Research Article

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Criteria for Psychological Assessment of Parents' Position in The Process of Rehabilitation of Children Who Have Suffered Severe Trauma

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RELEVANCE Psychological support of the family whose child is in rehabilitation after severe injury is one of the important areas of medical psychologist activities. The psychologist is to involve parents into the rehabilitation process as active participants. Thus, at the initial stage of support, the psychologist's task is to identify unproductive parental patterns and correct them in a timely manner.
The aim of the study is to develop psychological criteria for assessing the parental position in the situation of rehabilitation of children with severe trauma.

MATERIAL AND METHODS The trial setting was the Clinical and Research Institute of Emergency Pediatric Surgery and Trauma, Moscow, Russia. 40 parents of children with severe trauma were included in the study. Research instruments were as follows: overt observation of parent-child interaction based on selected evaluation criteria, clinical interviews as well as analysis of homework assignments with the child. To assess parental position in the rehabilitation process, a number of criteria were formed: involvement in the rehabilitation process, attitude towards their child and child's trauma, attitude towards their child's independence, attitude towards their parental role as well as the attitude towards the outcome of rehabilitation.

RESULTS Types of parental position in the process of the child's rehabilitation were clarified and updated; its subtypes were defined and characterized. So, according to the criterion "Involvement in the rehabilitation process", the following distribution by sample was observed: passive (10% of parents), formal (20% of parents), controlling (25% of parents) and productive (45% of parents). According to the criterion "Attitude towards their child" — rejecting (7% of parents), condoning (18% of parents), dominant (35% of parents), accepting (40% of parents). According to the criterion "Attitude towards their child's trauma" — superficial (10% of parents), defective-directed (32% of parents), positively-directed (18% of parents), adequate (40% of parents). According to the criterion "Attitude towards their child's independence" — directive (22% of parents), hyper-protective (25% of parents), permissive (18% of parents), democratic (35% of parents). According to the criterion "Attitude towards their parental role" — unformed (17% of parents), dependent (25% of parents), rigid (30% of parents), reflexive (28% of parents). According to the criterion "Attitude towards the outcome of rehabilitation" — amorphous (15% of parents), anxious (15% of parents), categorical (35% of parents), and flexible (35% of parents).

CONCLUSIONS The performed psychological assessment of parental position in the process of their child' rehabilitation after severe injury has revealed important intra-group differences, indicating that a significant part of parents need psychological help, since they cannot independently come to productive forms of interaction with their child in the process of his rehabilitation.

Keywords: pediatric rehabilitation, parental position, criteria for parental position

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INTRODUCTION

A child's severe trauma and the path of his further recovery are a special stage of child development, which can be designated as a social situation of rehabilitation. From the moment the child is traumatized, which is manifested to the family as a crisis, a spontaneous, necessary restructuring of the entire family system takes place. Adherence of an adult to a particular parental position largely determines the trajectory of the child's recovery [1–9]. A parent whose life mission is the task of overcoming severe resulting from trauma impairments of the child (cognitive, motor, emotional and personal) may experience difficulty in this process of mastering various methods and forms of rehabilitation. In the domestic literature, there are only single works that highlight the specifics of parenthood in the context of the rehabilitation of the child after severe injury [10–13]. Foreign studies are more diverse, but the emphasis is mainly on the study of such a phenomenon as the "inclusion" and "involvement" of parents in rehabilitation [14–17]. When working with parents in the context of child rehabilitation, the psychologist is faced with the task of assessing parenthood in family-specific life circumstances, namely: in a situation of severe trauma to the child (severe and moderate traumatic brain injury, severe spinal cord injury, acute cerebrovascular accident, etc.).

