needs of parents entering specialized psychotherapy for PTSD? To answer this question, we investigated parenting challenges, parent–child communication about PTSD, strengths, and social support experiences of parents with PTSD.

Method: The sample included 14 parents seeking PTSD treatment at a tertiary mental healthcare institution, while parenting children aged 4-17. Data were collected using semi-structured interviews and analysed using reflexive thematic analysis.

Results: On the one hand, parental dysregulation (e.g. exploding or shutting down) was an important challenge. On the other hand, parents' attempts to remain regulated (e.g. through overcontrol and overprotectiveness) also affected family life. When talking to their child about PTSD, parents were guided by what they considered beneficial for the child to know. An important strength was that parents tried to remain attuned to the child's needs, regardless of their own struggles. Parents also described experiences that could be understood as post-traumatic growth through parenting. Generally, parents experienced a lack of social support.

Conclusion: Our findings illustrate that parents entering PTSD treatment are highly motivated to do what is best for their child. Based on parents' lived experiences, preventive parenting interventions should address the impacts of both dysregulation and overcontrolling regulation attempts. Another important goal is reducing feelings of incompetence. Integrating the parenting role in psychotherapy for PTSD could also be beneficial. For example, setting parenting-related therapy goals can be motivating. Furthermore, parent–child interactions can be a mirror that reflects the parents' inner state: considering these interactions can help recognize changes in symptomatology.

Comprensión y apoyo a la crianza en padres que buscan tratamiento para el TEPT: un estudio cualitativo

Antecedentes: El trastorno por estrés postraumático (TEPT) de los padres puede afectar a la crianza y al bienestar psicosocial del niño. Por lo tanto, complementar la psicoterapia centrada en el trauma con intervenciones de crianza puede tener un importante valor preventivo. Es necesario comprender las experiencias vividas por los padres para adaptar dichas intervenciones a sus necesidades.

Objetivo: Este estudio abordó la pregunta: ¿cómo puede el apoyo preventivo a la crianza adaptarse a las necesidades de los padres que inician una psicoterapia especializada para el TEPT? Para responder a esta pregunta, investigamos los desafíos de la crianza, la comunicación entre padres e hijos sobre el TEPT, las fortalezas y las experiencias de apoyo social de los padres con TEPT.

Método: La muestra incluyó a 14 padres que buscaban tratamiento para el TEPT en una institución terciaria de salud mental, mientras criaban a niños de edades comprendidas entre los 4 y los 17 años. Los datos se recogieron mediante entrevistas semiestructuradas y se analizaron mediante análisis temático reflexivo.

Resultados: Por un lado, la desregulación parental (por ejemplo, explotar o cerrarse en sí mismo) fue un desafío importante. Por otro lado, los intentos de los padres de permanecer regulados (por ejemplo, mediante el control excesivo y la sobreprotección) también afectaban a la vida familiar. Al hablar con sus hijos sobre el TEPT, los padres se guiaron por

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HIGHLIGHTS

- In this study, we explore through interviews how we can better support parents in their parenting role when they seek PTSD psychotherapy.
- Our findings show that both attempts from the parent to stay 'in control' (for example, by being controlling or protective of the child), as well as moments when the parent 'loses control' (e.g. exploding or shutting down) can be challenging for the family.
- However, it is also clear that despite their struggles, parents are very motivated to do the best for their child, and prioritize their child's needs.

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lo que consideraban beneficioso que el niño supiera. Una fortaleza importante fue que los padres intentaron permanecer en sintonía con las necesidades del niño, independientemente de sus propias luchas. Los padres también describieron experiencias que podrían entenderse como crecimiento postraumático a través de la crianza. En general, los padres experimentaron una falta de apoyo social.

Conclusiones: Nuestros hallazgos ilustran que los padres que inician el tratamiento del TEPT están muy motivados para hacer lo que es mejor para su hijo. Basándose en las experiencias vividas por los padres, las intervenciones preventivas de crianza deberían abordar los impactos tanto de la desregulación como de los intentos de regulación excesiva. Otro objetivo importante es reducir los sentimientos de incompetencia. También podría ser beneficioso integrar la función parental en la psicoterapia para el TEPT. Por ejemplo, establecer objetivos terapéuticos relacionados con la crianza puede ser motivador. Además, las interacciones entre padres e hijos pueden ser un espejo que refleje el estado interno de los padres: considerar estas interacciones puede ayudar a reconocer cambios en la sintomatología.

Many people living with post-traumatic stress disorder (PTSD) are parents (Nicholson et al., 2002). The potentially adverse impact of PTSD on parenting and the parent–child relationship is well-supported in the scientific literature (Christie et al., 2019; Creech & Misca, 2017; Sangalang & Vang, 2017; Van Ee, Kleber, & Jongmans, 2016). Overall, parental PTSD is associated with negative parenting behaviours such as harshness (e.g. Bryant et al., 2018; Wang et al., 2023), a more negative subjective experience of the parenting role, such as higher levels of parenting stress (e.g. Hartzell et al., 2022), and lower levels of perceived parenting competence (Berthelot et al., 2020; Sager & Wamser-Nanney, 2022). It is important to note, however, that despite these challenges, parents with PTSD often also manage to sustain positive parenting behaviours and relationships with their child (Christie et al., 2019).

The exact pathways through which PTSD symptoms affect parenting are not yet fully understood, but evidence suggests that symptoms in the avoidance and negative alterations in cognitions and mood clusters (which are considered separate since the introduction of the DSM-5 [American Psychiatric Association, 2013], but were previously combined) may play a central role. Parents with more avoidance, numbing, and negative cognitions / mood symptoms are found to grant their child less autonomy (Wamser-Nanney & Sager, 2022), report lower family functioning (Evans et al., 2003) and parent–child relationship quality (Ruscio et al., 2002) and find the parenting role less satisfying (Berz et al., 2008; Samper et al., 2004) and more distressing (Peak et al., 2022). These findings suggest that PTSD-related avoidance, numbing and negative thoughts and feelings may hinder connection and involvement with the child.

Another important factor is emotional reactivity and dysregulation, which has been found to interfere with parents' ability to respond supportively to their child's emotions (Gurtovenko & Katz, 2020; Wamser-Nanney & Sager, 2022) and to be assertive in discipline situations (Franz et al., 2022; Kumar et al., 2020). Hyperarousal is associated with more negative attributions of the child and self (Sager & Wamser-Nanney, 2022) and lower parenting satisfaction (Berz et al., 2008; Wamser-Nanney & Sager, 2022). The role of intrusion symptoms in parenting is not yet clear. The few studies that do find an effect of this symptom cluster, show inconsistent findings: Van Ee, Kleber, Jongmans, Mooren et al. (2016) found associations between intrusion and observed attachment insecurity and extremely insensitive parenting, whereas Wamser-Nanney and Sager (2022) found an association with higher self-reported supportiveness.

