Published in final edited form as:

J Pediatr. 2020 January ; 216: 51–57.e2. doi:10.1016/j.jpeds.2019.09.059.

Parent Perspectives on Family-Based Psychosocial Interventions for Congenital Heart Disease

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Abstract

Objectives—To identify parents' preferences for goals and structure of intervention programs to support the psychosocial needs of families impacted by congenital heart disease.

Study design—Information about parent priorities for psychosocial programs was obtained in this mixed-methods study conducted at a pediatric hospital in the Mid-Atlantic region of the United States. Participants were parents (N = 34; 20 mothers, 14 fathers) of children with congenital heart disease between the ages of one to three years who had cardiac surgery at less than six months of age. Qualitative data were excerpts from semi-structured interviews. Quantitative data were participant choices regarding their ideal psychosocial program resulting from a card sort.

Results—Parents reported that psychosocial interventions should support partnership in their child's care, promote self-care, facilitate communication with providers, prepare parents for challenges after hospitalization, provide education about child neurodevelopment, and help parents engage social support. Parents reported needing formalized support across care, brief intervention models, in-person individualized or small group support, and involvement of multidisciplinary providers and peer mentors in the delivery of interventions.

Conclusions—Parents of children with congenital heart disease need psychosocial interventions that empower them to act as primary caregivers and effective advocates for their child. Individualized, formalized, and multidisciplinary approaches to psychosocial care are necessary to best accommodate the dynamic stressors related to parenting a child with congenital heart disease and may mitigate the impact of parent mental health problems on child outcomes.

Keywords

congenital heart disease; pediatric cardiac intensive care; parental mental health; psychosocial intervention; multidisciplinary care

Children with congenital heart disease (CHD) are at high risk for neurodevelopmental and behavioral impairments that impact educational, occupational, and quality of life outcomes.¹ With improved survival for children with CHD, it is important to identify modifiable factors to optimize neurodevelopmental and behavioral outcomes for this growing population.² Parent mental health is one such potential modifiable factor.³

Parents of children with CHD experience a high prevalence of anxiety, depression, and traumatic stress.^{4,5} Recent research has highlighted stressors that contribute to these mental health problems, including difficulties communicating with healthcare providers, insufficient preparation for the complex care needs of a child with CHD, and alterations to the parental role during hospitalization.^{6,7} Interventions aimed at improving mental health for parents of children with complex medical conditions using skills-based, informational and supportive approaches are promising,⁸ with studies demonstrating reductions in anxiety, depression, and acute stress symptoms among parents of children with CHD^{9–12} and other medical conditions.^{13–15} Preliminary studies have also demonstrated the positive impact of parent-focused interventions on CHD child outcomes, including improved neurodevelopment, feeding, and school attendance.^{11,16} However, family-based interventions are often difficult to implement, particularly during periods of acute stress and transition,¹⁷ and more research is needed to understand how interventions can be tailored to enhance their feasibility and acceptability to meet the needs of families.¹⁸

Qualitative research methods allow for a nuanced understanding of the experiences and preferences of parents and families impacted by pediatric illness.¹⁹ Qualitative and mixed methods research has been particularly advantageous in identifying the heterogeneous psychosocial needs of diverse groups, such as the population of parents affected by CHD, as compared with quantitative methods alone.²⁰ In the current mixed methods study, we engaged a diverse group of mothers and fathers to identify parent preferences regarding the goals and structure of intervention programs aimed at supporting the psychosocial needs of families impacted by CHD.