Features of parental position determine the specifics of the parent's contact with representatives of the rehabilitation team, the degree of cooperation and readiness for joint activities in the rehabilitation process, compliance and attitude to professional assistance, the degree of responsibility that parents take on during the child's recovery, etc. These parental qualities are extremely important in relation to the child's recovery, as they indirectly determine the trajectory of rehabilitation work. In domestic and foreign practice, the study of the specifics of parenting styles (D. Baumrind, 1975; A.E. Lichko, 1989; D.N. Isaev, 1996; A.Ya. Varga, 1997; A.I. Zakharov, 1997 ; E.G. Eidemiller and V. Yustitskis, 1999; and others); parental position (A.S. Spivakovskaya, 1981; T.V. Bragina, 2000; O.A. Karabanova, 2001; R.V. Ovcharova, 2003; and others); characteristics of parenthood in families raising a child with disabilities (I. I. Mamaichuk, 1989; G. A. Mishina, 1998; I. S. Bagdasaryan, 2000; O. S. Nikolskaya, 2003; E. M. Mastyukova, 2003; L. M. Shipitsina, 2005; E. A. Olkhina, 2006; V. V. Tkacheva, 2007; I. Yu. Levchenko, 2008; E. A. Savina, 2008; E. A. Poloukhina, 2009; and others) are widely represented. According to O.A. Karabanova, the concept of "parental position" includes such components as "the nature of the emotional acceptance of the child, the motives and values of education, the image of the child, self-image as parent, models of role-playing parental behavior and the degree of satisfaction with parenthood" [18, p. 118].

Our analysis of the literature showed that, in relation to the criteria for parental position, different authors identified various parameters for its assessment, on the basis of which parenthood classifications are built. Thus, V.V. Stolin (1983) typologized parental attitudes based on emotional and value criteria (sympathy-dislike, respect-disrespect, closeness-distance) [19]. A.S. Spivakovskaya (1981-2000) developed a classification of parental positions, including such parameters as "adequacy-inadequacy"; "dynamism-rigidity"; "predictability–non-predictability" [20]. R.V. Ovcharova (2006) understood the parental position as a system of the parent's attitude to his child, to himself as parent, to his parental role, to parenthood in general and to educational practice, and as a result she classified adequate and inadequate types of parenthood. Inadequate parental position included the following subtypes: indulging, overly demanding, alienating, unstable, perverse [21]. I.N. Galasyuk (2014) identified 7 types of parental position in relation to children with intellectual disabilities: partner, partner-mentoring, mentoring, mentoring-dominant, dominant, dominant-rejecting, rejecting [22]. N.N. Posysoev (2017) presented the following criteria for assessing the parental position in relation to a child with developmental disabilities: attitude towards oneself as parent, attitude towards the child, attitude towards the defect, attitude towards outside help, and attitude towards the future [23]. With all the variety of the described criteria for

parental position, the question of specialized criteria for evaluating parenthood in a situation of severe injury to the child in the process of rehabilitation remains open.

The **aim** of this study was to develop psychological criteria for assessing the parental position in the situation of rehabilitation of children who have suffered severe trauma. Based on the analysis of the works discussed above and taking into account the specifics of the rehabilitation situation, we selected the following criteria for a qualitative assessment of the parental position: involvement in the rehabilitation process, attitude towards the child, attitude towards the child's trauma, attitude towards the child's independence, attitude towards the parental role, and attitude towards the outcome of rehabilitation.

MATERIAL AND METHODS

The study was conducted on the basis of the Clinical and Research Institute of Emergency Pediatric Surgery and Trauma, Moscow. The study involved 40 parents. Of these, 81% were mothers, 19% were fathers. The distribution according to the diagnoses of children was as follows: 62.5% (25 children) - severe and moderate brain injury, 12.5% (5 children) - stroke (acute cerebrovascular accident), 7.5% (3 children) - severe vertebral - spinal cord injury, 7.5% (3 children) - severe concomitant injury, 5% (2 children) - lower limb amputation, 2.5% (1 child) - bilateral lower limb compartment syndrome, 2.5% (1 child) — structural focal epilepsy.