Parental PTSD symptoms are also associated with a range of psychosocial symptoms in children, including PTSD symptoms, anxiety, depression, general psychological distress and externalizing behaviour (Back Nielsen et al., 2019; Lambert et al., 2014; Ribaudo et al., 2022). This association is the result of a complex interplay of genetic and environmental risk (Amstadter et al., 2024; Lehrner & Yehuda, 2018). The role of parenting and the parent–child relationship in this interplay has been the subject of a growing body of literature. The association between parental PTSD and child psychopathology appears to result partially from difficulties in the early parent–child relationship (in those whose PTSD preceded or closely followed becoming a parent) such as impaired attachment and parental mentalization capacity, which negatively impact critical aspects of child development (Christie et al., 2019; Erickson et al., 2019; Luyten et al., 2017; Muzik et al., 2013; Van Ee, Kleber, & Jongmans, 2016). However, later parenting impairments, such as harsh, restrictive and punitive parenting, have also been found to mediate between parental PTSD or psychological distress and child internalizing and externalizing psychopathology (Bryant et al., 2018; Greene et al., 2018; Sim et al., 2018). The same is true for parenting stress, which some evidence suggests contributes even more to child internalizing and externalizing psychopathology than actual parenting behaviours (e.g. Hartzell et al., 2022; Huth-Bocks & Hughes, 2008; Samuelson et al., 2017). Thus, both parenting behaviour and experience of the parenting role in parents with PTSD can be pathways for prevention of psychosocial problems in children.

Within the broader range of parenting interventions aimed at preventing intergenerational transmission of mental illness (Siegenthaler et al., 2012; Thanhäuser et al., 2017), a number of interventions have targeted parents who have experienced trauma (e.g. abuse or intimate partner violence; Lindstrom Johnson et al., 2018; war or forced displacement; Gillespie et al., 2022; and military service; Creech et al., 2023; Gewirtz et al., 2014; Lester et al., 2011). The promising effects of these interventions, however, may not apply to the same extent to the subset of parents who go on to develop PTSD following trauma exposure. Generally, PTSD symptoms are known to diminish adherence and effectiveness of health interventions (e.g. Hou et al., 2020; Taggart Wasson et al., 2018). The same appears to be true for parenting interventions: lower effectiveness of a parenting intervention was found for veteran fathers with PTSD compared to those without (Chesmore et al., 2018), and for mothers with more severe PTSD symptoms compared to those with less severe symptoms (Ribaudo et al., 2022). This means that compared to those who do not develop PTSD following trauma, parents with PTSD may especially need parenting support, but appear to benefit less from currently available interventions. Understanding these parents' own experiences and needs through qualitative research can help shape more effective interventions for this group.

To identify areas in which parents with PTSD could benefit from parenting support, naturally, the challenges they face should be investigated. Across qualitative studies, parents with PTSD have described such challenges as a tendency to withdraw physically and/or emotionally, having a 'short fuse', overprotectiveness, and feeling like a bad parent (Ayers et al., 2006; Christie et al., 2020, 2023; McGaw et al., 2018; Ray & Vanstone, 2009; Sherman et al., 2016). Furthermore, many parents describe very limited communication with their children about their PTSD, citing reasons such as shame and fear that their child will lose respect for them (Sherman et al., 2015), or wanting to protect the child from emotional distress (Christie et al., 2023). In families of children with cancer, mothers with higher PTSD symptoms were also found to communicate more harshly and show less positive emotion when talking to their child about the cancer (Murphy et al., 2016, 2021). These communication challenges are especially relevant for interventions; helping parents adequately communicate with their child about their mental health problems contributes to the child's understanding that their parent's disorder is external to them, that improvement is possible, and that they are not to blame. This can help prevent psychosocial problems (Beardslee et al., 2003).

Besides challenges, it is also important to focus on strengths and resources of resilience. In previous research, parents with PTSD have described their children as sources of joy and support, providing a sense of purpose and motivation for recovery (Christie et al., 2023; Ray & Vanstone, 2009; Sherman et al., 2016). The social context of the family is also highly relevant in fostering resilience. Having sufficient social support can buffer negative consequences of parental trauma on parenting and child functioning (Hatch et al., 2020; Krauss et al., 2016; Thomas et al., 2018; Tracy et al., 2018). However, PTSD is associated with decreasing social support over time (Wang et al., 2021). Thus, many families may lack the social support they need. For instance, a qualitative study in families of veterans with PTSD showed that although support was available, it was largely perceived as unhelpful and misguided (Pollmann et al., 2023). Increasing parents' and children's social support can be a goal of preventive parenting interventions (e.g. Kaplan et al., 2014; Van der Zanden et al., 2010). It is important to investigate parents' social support experiences – for example, for whom social support is and is not available, what types of support parents find (un)helpful, and what might deter some parents from accessing it – so that this can be targeted more effectively.

1. The current study

In this study, we qualitatively investigate experiences of parents concurrently raising dependent children and seeking PTSD treatment at a specialized, tertiary mental health care institution. This population is characterized by relatively severe PTSD, often comorbid with other disorders, and histories of repeated traumatic experiences. By analysing these parents' lived experiences, we add to the existing literature in several ways. Previous qualitative research has primarily included military veteran samples (Cramm et al., 2022; McGaw et al., 2018; Pollmann et al., 2023; Ray & Vanstone, 2009; Sherman et al., 2015, 2016) or, when a more heterogeneous sample was included, it was largely comprised of parents who had already completed PTSD treatment and reported retrospectively on the parenting of their now adult children (Christie et al., 2023). Although this research has yielded valuable findings, the experiences of treatment-seeking parents remain underrepresented. The time when a parent seeks treatment is a crucial moment for detecting potential risks for their child and (preventively) intervening where needed; a 'window of opportunity' of which the potential is currently far from optimally realized (Everts et al., 2022). Thus, understanding the experiences of parents during this pivotal stage is crucial if we want parenting support to meet their needs.

In sum, our aim is to answer the overarching question: How can we shape preventive parenting support to the needs of parents entering specialized psychotherapy for PTSD? We do this by answering the following sub-questions: (1) What challenges do parents seeking PTSD psychotherapy experience in their parenting role? (2) How do these parents communicate with their children about their PTSD? (3) What are these parents' self-perceived strengths and positive experiences in the parenting role? (4) What are these parents' experiences with social support?

2. Method

2.1. Participants

We based our sample size on information power guidelines by Malterud et al. (2016). These guidelines follow the principle that if a sample holds a high amount of relevant information, a smaller sample size suffices, and vice versa. The guideline takes into account the breadth of the study aim, the extent to which participants can be selected to have relevant experiences, the strength of established theory on the topic, interview quality, and whether the analysis strategy is on a case (in-depth narrative or discourse analysis) or cross-case (uncovering and comparing people's experiences) basis (Malterud et al., 2016).

The desirable sample size for this study was determined to be 10-15 (for the full information power profile, see Meijer, Finkenauer, & Thomaes, 2023). Fourteen parents participated in this study. Inclusion criteria were: current PTSD diagnosis; current parenting responsibilities for one or more children aged 4–17 (this study is part of a project in which an intervention for this age group is developed: Meijer, Finkenauer, Blankers et al., 2023); and ability to complete the interview and questionnaires in Dutch. Exclusion criteria were: acute crisis or high risk thereof (e.g. acute suicidality, psychosis, or substance abuse); no contact with children; and all children having oppositional-defiant disorder, conduct disorder, or an IQ < 50. Demographic information is presented in Table 1.