Methods

Participants were 20 mothers and 14 fathers of 21 young children with CHD between the ages of one to three years. For parents to be eligible for the study, their child must have had cardiac surgery with cardiopulmonary bypass at less than six months of age at Nemours/Alfred I. duPont Hospital for Children between 2012 – 2014. Twenty-five families were

purposely selected for diversity on clinical and demographic characteristics from a list of 156 eligible families by an independent consultant. One or both parents from 21 of the 25 families approached about the study chose to participate (84% participation rate). Additional details regarding recruitment and enrollment are reported in Sood et al.⁷

This study was approved by the Nemours Institutional Review Board and written informed consent was obtained prior to study procedures. Parents participated in a one-hour semi-structured individual interview with a pediatric psychologist or psychology fellow. The interview was structured into three distinct components. Part 1 focused on identifying stressors and supports associated with receiving a diagnosis of CHD,⁷ and Part 2 focused on exploring parental coping strategies. Part 3, the focus of this manuscript, engaged participants in the design of their ideal psychosocial program geared toward supporting families of young children with CHD. Participants first reviewed brief descriptions of three sample psychosocial programs that varied with regard to *program goals* (eg, to help parents handle stress and use healthy coping strategies; to promote parental involvement in care during hospitalization) and *program structure* (e.g., format, timing, program leaders) (Table I; available at www.jpeds.com). The first sample psychosocial program consisted of three 45–60 minute small group meetings led by a psychologist or counselor on or near the hospital unit aimed at teaching parents skills to cope with stress during hospitalization. The second sample psychosocial program consisted of three 45–60 minute individual meetings co-led by a nurse and a psychologist or counselor at the baby's bedside aimed at supporting parental involvement in care. The third sample psychosocial program consisted of one 2–3 hour meeting co-led by the parent of an older child with CHD and a psychologist or counselor aimed at supporting families in understanding and preparing for common challenges of parenting a child with CHD. For each description, participants were asked what they thought about the program, what they liked about it, what was missing, and what aspects would not work for their family.

Parents then completed a card sort (Table II; available at www.jpeds.com) to obtain information about priorities for the goals and structure of psychosocial programs. Card sort methodologies have been used in the pediatric literature to understand how stakeholders process information and establish personal preferences.^{24,25} Participants were first provided with 11 index cards each containing a possible psychosocial program goal along with blank cards on which they could add additional goals, and were asked to select those that they wanted to include in their ideal program. Participants were then provided with cards representing multiple options for seven different aspects of program structure along with blank cards on which they could add additional suggestions, and were asked to select those that they wanted to include in their ideal program. Following each selection, choices were recorded and participants were asked about their rationale for selecting each card. A phone interpreter service was utilized for three Spanish-speaking participants.

Interviews were audio-recorded and transcribed, and de-identified transcripts were uploaded into Dedoose Version 7.5.16 (SocioCultural Research Consultants, LLC; Los Angeles, CA, USA). Participants completed a demographic questionnaire and gave permission for clinical data to be extracted from the electronic medical record. Participants received a \$25 debit card.

Statistical Analyses

Participant choices regarding the goals and structure of their ideal psychosocial program resulting from the card sort were analyzed using descriptive statistics. Qualitative data from interview questions regarding the three sample program descriptions and their ideal psychosocial program were analyzed using an inductive thematic approach,²⁶ which focuses on participants' subjective perceptions, feelings, and experiences. The qualitative code book was developed by an interdisciplinary team. Seventy-three excerpts across the first four interview transcripts were coded independently by two primary raters with inter-coder reliability of 0.85 (Cohen kappa), after which disagreements regarding codes were resolved through discussion. The remaining 30 interview transcripts were coded by one of the two primary raters. Consistent themes and representative quotes related to program goals and program structure were identified from coded data.

Results

The sample was diverse with regard to race/ethnicity (62% minority), socioeconomic status (53% middle or high school level education), annual household income (38% reported \$30,000 or less), and sex (41% male; Table 3 [available at www.jpeds.com]). Thirty-eight percent of participants' children were diagnosed with CHD prenatally and 43% underwent cardiac surgery in the first week of life.

Six broad themes about program goals emerged from the qualitative data (Table 4). Most parents described their ideal program as targeting multiple goals (94% endorsed two or more goals, 27% endorsed all six goals).

Support parents to partner in their child's hospital care.

Over three-quarters of parents indicated the need for education and support regarding how to partner with providers in their child's hospital care and described wanting to fulfill their parental role, particularly during periods of acute illness and during infant admissions. Both mothers and fathers expressed a desire to have a positive impact on their child's treatment course by helping their child feel as comfortable and calm as possible. Many parents felt that they eventually learned these skills from nurses through informal instruction but indicated that hands-on, formalized education would decrease their stress associated with learning to meet their child's unique needs.