One of the research methods was participant observation based on the selected evaluation criteria, the object of which was parental involvement, as well as ways of parental interaction and communication with the child during rehabilitation activities. In order to determine the parents' ability to navigate the specifics of the child's disorders, attitudes towards the child, his independence and possible outcomes of rehabilitation, as well as to assess the parental role, a clinical conversation was conducted with verbatim recording of the parent's answers to certain questions. A list of some questions to discuss with the parent: *What is the role of the parent in the rehabilitation process, as you see it? What do you think your child is experiencing now? What can he do? What can't he do? What are his strengths and weaknesses? In what areas does your child show independence? And in what areas he does not? How do you help him be independent? What do you think depends on you in rehabilitation? How do you see the prospects for your child? What do you think results of rehabilitation depend on? What do you think a parent can expect from the child? How do you support your child in the rehabilitation process? What do you do together with your child? etc.* As an auxiliary diagnostic tool, we used the analysis of homework assignments performed by the parent. Homework included keeping a diary of the child's recovery. The parent was given a table that included various assessment parameters, for example, speech and motor skills, emotional characteristics, independence and self care skills, initiative, wakefulness and sleep, etc. (The parameters were selected in each case individually, depending on the characteristics of the child's injury and age). Instruction: *"You are offered a table that contains different indicators of childhood recovery. Twice a week for a month, you are encouraged to take notes on your child's progress. You should not worry about the correctness or incorrectness of your observations. Try to observe the child and record what you notice. Upon completion of the work, we will discuss the results with you"*. The distribution of parents into groups based on the selected criteria was carried out using the method of expert panel evaluation. The assessment of the parents' position on each of the selected criteria (see below) was carried out through joint discussion and reaching a consensus by the experts of the rehabilitation team which included medical psychologists and neuropsychologists supporting the family in the rehabilitation process (at least three expert participants in each panel).

In order to assess the parental role in the rehabilitation process, a number of criteria were formed:

I. *Involvement of the parent in the rehabilitation process:* This criterion evaluates the parents' initiative in relation to joint activities with the specialists (do they show a desire to cooperate, make independent attempts to establish contact for this, ask questions during rehabilitation, follow recommendations, perform homework assignments).

II. *Attitude towards the child:* The nature of emotional contact with the child, the nature of assistance and support, as well as the system of requirements for the child and the tasks that are set for him are assessed.

III. *Attitude towards the child's trauma:* The criterion characterizes the parent's awareness not only of the specifics of the child's disorders, but also of his intact skills; the parent's motivation to expand this knowledge; the ability to understand the causes and motives of a particular behavior of the child, taking into account the diagnosis, the presence of independent parental criteria for assessing the dynamics of the child, as well as the adequacy of ideas about the child's potential.

IV. *Attitude towards the child's independence* characterized by the ability of the parent to create conditions for independent activity of the child.

V. *Attitude towards the parental role* is understood as the degree of responsibility that the parents take on during all rehabilitation activities, as well as the degree of their independence.

VI. *Attitude towards the outcome of rehabilitation* is interpreted as a preliminary assessment by the parents of the prospects of their child.

RESULTS

The analysis of the obtained results using the above criteria made it possible to single out for our purpose 4 subtypes of parental features in each group of the parameters:

Table

Types of parental attitude to a child

Points	Involvement in the rehabilitation process	Attitude towards the child	Attitude towards the child's trauma	Attitude towards the child's independence	Attitude towards the parental role in the rehabilitation process	Attitude towards the outcome of rehabilitation
1	Passive	Rejecting	Superficial	Permissive	Unshaped	Amorphous
2	Formal	Condoning	Defect-oriented	Overprotective	Dependent	Anxious
3	Controlling	Dominant	Positive- oriented	Directive	Rigid	Categorical
4	Productive	Accepting	Adequate	Democratic	Reflective	Flexible

As for the criterion of involvement in rehabilitation, four types of parental features were singled out: *passive, formal, controlling* and *productive*. The distribution of the sample is presented below (Fig. 1).

Parents with passive involvement, making up 10% of the entire sample (4 people), were characterized by a weak interest in working with the specialists in the rehabilitation process, shifting responsibility for children's recovery to the doctors. Those parents did not independently initiate contact, did not ask questions, could ignore/forget about recommendations and homework.