2.2. Ethical approval, design, setting and procedure

The Medical Ethics Review Committee NedMec confirmed that approval of this study was not required according to Dutch law, due to the absence of intervention or behaviour modification (reference number SL/avd/20/500115). Participants were recruited from January until November 2021, among outpatient patients of the Sinai Centrum, a specialized treatment institution for PTSD and other trauma-related disorders in the Netherlands. Sinai Centrum is a tertiary mental healthcare institution. As such, the sample is characterized by relatively severe and long-lasting PTSD, repeated trauma exposure across the lifespan, comorbidities such as depression and personality disorders, and high prevalence of impairments in overall functioning. Clinical background characteristics are presented in Table 2. All participants were receiving PTSD psychotherapy (Eye Movement Desensitization and Reprocessing [EMDR], Imaginary Exposure with Exposure-in-Vivo, and/or Imagery Rescripting) or on the waiting list.

Patients were recruited through flyers in waiting rooms and by therapists, who asked patients with children if they agreed to be approached. A researcher then called the patient to provide information about the study. If the patient was interested, they were screened for inclusion and exclusion criteria, and received an information letter. Research appointments were planned several days later, to allow patients enough time to consider their participation. The patient and researcher LM met one-on-one at the centre ($n = 11$), at the patient's home ($n = 2$), or on video call ($n = 1$), according to participants' preference.

After reading the information letter and discussing questions and concerns, patients provided written informed consent. They then completed background questionnaires on a tablet or in a pencil-and-paper booklet. The researcher remained in the room to answer questions. After completion of the questionnaires, the interview took place. Interviews lasted 68 min on average (range: 34–104 min).

2.3. Materials

A semi-structured interview schedule was used. The topic list contained questions about challenges, communication, strengths, and social support (see Meijer, Finkenauer, & Thomaes, 2023) but allowed for deviation into topics that came up in the interview. Interviews were audio recorded and transcribed verbatim using speech-to-text software, followed by manual correction. Identifying information (names, places of residence, etc.) was redacted in the transcripts. Audio files were deleted after analyses were completed. For information and psychometric properties of questionnaires that were used to collect background information, see Supplemental Material.

2.4. Analysis

We analysed interviews using the reflexive thematic analysis approach (Braun & Clarke, 2006, 2019) in

Table 1. Demographic information for parents and index children.

Variable		Parent (n = 14)				Index child (n = 14)			
		Frequency	%	Mean (SD)	Range	Frequency	%	Mean (SD)	Range
Gender	Male	6	42.9			8	57.1		
	Female	8	57.1			5	35.7		
	Non-binary or Other	0	0			1	7.1		
Age				42.29 (6.80)	32–52			11.08 (3.68)	5–16
Number of children				2.36 (0.75)	1–3				
Partnered	Yes, with biological parent of index child	6	42.9						
	Yes, partner is not biological parent	1	7.1						
	No	6	42.9						
	Rather not say	1	7.1						
Ethnicity	Dutch	10	71.4			9	64.3		
	Surinamese	3	21.4			3	21.4		
	Mixed	0	0			2	14.3		
	Other	1	7.1			0	0		
Index child living situation	Full-time with participating parent					12	85.7		
	50-50 with participating parent and other parent					2	14.3		
Highest completed education level	Practical pre-vocational	2	14.3						
	Theoretical pre-vocational	5	35.7						
	Vocational	3	21.4						
	Higher vocational	2	14.3						
	University bachelor	1	7.1						
	University master	1	7.1						
Current employment situation	Working part-time or full-time	6	42.8						
	Homemaker, no formal employment	2	14.3						
	Fully unable to work	2	14.3						
	Partially unable to work or on temporary sick leave	3	21.4						
	Receiving benefits, but not unable to work	1	7.1						

Nvivo 20 (QSL International Pty Ltd., 2020). In this approach, the researcher develops themes as ‘stories about the data’ (Braun & Clarke, 2019, p. 594); patterns of data fragments that the researcher interprets as united by common meaning, and meaningful to answering our research question (Braun & Clarke, 2019). LM coded these interview transcripts systematically. First, all interview transcripts were read multiple times and initial ideas about possible themes were noted. Second, broad fragments were assigned at least one of four preliminary codes indicating which sub-question they might be meaningful to (challenges, strengths, communication, and social support). Third, within these broad fragments, increasingly more in-depth codes were assigned to data fragments. Finally, codes were connected and organized into themes. The coding and theme-generating process was cyclical: the researcher returned to the transcripts and fragments repeatedly to refine codes and themes (Hennink et al., 2020).

2.4.1. Reflexivity

Reflexivity was promoted in three ways. First, LM kept a written reflexivity log throughout all stages of data collection and analysis. During the interview process, reflections, impressions, and assumptions were recorded in this log. During the coding process, considerations and decisions in the assigning of codes and themes were recorded in the log. Second, BK immersed herself in a subset of interview transcripts, and we discussed our impressions and possible themes. This was done to deepen our understanding on how we were relating to the data. Third, LM discussed the codes, quotes from interviews and (preliminary) themes with peers several times across the development of the thematic framework. This process of critical reflection on the thematic framework with peers, discussing meaning and clarity of themes, themes that appeared over- or underemphasized, unexpected or contradictory findings, helped further refine the thematic framework. These reflexivity processes were recorded in the reflexivity log, which (in Dutch) can be obtained from the authors upon request.

Positionality and Context. Our social identities and the context in which we carry out our research influence how we conduct research, including the questions we ask, how we relate to participants, and how we interpret data (Jacobson & Mustafa, 2019). Although there are many aspects to social identity and context and we cannot reflect on them all here, we choose to share the following on our positionality to better situate this study. The population in this study is likely to experience marginalization – as a result of mental illness and its associated stigma, and possibly also due to other intersecting marginalized

Table 2. Descriptive statistics on clinical background variables for parents and index children.

