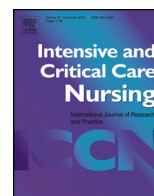




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Original article

Relation between parental psychopathology and posttraumatic growth after a child's admission to intensive care: Two faces of the same coin?

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ABSTRACT

Objectives: Confronted with the potentially traumatic experience of a child's admission to a paediatric intensive care unit, parents may experience psychopathological post-trauma symptoms as well as posttraumatic growth. The aim of this cross-sectional study was to explore the relation between psychopathology symptoms, namely, posttraumatic stress disorder, anxiety and depression, as well as post traumatic growth in parents following their child's hospitalisation in a paediatric intensive care unit.

Methods: Six months after their child's discharge, 143 parents completed the questionnaire, which assessed post traumatic growth (*Posttraumatic Growth Inventory*), post traumatic stress disorder (*Davidson Trauma Scale*), depression and anxiety (*Hospital Anxiety and Depression Scale*).

Results: Of the 143 parents, 23.1% reported symptoms of post traumatic stress disorder, 21% reported symptoms of moderate to severe anxiety, 9.1% reported symptoms of moderate to severe depression and 37.1% reported at least a medium degree of post traumatic growth. There was a moderate, direct association between post traumatic stress disorder, depression and anxiety with post traumatic growth. Higher scores in anxiety, depression and post traumatic stress disorder were associated with higher levels of post traumatic growth, contradicting the notion of an inverted U-shaped relationship between psychopathology symptoms and post traumatic growth.

Conclusions: Given that positive and negative outcomes after a child's critical admission tend to co-occur, it is surmised that parents who indicate post traumatic growth do not deny the difficulties. While not negating the negative impact on the mental health of a parent with a child admitted to intensive care, including the assessment of post traumatic growth as an outcome following this event has important implications for research and clinical practice.

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Implications for clinical practice

- Parents who have experienced the hospitalisation of their child in a paediatric intensive care unit display significant levels of posttraumatic stress, anxiety, depression and posttraumatic growth six months post-discharge.
- As positive and negative outcomes following a child's admission to the PICU tend to co-occur, parents who indicate posttraumatic growth tend not to deny the difficulties.
- Not considering the possibility of both positive and negative psychological consequences of this experience would provide an incomplete view of the psychological impact on parents of their critically ill child's hospitalization.
- Interventions to facilitate the psychological adaptation of the family following the admission of a child to the PICU should aim at preventing psychopathological symptoms and helping families find growth and meaning following the event.

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Introduction

The existing literature on parental reactions after a child's admission to a paediatric intensive care unit (PICU) has focused on exploring the presence and severity of psychopathological reactions, primarily posttraumatic stress disorder (PTSD) and less frequently, anxiety and depression (Bronner et al., 2008; Bronner et al., 2010; Colville and Gracey, 2006; Colville and Pierce, 2012; Fauman et al., 2011). However, over the past two decades, there has been increasing acknowledgement that facing traumatic events can cause the individual to function at a higher level than before, an event termed posttraumatic growth (PTG) (Tedeschi and Calhoun, 1996). A single study has explored this phenomenon among parents of critically ill children and found moderate levels of PTG among this group (Colville and Cream, 2009).

Thus, the evidence suggests that facing the experience of having a child undergo intensive care treatment may produce both positive and negative consequences for parents. However, a question that has emerged from the literature is whether PTG is related to a higher or lower level of psychopathological symptoms following a traumatic event. Understanding the relation between these opposing consequences of a traumatic event would provide valuable information for developing intervention strategies. To our knowledge, only one study (Colville and Cream, 2009) has explored both the positive and negative outcomes of having a child undergo intensive care treatment. Using a sample of 50 parents four months after their child's discharge from a PICU, they found an inverted U-shape relation between PTG and PTSD, with higher levels of PTG corresponding to medium levels of PTSD symptoms. They also found that PTG was unrelated to symptoms of anxiety and depression.