Parents with formal involvement, making up 20% of the sample (8 people), while demonstrating active position, turned out to be helpless in relation to the rehabilitation of their own child. This subgroup might show willingness to cooperate, ask questions, agree with the specialist's position and show an intention to follow the recommendations and homework assignments. However, as time passed, the specialists could notice that the recommendations were not followed and homework assignments were not performed.

Parents with the controlling type of involvement (25% of the sample, 10 people) accepted the tasks of the child's recovery as personally significant, but tried to defend their own understanding of this work (for example, they indicated their own vision of the form of activities with the child, sometimes ignoring the specialists' opinions and not taking into account the current abilities of the child). They were active in establishing contact with the psychologist, but received information and recommendations selectively. The motive for their participation in individual sessions with the child was determined by the need to control the activities of the child and the specialist.

The fourth type of ***parental involvement was defined as productive one*** (45% of parents, 18 people). Those parents showed high motivation in relation to the rehabilitation of their child; they also assessed the tasks of the child's recovery as personally significant. Moreover, there was a desire to cooperate with the psychologist and increase the effectiveness of their own ways of interacting with the child. They independently asked questions about pressing issues regarding their child, tried to put the proposed recommendations into practice, and were diligent in regard to homework. Their motive for participation in the sessions with the child was characterized by the need to master new methods and forms of interaction with their child.

As for "Attitude towards the child" criterion, the following parental subtypes were singled out: *rejecting, condoning, dominant, and accepting*. The distribution of the subtypes by groups is shown below (Fig. 2).

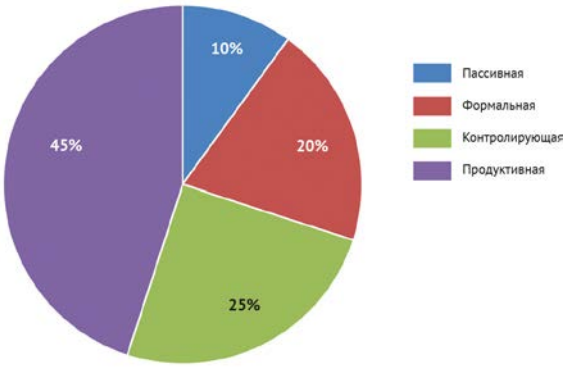

Fig. 1. Distribution of the parents by types of involvement in the rehabilitation process, %

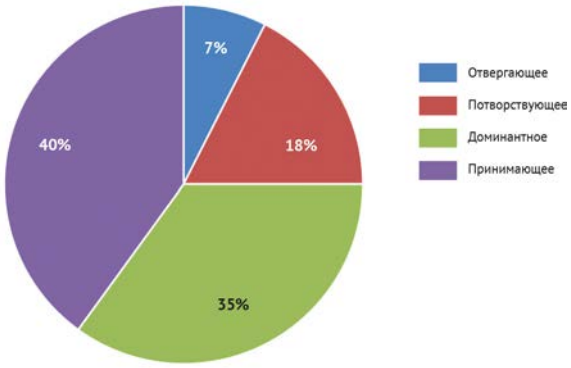

Fig. 2. Distribution of the parents by types of attitude towards their child in the process of rehabilitation, %

The parents with the rejecting type of attitude towards their child (7%, or 3 people) demonstrated emotional coldness and latent detachment from their child. Those parents might be externally present next to the child, support his physical care, but emotionally turned out to be closed (emotional contact was weakly manifested). With regard to meeting the child's needs, emphasis was placed on physiological ones, while the needs for emotional communication were ignored. The system of requirements for the child was either absent or inadequate to his abilities.

The condoning g type of attitude towards the child (18%, or 7 people) was characterized by high child-centeredness (the orientation of parents to their child with a lack of attention to their own needs), enmeshment (i.e. excessive attachment of the parent to the child), the desire to satisfy the child's needs (both in physical care and emotional communication), indulgence, while there was no system of requirements for the child, no guidelines for reasonable boundaries of acceptable behavior were indicated.