Variable		*n*	Frequency	%	Mean *(SD)*	Range in study	Range of instrument / subscale
Number of different types of traumatic experiences (LEC-5)	Participant directly exposed	14			5.79 (2.26)	2–9	0–17
	Participant indirectly exposed (witnessed, learned about it happening to close family member or friend, or was confronted with it as part of their job)	14			11.36 (9.78)	1–30	0–51
Index trauma (LEC-5)	Physical violence	13	3	23.08			
	Violence with use of a weapon	13	1	7.69			
	Sexual violence	13	4	30.77			
	Armed combat or presence in a war zone (as military or civilian)	13	4	30.77			
	Life-threatening illness or injury	13	1	7.69			
PTSD symptoms (PCL-5)	Total symptom severity	14			53.21 (9.38)	35–70	0–80
	Total symptom severity above clinical cutoff	14	14	100			
	Reexperiencing	14			13.07 (3.02)	6–19	0–20
	Avoidance	14			5.57 (1.34)	3–8	0–8
	Negative cognitions and mood	14			18.79 (4.00)	10–25	0–28
	Hyperarousal	14			15.79 (3.33)	11–22	0–24
Comorbid diagnoses (DSM-5)	Number of comorbid DSM-5 diagnoses at intake (excl. PTSD)	14			0.71 (1.07)	0–3	
	Depression (single or recurrent episode)	14	2	14.29			
	Substance use disorder	14	1	7.14			
	Obsessive-compulsive personality disorder	14	1	7.14			
	Avoidant personality disorder	14	2	7.14			
	Borderline personality disorder	14	2	7.14			
Problems in overall functioning (OQ-45)	Total problems in overall functioning	13			104.31 (21.50)	74–146	0–180
	Total score (very) high compared to normal population	13	13	100.00			
Symptomatic distress (OQ-45)	Subscale score	14			63.79 (12.24)	48–89	0–100
	Subscale score (very) high compared to normal population	14	14	100.00			
Interpersonal relationship problems (OQ-45)	Subscale score	13			22.15 (6.09)	6–30	0–44
	Subscale score (very) high compared to normal population	13	12	92.31			
Social role problems (OQ-45)	Subscale score	13			17.33 (6.66)	5–28	0–36
	Subscale score (very) high compared to normal population	13	10	76.92			
Anxiety and Somatic Distress (OQ-45)	Subscale score	13			33.77 (5.53)	28–46	0–52
	Subscale score (very) high compared to normal population	13	13	100.00			
Index child psychosocial and behavioral functioning (SDQ)	Total difficulties	13			15.92 (7.94)	3–28	0–40
Emotional problems (SDQ)	Subscale score	13			4.31 (3.01)	0–10	0–10
	Subscale score (very) high compared to normal population	13	5	38.46			
Conduct problems (SDQ)	Subscale score	13			2.77 (2.17)	0–8	0–10
	Subscale score (very) high compared to normal population	13	4	30.77			
Hyperactivity (SDQ)	Subscale score	13			6.31 (2.81)	0–10	0–10
	Subscale score (very) high compared to normal population	13	5	38.46			
Problems with peers (SDQ)	Subscale score	13			2.54 (1.94)	0–6	0–10
	Subscale score (very) high compared to normal population	13	4	30.77			
Prosocial behavior (SDQ)	Subscale score	14			7.21 (2.86)	1–10	0–10
	Subscale score (very) low compared to normal population	14	5	35.71			

Notes: LEC-5 = Life Events Checklist for DSM-5 (Weathers et al., 2013); PCL-5 = PTSD Checklist for DSM-5 (Blevins et al., 2015); DSM-5 = Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013); OQ-45 = Outcome Questionnaire-45 (Lambert et al., 1996); SDQ = Strengths and Difficulties Questionnaire (Goodman, 1997).

identities – and we as researchers are ‘outside’ of this marginalized group. Participants were clients at the institution where LM and KT are employed. LM, who conducted and analysed the interviews, was not involved in participants’ treatment. Regardless, we acknowledge our ‘outside’ perspective and relative power, compared to our study participants, associated with certain parts of our social identities.

At the time of writing, LM is a PhD candidate in interdisciplinary social science, an early career researcher, working at a PTSD treatment institution and university, a white Dutch person and member of the LGBTQIA+ community. KT is a psychiatrist and clinical scientific researcher, a white cisgender Belgian-Dutch woman and mother of four adolescent/young adult children. BK is a cisgender Turkish-Dutch woman, finishing her masters in Clinical Psychology. CF is a faculty member at a Dutch university with expertise in adolescence and youth development, German, a white cisgender woman and mother of two adult children.

2.4.2. Quotes

We present participant quotes verbatim (translated to English; for an overview of original quotes and translations, see Meijer, Finkenauer, & Thomaes, 2023). Ellipses indicate omissions and square brackets indicate redactions for clarity or to preserve anonymity.

3. Results

3.1. Background

The sample consisted of six men and eight women, with an age range of 32–52 ($M = 42.29$, $SD = 6.80$). Out of 14, 4 participants had a non-Dutch background, of whom three Surinamese and one from a South-East European country. Participants had between one and three children ($M = 2.36$, $SD = 0.75$). Seven of fourteen participants had a partner. In six out of seven cases, this partner was the biological parent of the index child. Twelve participants performed paid or unpaid work, either in formal employment or as a homemaker. Index children ranged in age from 5 to 16 years ($M = 11.08$, $SD = 3.68$). Eight index children were male, five female, and one non-binary. See Table 1 for further demographic information.

Participants reported a range of traumatic experiences on the Life Events Checklist for DSM-5 (LEC-5), with sexual violence and armed combat or presence in a war zone as military or civilian being the most common index traumas ($n = 4$ each). As expected in a treatment-seeking sample, PTSD symptoms on the PTSD Checklist for DSM-5 (PCL-5) exceeded the clinical cutoff for all participants (clinical cutoff = 31-33; range in study = 35-70; instrument range = 0-80) and average PTSD symptom severity was high ($M = 53.21$, $SD = 9.38$). See Table 2 for further clinical information.

3.2. What challenges do parents with PTSD experience?

3.2.1. Parenting with PTSD means struggling to control something uncontrollable

Parents described dealing with their PTSD in the family context as a continuous attempt at controlling something uncontrollable. Parents' attempts to keep traumatic memories at bay and avoid triggers clashed with children's inherent spontaneity and frankness. As such, both sides to the struggle of control – gaining and losing it – were an undercurrent in many of the challenges parents experienced.

3.2.2. Gaining control

Assuaging feelings of anxiety and worry was a major reason why parents felt the need to have control over the child and life at home. This would often result in overprotectiveness towards the child.

> *The past months we have tried to figure out when* [my need for control] *really got worse, and it's actually from when the oldest started sixth grade and actually yeah, wanted to do his own thing. And well, then I can't protect him anymore. (…) Then I can no longer have control and really bad things could happen.* [05]

Some participants directly related this anxiety to their trauma. These parents hoped that by being protective, they could prevent their child from experiencing the same:

> *I was calling all day to ask how he was doing. And when he came back, I would ask a lot of questions (…) Oh, who was there, what did they look like? (…) I recorded him many times (…) I have lots and lots of tapes, when he comes back from his dad, I always have a sort of interrogation. I put my phone and then (…) just to hear what he would say, if anything mean happened, if he was hit or … You know? (…) To catch the perpetrator, like: listen, he did say that.* [04]

In other cases, parents' anxiety extended to all areas of the child's life, such as school performance, participation in traffic, and health. Participants typically expressed awareness that this level of overprotectiveness could negatively impact their child, and actively tried to reduce it. These efforts could also be stimulated by the child:

> *Yes, I am really protective towards my children. So, my oldest daughter is wonderfully articulate, just like me* [laughs] *but she just says: mom, stop, you're doing it again. So that is really good.* [09]

Another reason why parents felt a need for control was to protect themselves from overstimulation. In these cases, the home and family environment was like a bastion that parents might fortify through acts such as excessive cleaning or stocking. Unpredictable changes to the home environment, like children's friends visiting, could cause anxiety. To be able to carry out their parenting responsibilities, parents may feel the need to subject the child's behaviour to the same level of control:

> *Because of everything, I have become quite a control freak. (…) So, I find it really hard to just let her be at home, doing what she wants to do (…) like painting*

> *and such (…) My panic button gets activated and all I do is correcting, correcting. And eventually I take over to ensure that, yeah, I don't get too overstimulated again.* [06]

Losing control. Whereas the scale could be tipped to loss of control by any number of factors, participants described it as especially challenging that their child was a potential trigger. In some cases, this link was direct; specific behaviours (e.g. screaming) could trigger the parent. In other cases, the link was more indirect; experiences in their child's life would remind participants of their own trauma, evoking an intense emotional response:

> [My daughter] *recently had a classmate who (…) taunted or embarrassed her on social media, in front of a whole group. (…) I felt her powerlessness and I felt that too, and rage came up inside me. (…) I almost wanted to rattle that child. These are things that make me think like, yeah, that triggers something in me (…) My child is backed into a corner and I feel powerless, yes, wow, that's when it comes back.* [08]

Parents' reactions when losing control could be broadly divided into over- and underreactivity. In participants' own words, overreactivity was described as 'having a short fuse' or 'exploding'. During such explosions, parents found themselves responding disproportionally to small things their child did:

> *In the morning before school, breakfast, accidentally dropping the plate off the table. Well, I would really explode, because that didn't fit into my rhythm (…) First there is my startle response and from that startle response, yeah, I already react before I can really think about it. And then the anger is already there (…)* [My daughter] *starts to cry and then you realize what happened again. Yeah, and then you can comfort her, but still, it keeps happening.* [06]

Underreactivity, which participants described in terms such as 'shutting down', 'closing themselves off' or 'freezing', could happen in situations where the child showed unwanted behaviours:

> *Usually I just ignore him, that's my only solution. More like I close myself off from it.* [02]

Similarly, some participants experienced shutting down when their child came to them for attention or affection, making it difficult to respond sensitively to their child's emotional needs:

> *For example, when they are upset about something, sure, I can care for them. But if it takes too long, I go into a stress moment and I push them towards my mom because I'm like: OK, that's enough.* [13]

3.2.3. Parents' PTSD and child needs are perceived as incompatible

Participants often saw it as their responsibility to ensure their child noticed their PTSD as little as possible:

> *For example the flashbacks or the smells (…) I find it really hard to suppress that too. I see that they don't (…) notice it yet, because I'm usually just sitting behind my desk, sort of. But yes, I am afraid that they are going to figure that out, actually. Yes, for me, I would prefer to keep them a little in the dark with that.* [14]

This perceived incompatibility between the reality of living with PTSD and the child's best interest would often be resolved with self-effacement. For example, some would describe wearing a 'happy mask' for their children throughout the day, only to have symptoms emerge with increased intensity at night. Furthermore, some parents delayed or paused PTSD treatment because they felt it would get in the way of parenting responsibilities.

3.2.4. Feeling like you fall short as a parent

Many participants felt very negatively about themselves as parents. They expressed that their PTSD prevented them from being the parent they felt they should be and struggled with the fact that fully shielding their children from their PTSD was not possible. A father reflected on the difference in how his child perceived him before and after developing PTSD:

> [My daughter] *said something a while ago: 'I feel so sorry for* [her younger siblings] *because they don't know dad from before he became so sick'. And she said: 'On the other hand, those memories are starting to fade away for me as well, about what dad was like and how fun and nice it was' (…) Yeah, that is really quite tough, I'll tell you that. That is heavy.* [07]

Relatedly, participants often expressed worry about long-term impacts on their child of growing up with a parent with PTSD. Some recognized their child adopting maladaptive thought-patterns:

> *The doctor said literally: 'You're allowed to cry when you're in pain'. He* [the participant's son, who was injured] *said: 'No, marines don't cry either'.* [12]

In other cases, participants worried about role reversal, seeing their child taking on too much responsibility trying to help them:

> *When I have a hard time and she notices that, she literally comes to me and then she gives me her stuffed animal like: 'Here dad' and she climbs into my lap and comforts me. I find that really heavy for a five-year-old girl.* [06]

> *When I go to the bakery, I always go with my two daughters and my son, or with my wife. So, I have my eh, my cordon around me. Then I'm protected. (…) But this also places a responsibility onto the children. Now, if I get out of the car, one of them gets out as well. If someone starts talking to me, they always come stand in front of me. So that a kind of distance is guaranteed. And they do that automatically, kind of. Or well, maybe I taught them. (…) We're thinking of getting a service dog. Yes, that would be ideal. Because the children are sort of doing that job right now.* [10]

Finally, some participants worried about the impact of potentially scary situations their child had gotten involved in due to their PTSD, such as witnessing them being unresponsive during dissociative episodes or behaving erratically or aggressively because of intrusive symptoms.

3.2.5. Some periods in child development are especially challenging

Two periods of child development stood out as especially challenging: infancy and adolescence. Some participants described exacerbation of PTSD symptoms after the birth of their child, especially because of the child's crying and a lack of sleep. As children reached adolescence, their increasing need for autonomy and privacy often collided with participants' overprotectiveness. Additionally, several participants who experienced abuse found it difficult to cope with their adolescent child's physical and sexual maturation:

> *My trauma has to do with men, and because he got older, I started to see him as a man. So I kept him at a distance although he actually is an emotional child who loves to hug a lot and wants attention and such. But I kind of pushed him away which made him feel bad actually, and it became noticeable at school. His results went down because he assumed I no longer loved him.* [04]

3.3. How do parents communicate with their children about their PTSD?

3.3.1. Disclosing was inevitable

Most participants had told their child about their PTSD. Typically, they did so because they considered it more or less inevitable; either because the child had been present during the traumatic experience(s), because the parent would go to inpatient treatment, or because the child noticed symptoms and began asking questions.

> *I can't keep it quiet, because at night, the middle one and the youngest one now say: 'Dad, why do you yell at night? You do that a lot, yelling at night: 'Don't do it! No! Get out! Shoot!" I say: 'Yes, maybe because of a dream, because of the war'. I can't fool them.* [11]

3.3.2. Disclosing proactively

When parents chose to disclose proactively, it was usually because this aligned with their parenting values, such as honesty and openness. Another reason, expressed by some participants who experienced abuse, was to prevent their child from experiencing something similar:

> *When* [my daughter] *was the age I was when it happened to me. I was 14. I think that's when I told her because I was like: yeah, that's when it happened to me. I don't want the same to happen to her.* [03]

Some participants also chose to disclose in hopes that their child would never become a perpetrator:

> *I told them about the bullying. More like the explanation of: you don't want to do that to someone (…). I really see that he has taken that to heart. I'm really proud of that.* [14]

3.3.3. Communication is guided by what parents consider in the child's best interest

In parents' recounting of their conversations with their child about their PTSD, it was apparent that they thought about what would be in their child's best interest and that they wanted the communication to serve this goal. Most parents let their child take the initiative in talking about PTSD; they would answer if their child asked questions, but would not initiate conversations themselves.

> *As soon as something comes up, coincidentally just recently (…) [my daughter] fell down the stairs. I completely panic, because I'm like, here we go again. Then she says: 'Why do you always do that?'. Then I explain like: 'This is a piece that belongs to my PTSD. I've been through so much with you that is still very stuck in my body, that makes me scared that something will happen again'. That's how I explain it.* [09]

Moreover, parents considered what was developmentally appropriate to share, and usually told their children more as they got older. Some participants found it helpful to use age-appropriate media (e.g. picture books like 'The fairytale of the brave knight', which is written by a psychologist to explain military-related PTSD to children, or an informative TV programme about sexual abuse) to help explain to their child what they were going through.

> *With that first inpatient treatment on* [date] *when I had to explain why I would not be home for three months, I ended up buying a little book and reading it with her. (…) And they explain it in terms of a storm. Dad has storm in his head and that's why he's angry sometimes, wants to be alone, etcetera. (…) What should you tell her? It's tricky. What helps her? Not a lot, so when I'm here* [at the treatment center], *she knows I'm at the talk doctor and she knows I'm talking about the storm. So you speak in those basic terms.* [06].