Promote parental self-care and stress management.

Almost all mothers and more than half of fathers described the need for education and support for parental self-care, including learning to reduce stress and cope with symptoms of depression. Parents reported that this would help to normalize and validate their experiences. Parents also described that education should focus on how self-care can facilitate medical decision-making and allow them to better parent their child.

Facilitate effective communication between parents and medical providers.

More than half of parents, particularly mothers, reported the need for support to promote good communication with their child's doctors and nurses. Parents described that knowing

what questions to ask, and how to ask them, would allow them to feel more confident in their medical decisions and act as an effective advocate for their child.

Prepare parents for common challenges after hospitalization.

More than one-half of parents, particularly fathers, discussed the need for formal preparation for the management of common challenges following hospital discharge, such as difficulties with feeding and sleep. Parents recalled thinking that life would return to normal after discharge but felt overwhelmed and scared when they first returned home. They noted that receiving more preparation during hospitalization would have eased this transition.

Educate parents about child neurodevelopment.

The majority of parents reported the need for education on how to promote child development within the context of CHD. Parents were interested in learning to set reasonable expectations that support their child's development. Parents indicated that learning about typical development for a child with CHD would decrease stress and anxiety about their child's developmental differences.

Help parents to engage effective social support.

Three-quarters of mothers and half of fathers reported a need for education on how to effectively communicate with and engage support from family and friends. Parents described that social support was instrumental in reducing stress during and after hospitalization. However, they also found that family and friends could become burdensome without concrete instruction (e.g., help with cooking meals) or systems for disseminating information (e.g., Facebook posts).

Four broad themes regarding program structure emerged from a review of the qualitative data, as described below and in Table 5. The specific cards selected by participants representing different aspects of program structure are displayed in the Figure.

Offer formalized support at each stage of care.

Parents reported the need for formalized support at each stage of their child's care. Parents recalled needing the most support during their child's first hospitalization and viewed this period as important for brief, frequent visits aimed at helping parents cope and prepare for challenges after discharge. Parents indicated that formalized support after discharge may be most helpful if it is delivered at regular intervals (e.g., three months and six months post-discharge) and is focused on addressing unexpected difficulties after discharge. Almost all parents who received a prenatal diagnosis indicated the need for formalized support during the prenatal period, with the goal of preparing to meet their child's needs after birth and proactively learning to maintain hope and cope with stress.

Develop brief psychosocial intervention models.

Parents largely reported that brief intervention at each stage of care would be more feasible and acceptable than longer interventions. Parents described that, particularly during hospitalization, they may have difficulty dedicating time and attention toward longer interventions and would prefer to spend the majority of their time focused on their child.

Parents indicated that 2–3 meetings would allow for brief follow-up after the introduction of educational materials or support.

Provide in-person individualized or small group support.

Almost all parents preferred that formalized psychosocial support be delivered in person, either individually or in small groups. Parents wanted the opportunity for dialogue with their provider or other parents, and almost universally felt that in-person meetings would be the most engaging. Parents felt that the privacy of a meeting room would allow them to share more openly with a provider and that time away from the unit may be important. However, parents indicated that patient care education should be delivered at bedside to allow for hands on teaching. Most parents felt that small group meetings should accommodate hospital schedules (e.g., in the afternoon to accommodate morning rounds) and family schedules (e.g., on weekends to accommodate work and school/daycare).

Engage multidisciplinary providers and peer mentors to provide psychosocial support.

Most parents described wanting to have their complete care team involved in providing formalized psychosocial support, with each provider meeting a distinct need. Parents viewed psychologists as important for addressing stress and symptoms of depression and for understanding and applying clinical information given by doctors and nurses. Parents, particularly mothers, viewed nurses as having the most knowledge about caring for their child and felt that nurses should be involved in patient care education during hospitalization. Parents viewed doctors as having the most knowledge about their child's diagnosis, treatment, and prognosis and expressed a need for doctors to be involved early in diagnosis or hospitalization to set expectations for their child's clinical course.