The dominant attitude towards the child (35%, or 14 people) was characterized by the parents' insensitivity to the needs of their children and their current state, centering on their own vision of children's needs. The presented system of requirements turned out to be rigid, not always adequate to the actual and potential abilities of the children.

Parents with accepting attitude towards their child (40%, or 16 people) were highly oriented towards the child, his needs (both for physical care and emotional communication), demonstrated warm contact and had a flexible, adequate system of requirements, which was commensurate with the zone of actual and potential child development.

As for "Attitude towards the child's trauma" criterion, the following subtypes were singled out: *superficial, defect-oriented, positive-oriented, and adequate* (Fig. 3).

The first type— ***superficial attitude of the parent towards the child's trauma***—was noted in 10% of the sample; 4 people. Those parents showed a low level of awareness about the features of the child's trauma (insufficient understanding of the defect and the child's intact abilities). They neither understand the reasons for this or that child's symptoms / manifestations / behaviors, nor designate their own criteria for the dynamics of the child's recovery; progress or rollback in the child's condition was not independently recorded; their claims for recovery were unformed. In addition, there was no parental interest in expanding their own knowledge of the trauma's characteristics and the child's condition.

Defect-oriented attitude (32%, or 13 people) was associated with the fixation of parental attention on the impaired abilities (or negative manifestations) of the child. At the same time, parents were not always able to understand the causes of those symptoms; they often turned to the specialists in order to get an explanation for one or another picture of recovery. The positive moments of the dynamics might sometimes not be noticed or not perceived as significant and satisfactory. They had low expectations in relation to the restorative abilities of the child.

Positive-oriented attitude (18%, or 7 people) was characterized by the fact that parents mainly focused on the positive aspects of recovery or on the child's intact abilities and underestimated the severity of his condition. At the same time, they might inadequately interpret the manifested symptoms, attributing the

desired qualities and meanings to one or another child's behavior (not measuring up the structure of the defect and ignoring the severity of the disease). Failures and setbacks in recovery were not perceived as significant. Those parents could overestimate the potential of the child. Explanations of the specialists on the structure of the defect were often not accepted if this description did not correspond to the parental image of the child's trauma (*for example, the mother of a 6-year-old child with cognitive, emotional, and personality disorders in the form of negativism, impulsiveness, aggressiveness, as well as attention deficit, interpreted the child's refusal to complete the task as a manifestation of non-conformity and the ability to defend his position. With all due respect to such human qualities, this parental assessment turned out to be incorrect and led to difficulties in overcoming the "field" behavior of the child, as well as in developing the ability to adhere to the rules of social interaction*).

Parents with the adequate attitude to the trauma (40%, or 16 people) demonstrated sufficient awareness of their child's illness, sought to deepen their own understanding of the structure of the defect and the causes of the current child's condition. They might independently designate the manifesting symptoms (they had criteria for their own assessment), the child's intact abilities, gave an approximately correct interpretation of one or another child's behavior, and paid attention to significant moments of the dynamics. In general, parental expectations and claims were commensurate with the current state of the child.

As for "Attitude towards the child's independence" criterion, the following subtypes were singled out: *permissive, overprotective, directive, and democratic* (Fig. 4).

Permissive attitude (18%, or 7 people) was observed in situations where the parent neither show any limits to the child, nor impose any requirements and rules on him. The child was given excessive spontaneity and freedom, while in a situation where the child needed help, the parent turned out to be ineffective.

Overprotective attitude (25%, 10 people) was characterized by the fact that the parent was overly attentive to the child, hypersensitive to his needs, sought to protect him from any difficulties encountered (even feasible), tried to help the child in everything.

Directive attitude to the child's independence was noted in 22% of parents (9 people) and was associated with the parents' attempts to totally control the child, while achieving their own goals, despite the child's condition and actual abilities. They openly demanded diligence from the child, reacted affectively to his mistakes, sometimes they might shame the child in public without providing help and support.

Democratic attitude (35%, or 14 people) referred to those parents who were inclined to trust the child to independently solve tasks within their power. At the same time, they showed understanding and tactful attitude towards children's successes and failures, and, if necessary, turned on in time and provided assistance and support.