Parents also usually did not tell their child about their trauma, or only minimally so, because they knew this could be shocking. Several chose not to use the word 'PTSD', either because they thought their child would not understand, or because they worried their child would look it up online and find information that would disturb them. Instead, parents typically focused on explaining things that they perceived as directly meaningful to the child. For example, why they could not do certain activities together, or symptoms the child noticed, such as panic attacks, intense startle responses, and irritability. Sometimes parents also told their child they were going to therapy to get better.

3.3.4. Wanting to do what's best for the child can also mean not telling

Parents doing what they considered in the child's best interest sometimes also resulted in the opposite decision: not telling their child. Important reasons why some (initially) chose not to tell their children about their PTSD, were that they thought the child was too young, it would be a burden, and that the child would worry about them if they knew. Some participants also chose not to disclose because their trauma was perpetrated by someone the child knew (e.g. a family member or the other parent) and they did not want to speak badly of this person.

Notably, when parents had not told their child, often they expressed that their child knew there was 'something'. For example, the child would notice PTSD symptoms and ask about them, or wonder why their parent was unable to work or do activities with them. A parent who had eventually told their child when they asked directly, reflected on this:

> [My child] *actually said: 'Wow, why didn't you tell me sooner? Because I always felt like something was up, but I never knew what, and do you have any idea how confusing that is?' And then I thought: Wow, yes, a parent, it sounds weird, but as a parent, you do not consider that at all. That* [not knowing] *can have an impact on a child, too.* [05]

3.3.5. Children can know, but not understand

Children typically responded positively to their parents' disclosure, and were happy that their parent was getting the help they needed. However, some parents felt that although their child now 'knew', they still did not really 'understand'. In other words, participants felt that their child's understanding of what it was really like to have PTSD was limited. This could lead to clashes when participants felt that their child did not sufficiently take them into account (e.g. making loud noises despite being told this was a trigger). In a few cases, parents were worried about their child's reaction, because the child responded with strong emotions or drew disturbing, not always correct conclusions based on their own interpretation.

3.4. What are self-perceived strengths and positive experiences of parents with PTSD?

3.4.1. Parenting as a source of positivity

Participants described that, despite its challenges, they enjoyed the parenting role. Seeing their children grow and develop, the mutual love between them and their child, doing fun activities together, and being proud of their family were cited as some of the most joyful aspects of being a parent. Participants also often expressed their child was a source of motivation for their recovery. Some children (usually adolescents) explicitly encouraged their parents to seek help for their PTSD. However, more often parents felt the need to seek treatment implicitly, because they saw how their PTSD affected their child or prevented them from doing activities together. Caring for the child also brought structure and purpose to participants' daily lives. Finally, for some participants, their child was a reason to keep going in especially difficult times:

> *If I didn't have kids, I think I wouldn't even be alive anymore. On the one hand they're the greatest trigger in my life, on the other hand they're my greatest source of energy.* [10]

3.4.2. Providing a healthy social-emotional context for the child

Participants stated their children were 'number one' in their life, and that it was their priority to provide them with a healthy social-emotional environment to grow up in. As such, they were all positive about the idea of preventive parenting support:

> *I can suddenly see: Wow, I overreacted. I am now actually doing what my parents did to me, which wasn't healthy. And now I'm doing it to my own child. That's not what you want. So yes, if it is possible to give people tools like, how do you recognize that and how can you turn that around, I think that would be really good.* [08]

Many participants named open and honest communication as an important value in their families, and were happy that their children had a close bond with them and their siblings. They often contrasted this with their own childhood, in which they could not talk to their parents or were even afraid of them. Additionally, some participants described the importance of making the home environment a calm, predictable and safe place for all family members (e.g. by having set routines), and making life as normal as possible by focusing on what was possible despite their PTSD. To ensure that their child could 'just be a child', parents would make conscious efforts not to rely on them for emotional or practical support. Some also sought therapy for their child, to ensure the child had a place to express themselves and address potential effects of their PTSD on the child's wellbeing.

3.4.3. Children as mirrors

Participants noted that their children were like a mirror to them; often, they began to understand their own experiences through seeing them reflected in their child. In turn, this helped them identify areas to focus on in their recovery.

> *When I ask* [my daughter]: *how are you feeling? Happy? Sad? Angry? She shuts down (…). She is unable*

> *to reach her emotions and she cannot put them into words either. (…) I recognize that, I don't do that either. (…) So, then you have a new question that you bring* [to therapy]: *Help me express my emotions. For me, everything is angry.* [10]

Relatedly, when participants made progress in their PTSD recovery, they often recognized this through changes in the interaction with their child.

> *When I came back home* [after inpatient treatment], *I saw that I could respond differently, and sometimes I really saw surprise on* [my daughter's] *face like: 'Hey, he's not getting angry!'* [06]

3.4.4. Parenting as an area for post-traumatic growth

Many participants found positive outcomes of their trauma in the parenting role. Several participants described having made a conscious decision to break the cycle of trauma when they became parents, for example by providing their children with the safe home they never had, or moving away from their home country so their children would not experience war and have more opportunities. Some also taught their children life lessons and values based on their own traumatic experiences, such as perseverance, gratitude, kindness, respecting people's boundaries, and nonviolence:

> *He* [the participant's child, upon learning about the participant's trauma] *was like: I want to know* [the perpetrator's] *name because I will beat him up (…). Something very protective came over him immediately and he wanted to get revenge straight away (…) So then we actually had a really good conversation about well, that revenge doesn't solve anything and that it's mostly about how you deal with it yourself. And that it's really difficult for both of us, but we are going to break the chain together. And now, fortunately, he can see it that way too.* [05]

Despite worrying about detrimental effects of their PTSD on their child, some parents also noticed positive effects. One father attributed his daughter's kindness and willingness to help others, to lessons she had learned from his PTSD. Similarly, a mother described how the shared experience of trauma and PTSD had brought her and her children closer together. Finally, some parents stated the parenting role had given their life new meaning after their trauma. For example, a father expressed that becoming more involved with his children gave meaning to his life after years of being away from his family due to military service and inpatient treatment.