Previous studies aimed at exploring the relation between PTSD symptoms and PTG with a variety of trauma-exposed populations have yielded inconsistent results. Tedeschi (2011) reports that facilitating PTG may provide opportunities to reduce PTSD symptoms among combat veterans and their families. Consistent with this, some studies suggest that PTG following trauma is associated with lower PTSD symptoms over time (Frazier et al., 2004; Ullrich and Lutgendorf, 2002). Conversely, other studies have found that PTSD symptoms are positively associated with PTG scores (Helgeson et al., 2006; Levine et al., 2009; Morris et al., 2005; Taku et al., 2007; Jin et al., 2014), and again, other studies have found that these variables were uncorrelated (Powell et al., 2003). Barakat et al. (2006) find a positive relation between posttraumatic stress symptoms and PTG, whereas, consistent with the results by Colville and Cream (2009), Kleim and Ehlers (2009) find a curvilinear relationship between PTG and post-trauma depression and PTSD. Although the relation between PTG and depression and anxiety has been much less studied, the meta-analytic review of Helgeson et al. (2006) concludes that PTG is significantly associated with lower depression and unrelated to anxiety.

The picture that emerges from the literature is that the relation between positive and negative outcomes after trauma is unclear. In addition, to our knowledge, only the study of Colville and Cream (2009) has explored the positive and negative outcomes in parents after a child's admission to the PICU. Therefore, in this study, we aim to gather evidence about the association between PTG and the symptoms of psychopathology, i.e., symptoms of depression, anxiety and PTSD, among parents of critically ill children.

Method

Setting

Data were collected from a PICU located in a tertiary level hospital with 16 beds, eight physicians and 49 nursing staff. The

nurse-to-patient ratio is 2:1. Regarding psychosocial services provided in the PICU, a social worker attends to families upon request, and a psychologist from a non-governmental organisation provides psychological support twice a week to the children with heart conditions and their families.

Ethical approval

The study was approved by the institutional review board (approval number 13/015) of the hospital where the study was conducted. All participants signed an informed consent form that guaranteed confidentiality and described the study, including its purposes, potential risks and benefits.

Participants

The parents of children who had been admitted for more than 12 hours to a 16-bed PICU in a tertiary hospital in Madrid, Spain, were asked to participate in the study six months post-discharge of their child. Exclusion criteria were the inability to speak sufficient Spanish to complete the questionnaire and the death of the child during the admission or within the six month follow-up period.

Data collection

Procedure

This study was part of a series of studies designed to assess the psychological outcomes of having a child admitted to a PICU. The parents of every child that had been admitted to the PICU for more than 12 hours were contacted by email, post or telephone six months after the child's discharge from the PICU and were asked to complete and return the included questionnaires.

Instruments

Medical data. Data to complete the Paediatric Index of Mortality II (PIM2; Slater et al., 2003), which predicts the mortality risk in the PICU during the first 24 hours of admission, were obtained from the child's medical records. To determine the severity of the child's condition as perceived by the parent, the parents were asked to respond, using an eight-point Likert scale that ranged from 0 to 7, to the following question: *How severe do you think your child's condition was at the time of your child's admission to the PICU?*

Davidson trauma scale (DTS; Davidson et al., 1997). The DTS is a 17-item self-report measure that assesses the 17 symptoms of PTSD as defined in the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition-Text Revision) and included under criteria B: re-experiencing; C: avoidance/numbing and D: hyperarousal (American Psychiatric Association., 2011). The DTS yields a total score ranging from 0 to 136. A cut-off of 40 is recommended for classification of those with PTSD, with a diagnostic accuracy of 83% (Davidson et al., 1997). A more recent study (McDonald et al., 2009) has found that the DTS has adequate internal consistency ($\alpha = 0.97$) and concurrent, convergent and discriminant validity. The Spanish version has demonstrated adequate internal consistency ($\alpha = 0.90$) and test-retest reliability ($ICC = 0.87$) (Bobes et al., 2000). The three DTS subscales (re-experiencing, avoidance/numbing, and hyperarousal) were computed by adding all subscale items and dividing by the total number used in the scale (McDonald et al., 2009), resulting in a possible range of 0–4.

Hospital anxiety and depression scale (HADS; Zigmond and Snaith, 1983). The HADS is a 14-item, self-reporting screening scale with two 7-item Likert subscales, one for anxiety and one for depression. For both subscales, a score of 8–10 indicates a mild case and a score ≥ 11 indicates a moderate to severe case. A literature review

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