As for "Parental role" criterion, the following subtypes were singled out: *unshaped, dependent, rigid* and *reflective*. The distribution of subtypes by groups is shown below (Fig. 5).

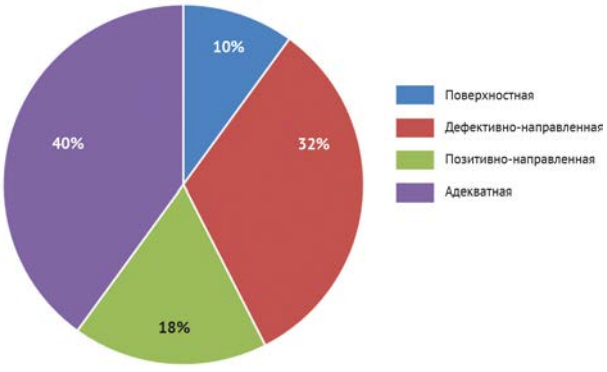

Fig. 3. Distribution of the parents by types of attitude towards their child's trauma, %

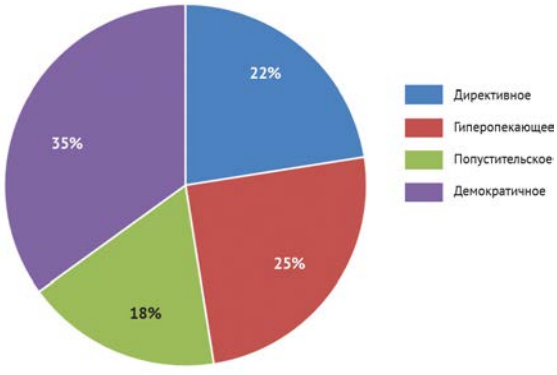

Fig. 4. Distribution of the sample according to the parameter "Attitude towards their child's independence", %

Unshaped parental role (17%, or 7 people) was determined by the fact that parents could not designate their place in the rehabilitation process. They believed that the recovery of the child is practically independent or depends insignificantly on parental actions. In their reasoning, the parents mainly relied on specialists/destiny/God, etc. Parental ideas and knowledge about how to behave in various situations related to the child turned out to be syncretic (for example, in a situation of low motivation or negativism of the child).

Dependent parenting role was characterized (25%, or 10 people) by the parent's fragmented perceptions of the nature of the interaction with the child (for example, the parent could master the basic tasks of caregiving, while being uncertain about developmental tasks). In unexpected, atypical situations, those parents felt helpless, did not know what to do, and therefore often turned to the specialists for help.

Rigid parental role (30%, or 12 people) was determined by the fact that parents had already mastered a number of rehabilitation tasks (caregiving, development of movement and communication skills, learning tasks, etc.) and showed independence in many aspects. At the same time, in some situations, they were uncritical about their own actions. Those parents adhere to their own idea of proper parenting behavior. The appeal to the specialists was due to the desire to prove themselves right, and not to get feedback in order to correct their own unproductive methods of interaction with the child.

Reflective parental role (28%, or 11 people) was manifested in the fact that the parents of this group could designate a realistically possible, adequate area of their responsibility in relation to the child's rehabilitation. They neither ascribe superpowers to themselves, nor sink into feeling powerless. They have formed a relatively clear idea of what should be done in various conflict situations that arise in the process of interaction with the child. At the same time, those parents were characterized by the desire to receive expert feedback, which they heard and accepted, and on the basis of this they corrected their own ways of communicating with the child.

As for "Attitude towards the outcome of rehabilitation" criterion, *amorphous, anxious, categorical,* and *flexible* subtypes were singled out (Fig. 6).

Amorphous attitude towards the outcome of rehabilitation (15%, or 6 people) was manifested in the fact that the parents did not dare to indicate any more or less definite position regarding their child's future. In fact, those parents did not have stable guidelines to outline the development prospects, did not try to look far into the future and limited themselves to the urgent tasks of rehabilitation.