3.5. What are the experiences with social support of parents with PTSD?

3.5.1. Avoiding asking for social support to protect yourself

Generally, participants received little social support. One of the reasons was a general lack of trust and reluctance to let people come close. This was expressed both in refusing emotional support (e.g. not opening up to others) and practical support (e.g. not letting others take care of their children out of fear they might harm them). Often, previous attempts at asking for support had been met with unhelpful reactions and a lack of understanding. These reactions included denial, minimizing, victim blaming, or stigmatization from people close to them. One participant gave a painful example of how stigmatization impacted himself and his children:

> *It would be nice if the taboo goes away. There are still people who think: 'Oh you have PTSD, well then you abuse your children, you're aggressive', you name it. At one point, one of the parents at school heard* [that I have PTSD] *and they are no longer allowing their children to play at our house when it's just me there. (…) That really breaks you!* [10]

3.5.2. Avoiding asking for social support to not be a burden

Another important reason participants noted for a lack of social support was not wanting to burden others. Participants described that they were someone other people relied on, not someone to rely on others:

> *I am the safety net for everyone and everything. I can do anything. I don't care what it costs me, that's how I'm gonna run, and once I'm running like that, I'm not gonna stop. Is that good for me? No, absolutely not. Should I ask for help? Yes. Do I do that? No. I simply keep going, to the point of great frustration.* [06]

Within families, complex intergenerational dynamics involving secrecy and avoidance of difficult topics could prevent participants from receiving support, especially when PTSD stemmed from intrafamilial abuse:

> *I live inside a pattern, because my mom has gone through the same thing (…). But I know that about her, but she doesn't know that about me.* [I don't want her to know] *because my mom is (…) a nervous person who gets too caught up in things and she's been through a lot already. So why should I also put my problem on her?* [13]

3.5.3. Erosion of social support: only a few remain

Many participants' social support dwindled over the course of their PTSD. Partially, this was their own doing; participants described avoiding the people around them, and sometimes cutting contact with people they found unsupportive. However, being 'dropped' by people they were previously close to was also quite common. Often, participants explicitly related the erosion of support to their PTSD symptoms. For instance, they described avoiding social events because they worried about not having full control (e.g. not knowing what the space would look like or who would be there), being triggered, or it taking too much energy. Some participants also expressed that contact with friends was difficult, because they could not be supportive or 'fun' while struggling with PTSD. Finally, financial problems sometimes played a role. Some participants had to stop working due to their PTSD, which resulted in losing relationships because they could no longer afford to attend activities or support others financially.

Commonly, one or a few support figures remained after this erosion process. Although family relationships were often complex, family members were among the most common remaining support figures. For a number of participants, friendships were also a source of support. Friendships that lasted and were found helpful were characterized by a sense of trust. Notably, these friends had often experienced similar traumas.

3.5.4. When there is trust, support can be highly meaningful

For those participants who did have someone they could trust, support from this person could be very meaningful. For example, support figures were often the first to point out that they were worried about the participant's mental health, and encouraged them to seek help. Furthermore, participants appreciated being able to talk to support figures about their PTSD and/or parenting struggles.

> *When there is something, I can always go to him. (…) When things are really bad, I do that. Then he is just a listening ear. He can't give me advice like: well, this is how you should do it. Not like that. But that listening ear is really nice.* [02]

In line with the finding that support from people with similar experiences was considered especially helpful, many participants named understanding and recognition as a major form of support.

> [My friend] *has gone through something similar (…) it just feels good that you don't always have to explain why something is the way it is or where it comes from.* [05]

Contrastingly, some participants expressed feeling especially supported through interactions that had nothing to do with their PTSD, as these could provide distraction, relaxation and a sense of normalcy.

> [My neighbor] *isn't going to ask an annoying question, he will never refer to my history, so I can just relax. So, he's really someone who, well my wife sometimes says: please go have a beer at the neighbor's now, you know? (…) Then you can just put it away for a while.* [10]

Although entrusting someone with their child could be difficult for some due to mistrust of people, participants who did have a trusted person to help with childcare named this as especially helpful. For example, a participant described her adult daughter's offer to take care of her young brother, the participant's son, if needed:

> *I came* [to my daughter's house] *and she gave me a lecture like: 'Oh, that is for him, this is for him, that is for him. This will be his room if he may ever live with me. If there is ever a time where you can't handle it, just let him come here' (…) That safety net is there.* [04]

3.5.5. Supportive potential of resources in the family ecosystem is not realized

Very few participants had a more extensive support 'ecosystem', for example including parents-in-law, colleagues, neighbours, religious community, or teachers at the child's school. For the majority, the supportive potential of people and institutions around them was not realized; in fact, they often caused more stress. For example, those with partners described how PTSD put a strain on the relationship, and were worried about reaching a breaking point where the toll of their PTSD would become too high. Some participants also had to stop working because of PTSD and described financial concerns. Long-lasting conflicts with institutions, such as the child's school or social security provisions, were also described by some participants as inflicting stress upon the family.

4. Discussion

In this study, we aimed to further the knowledge about how preventive parenting support can be shaped to the needs of parents entering PTSD psychotherapy. We interviewed parents who were concurrently seeking specialized PTSD psychotherapy and parenting dependent children. To answer our overarching question, we explored four sub-questions about challenges, parent–child communication about PTSD, strengths, and social support.

From our findings, it is clear that parents with PTSD experience a number of challenges, in which attempts and failure to 'control something uncontrollable' form an important pattern. This seems to parallel the concept of the 'window of tolerance' (Siegel, 1999). An individual's window of tolerance denotes their capacity to regulate stress. In PTSD, this capacity is reduced (Corrigan et al., 2011). Exceeding the window can lead to states of hyperarousal (overreactivity, described in words such as 'exploding' by participants in this study) or hypoarousal (underreactivity, described by participants as 'shutting down') (Siegel, 1999). The effect of these states on parenting has been subject to research showing mixed results: whereas self-report studies find associations between PTSD symptoms and both parental underreactivity and overreactivity (e.g. Powers et al., 2022), observational studies only find associations between PTSD symptoms and parental underreactivity (Brockman et al., 2016; Franz et al., 2022). In our study, it appears that not just the moments where parents exceed their window of tolerance are challenging. Parents' continuous struggle to remain inside their window, through overprotectiveness and attempts to control the home environment and child's behaviour, may impact family life equally if not more. Parental overprotectiveness and control have been associated with child internalizing problems (Vigdal & Brønnick, 2022), suggesting these challenges may be especially important for preventive intervention.

Another important theme was that parents felt like they were constantly falling short, and that the reality of living with PTSD was incompatible with their child's best interest. These pervasive feelings of parenting-related guilt, shame, and incompetence are consistent with findings from both quantitative and qualitative studies (e.g. Christie et al., 2023; Sager & Wamser-Nanney, 2022), showing a negative impact of parental PTSD on perceived parenting competence. Since low perceived parenting competence contributes to less positive and more negative parenting behaviours (Jones & Prinz, 2005) and is known to hinder effectiveness of parenting interventions (Deković et al., 2010; Hartung & Hahlweg, 2011), interventions for parents with PTSD should prioritize addressing perceived parenting incompetence and associated feelings such as guilt and shame.

Our findings also show that parents try to remain attuned to their child despite the severity of their PTSD and related problems. For example, parents appear to base their decisions in communicating with their children about their PTSD on what they think will best serve their child. Our findings on communication seem to diverge from those of previous studies, which describe parent–child communication about PTSD as generally difficult and something that is kept to a minimum or avoided until a crisis makes it inevitable (Christie et al., 2023; McGaw et al., 2018; Sherman et al., 2015). Future research might explore explanations for this difference (e.g. parents in this sample may have been more comfortable talking about their mental health due to longer treatment history, or there may be cultural differences in parent–child mental health communication). Furthermore, specific aspects of communication should be explored in more detail. This work has already been done in quantitative and qualitative research in the context of historical and collective traumas such as war and persecution (e.g. Dalgaard & Montgomery, 2015; Kerbage et al., 2024; Measham & Rousseau, 2010; Nagata & Cheng, 2003), as well as other traumas that happened to the child alone or together with the parent (e.g. Sloover et al., 2024). These studies suggest that the timing, tone, and content of trauma-related conversations may be more important than whether or not traumatic experiences are disclosed. Future research should investigate whether the same is true when the parent has experienced trauma but the child has not, and whether parental PTSD impacts relevant aspects of communication in this case.

More broadly, parents' efforts to keeping the child's best interest in mind despite their own struggles are in line with existing evidence. In a systematic review, Christie et al. (2019) described that positive parenting outcomes appear to be unrelated to PTSD severity, suggesting that parents are able to maintain positive parenting behaviours even in the face of severe PTSD. This is also meaningful for clinical practice. Parents in this study frequently expressed a desire to get better for their children and be the best parent they could be. Setting parenting-related therapy goals (e.g. being able to do certain activities with the child) could thus increase motivation. Furthermore, parents noted that their child was often the mirror in which they first saw the worsening or improvement of their PTSD symptoms. Taking note of this 'mirror function' of children could prove useful in clinical practice. Asking parents to reflect on how their child responded to them recently and vice versa, can help them recognize changes in symptomatology.

Interestingly, participants described experiences that could be understood as post-traumatic growth (Jayawickreme et al., 2021; Tedeschi & Calhoun, 2004) through parenting: being a parent gave them the opportunity to make positive changes and find meaning after trauma. Positive change in relationships is a well-documented domain of posttraumatic growth (Tedeschi & Calhoun, 2004), and studies have found posttraumatic growth in the form of improved parenting and parent–child relationships in parent–child dyads affected by trauma that happened to the child (e.g. illness or disability: Halldorsdottir et al., 2022; Koliouli et al., 2022). Our findings suggest posttraumatic growth through parenting may also occur when a parent experienced trauma but their child did not, although this idea warrants further research.

The finding that participants' social support networks eroded while they suffered from PTSD, is consistent with the broader literature, showing declining social support over time in individuals with PTSD (Wang et al., 2021). This finding is worrying for two reasons: adequate social support promotes PTSD recovery (Keyan et al., 2024; Wang et al., 2021) and has been found to buffer against effects of maternal trauma on negative parenting behaviours, risk of child abuse, and child psychological and behavioural problems (Hatch et al., 2020; Krauss et al., 2016; Thomas et al., 2018; Tracy et al., 2018). Thus, strengthening social support structures is an important intervention target to promote wellbeing of both parents with PTSD and their children. Expanding the social network could be complex because PTSD-related cognitions (e.g. 'You can only rely on yourself', 'Other people will harm my children') hinder support-seeking. In addition to challenging these cognitions in therapy, strengthening remaining connections may (initially) be more feasible than making new ones.

When considering these themes, one might question: is it really necessary to provide parenting support *in addition to* psychotherapy? Indeed, recent evidence suggests trauma-focused psychotherapy generates improvements on a range of outcomes beyond PTSD symptoms (e.g. Hoeboer et al., 2024). Given that the main challenges reported in this study appear closely related to PTSD symptoms – such as hyperarousal and negative alterations in cognitions and mood – one could argue that PTSD psychotherapy would be sufficient to resolve parenting problems. To our knowledge, this hypothesis has not been tested with sufficiently robust study designs to draw any conclusions. As such, it remains an important question for future research. Until then, we would argue that offering preventive parenting support to parents entering PTSD psychotherapy is the right thing to do. Maladaptive interaction patterns may have been established in families years before a parent enters treatment, and may take an equally long time to undo. Thus, capitalizing on the 'window of opportunity' that opens when a parent enters treatment is important for the benefit of both the patient and their family.

4.1. Limitations and strengths of the study

Our findings must be interpreted in light of several limitations. A first limitation is potential selection bias. Many parents suffering from PTSD may not have the privilege of seeking professional help. Our sample sought treatment at a tertiary mental healthcare institution, so that participants were likely to have received various therapies in the past. On the one hand, the fact that parents from such a population still showed a generally high level of awareness of how their PTSD impacted their child, could be interpreted as positive. On the other hand, one might argue that their therapy history is what gave them this level of awareness. This raises the question of whether we can expect similar levels of awareness and openness to parenting support in other PTSD populations, or even whether parents 'said the right things' without this necessarily reflecting their actual parenting behaviours. The current literature suggests that parents with PTSD may actually be more likely to underestimate themselves (i.e. their own ratings of their parenting are more negative than those of an observer; Muzik et al., 2017), and while parental PTSD symptoms are associated with negative parenting outcomes (Christie et al., 2019), this association is absent when parenting behaviour is rated by children (Allbaugh et al., 2024). Additionally, within our treatment-seeking sample, those with the most acute parenting problems may have declined participation. As such, we may not have been able to capture the full range of parenting experiences, likely failing to represent those parents with the most severe problems. It thus remains an important question for future research whether parenting support for parents with PTSD does actually work and for whom.

Second, for a better understanding of parent–child dynamics, it would be highly valuable to explore both parents' and children's perspectives. We originally aimed to do this, but did not manage to include any children (parents did not consent or children were not interested). Whereas a number of qualitative studies have included children of parents with military-related PTSD (Cramm et al., 2022), children of parents whose PTSD results from other types of trauma remain underrepresented. Including these children's perspectives remains imperative for future research.

Third, this study was conducted during the COVID-19 pandemic; although many of our findings correspond to those of studies conducted at other times (e.g. Ayers et al., 2006; Christie et al., 2020, 2023; McGaw et al., 2018; Ray & Vanstone, 2009; Sherman et al., 2015, 2016), we cannot be sure of the extent to which experiences such as lockdowns and mandatory homeschooling colour our findings.

Despite these limitations, this study is, to our knowledge, the first to investigate lived experiences of parents concurrently parenting dependent children and seeking PTSD treatment. Participants came from a population of tertiary mental healthcare patients, with repeated exposure to traumatic events, relatively severe PTSD, and a far-reaching impact on daily life. As such, this study adds to the literature by showing how parents facing severe and complex consequences of trauma nonetheless remain focused on their child's wellbeing.

4.2. Conclusion

Our findings indicate that the parenting role and child wellbeing remain central to the lives of parents seeking PTSD treatment, even when their own problems are severe. Parenting interventions for trauma-exposed parents have already shown promising results. Adapting these to fit the needs of parents with PTSD and offering them during the 'window of opportunity' when a parent presents for treatment, is likely to benefit parents as well as their children.

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No potential conflict of interest was reported by the author(s).

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Author contributions (CRediT)

Laurien Meijer: Conceptualization, data curation, formal analysis, investigation, methodology, project administration, writing – original draft, writing – review and editing; Kathleen Thomaes: Conceptualization, funding acquisition, methodology, supervision, validation, writing – review and editing; Buket Karadeniz: Formal analysis, validation, writing – review and editing; Catrin Finkenauer: Conceptualization, methodology, supervision, validation, writing – review and editing.

Ethics statement

This study was confirmed exempt from approval according to Dutch law by the Medical Ethics Review Committee NedMec, due to absence of intervention or behavioural change (reference number SL/avd/20/500115), and was performed in accordance with the Declaration of Helsinki (World Medical Association, 2013).

Informed consent statement

Written informed consent was obtained from all individual participants included in the study. This included the publication of anonymized data (quotes from interviews included in this article).

Data availability statement

Study materials can be accessed on Open Science Framework (Meijer, Finkenauer, & Thomaes, 2023). Questionnaire data and anonymized interview transcripts can be obtained from the authors upon request.

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