Anxious attitude (15%, or 6 people) was characterized by the fact that the parents fixated on the child's impairment, disability or any other possible childhood difficulties, often talked about their worries and possible child's failures in the future.

Categorical attitude (35%, or 14 people) was noted among those parents who were focused only on the positive result of the child's recovery (for example, faith in the complete healing of the child), sought to make the child the way he was before the injury.

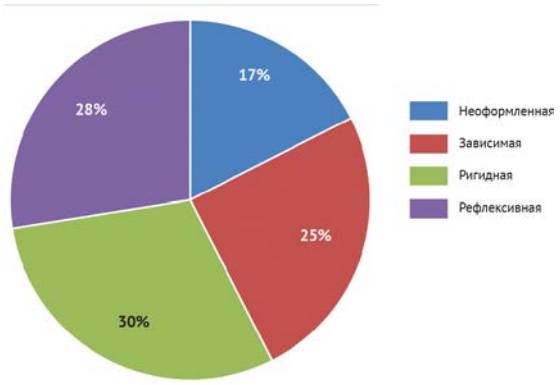

Fig. 5. Distribution of the sample according to the parameter "Attitude towards their parental role", %

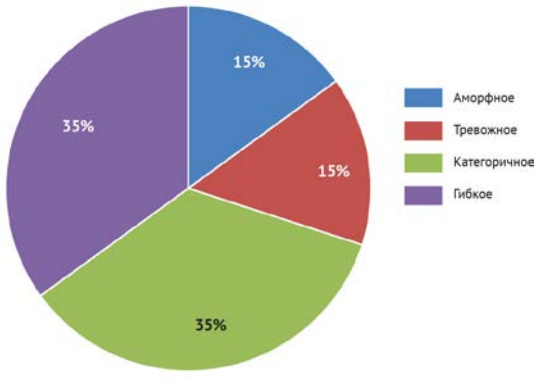

Fig. 6. Distribution of the sample according to the parameter "Attitude towards the outcome of rehabilitation", %

DISCUSSION

Flexible attitude to the outcome of rehabilitation (35%, or 14 people) was recorded by the experts, when parents, on the one hand, indicated adequate expectations, commensurate with the rehabilitation potential of the child, and, on the other hand, accepted the likelihood that the child would no longer be the same as he was before the injury. Those parents were aware of the changed trajectory of the future personal and social development of the child.

The complex picture of the relationship between unproductive and productive characteristics of the parental position draws attention to itself. The fact that the positions of a significant part of the parents during the initial examination were highly rated can be associated with the very circumstances of the child's traumatization and the urgency of the situation which required the parents to mobilize their activity, involvement and cooperation. At the same time, we would like to note that one and the same parental position could have both productive and unproductive characteristics, which required a separate analysis and determination of specific areas of assistance to every parent for a constructive change of their position in the process of the child's rehabilitation.

High scores according to the proposed criteria were desirable characteristics of the parental position, which can be qualified as indicators of mature, adequate parenthood in rehabilitation conditions. Low scores were indicators of the immaturity of the parental position. However, the relationship between the adequate parental position and the effectiveness of a child's recovery from severe trauma remains to be empirically investigated.

This study did not imply an assessment of the parental position according to the above criteria over time, it was a cross-sectional one and carried out at the initial stages of rehabilitation. At the same time, the selected criteria can be used to assess the dynamics of the parental position in the process of rehabilitation of children who have suffered a severe injury.

CONCLUSION

This study is an attempt to identify diagnostically significant criteria of parental position in the course of rehabilitation of children who have suffered severe trauma. The results of the research showed that parents cannot always on their own come up with productive methods and forms of interaction with their child in the process of rehabilitation. Relying on the spontaneous deployment of this process can lead to difficulties in realizing the child's rehabilitation potential. The identified criteria can allow specialists involved in family support in the situation of severe childhood trauma to assess the characteristics of the parental position and correct its ineffective forms in a timely manner. Further research in this area requires a more thorough study of the conditions for the formation of a mature parental position in the rehabilitation of children who have suffered severe trauma, in particular, the role and tasks of the medical psychologist in this process.

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