Nearly three-quarters of parents also discussed the importance of involving other parents in the delivery of education and support. During hospitalization, parents expressed a need to meet with other parents whose children are experiencing similar diagnoses to foster social support. Parents felt that other parents would be most able to empathize with and validate their emotional experiences and expressed an interest in problem solving together. After hospitalization, parents expressed a need to meet with parents whose children are further along in treatment to learn what to expect long-term and how to prepare for their child's unique needs, and to seek reassurance about their family's future.

Discussion

Psychosocial intervention programs for parents of young children with CHD have the potential to improve parent and child outcomes,^{9–12} but more research is needed to determine the acceptability and feasibility of intervention strategies for this population, particularly during times of acute stress and care transition.¹⁷

Both mothers and fathers reported a need for programs focused on the direct management of parental anxiety, depression, and stress. However, parents also expressed reluctance to participate in self-care interventions which could divert time and attention away from their child. Parents of children diagnosed with cancer have reported similar challenges, and have identified the attempt to balance the needs of the child with self-care as a barrier to engaging

in interventions aimed at promoting parent and family adjustment.²³ Providers should facilitate parent participation in interventions by providing education on the link between parental mental health and child outcomes. Past research indicates that an individual's subjective appraisals of medical events are associated with traumatic stress symptoms.²⁷ Providers have an opportunity to impact the parental experience through interventions that address maladaptive cognitions and appraisals common among parents of children with CHD.

A high percentage of mothers and fathers identified the need for education and support on how to partner with providers in their child's hospital care. Past studies have found that parent engagement in infant care benefits both parents and children²⁸ and parents reported decreased anxiety following an intervention aimed at creating care partnerships between parents and medical providers.¹² Parents also benefit from opportunities to act as an advocate for their child's needs in critical care settings²⁹ and view communication with medical teams as key to facilitating medical decision-making.^{30,31} Parents in the current study identified a clear need for support surrounding communication with medical teams. Opportunities for parents to participate in their child's care and serve as advocates for their child's needs should be supported through formalized protocols. Parents reported that formalized training in caring and advocating for their child would reduce stress during and after hospitalization by decreasing the demands on parents to independently acquire this information. Results of this study also indicate that psychosocial screening should extend beyond assessment of mental health symptoms to capture parents' engagement, confidence in their child's care, and perception as their child's primary caregiver and decision-maker.

Developmental care in cardiac settings is most successful when delivered by multidisciplinary teams³² consistent with the needs vocalized by parents in the current study. Although psychosocial interventions may typically be implemented by social workers and psychologists, results of the current study highlight the importance of physicians' and nurses' direct and consistent involvement in the psychosocial care of families. Peer support promotes adjustment for families in NICU settings.³³ Parents in the current study similarly indicated that formalized peer support during and after hospitalization would be important for emotional support, information, and fostering hope about their family's future. Opportunities to attend regularly scheduled parent support group meetings and to hear from parents whose children are further along in their treatment were also highlighted as important interventions by the parents from the current study.

Psychosocial interventions have yielded promising results during the prenatal and preoperative periods,^{34,35} during hospitalization,^{10,16} while preparing for discharge,³⁶ and after discharge.¹¹ Similarly, parents in the current study reported the need for psychosocial interventions across phases of care. Supporting parents across the continuum of care may decrease stress associated with transitions during their child's care.¹⁸ Although the need for interventions following prenatal CHD diagnosis was nearly unanimous among parents who received a diagnosis prenatally, very little research has addressed family-based psychosocial interventions during the prenatal period.³⁴ Future research should examine prenatal parent-focused interventions that provide education and proactively teach parents to manage anxiety and stress. Future work should also evaluate the cost-effectiveness of programs that

seek to improve psychosocial wellbeing and developmental outcomes for children with CHD and their families.

Several limitations should be noted. Interviews were facilitated with predefined program cards and by psychologists, and although parents were encouraged to add additional information to create their ideal program, this framework may have narrowed the scope of parent responses. For example, although past research has consistently identified finances as a significant stressor for parents of children with CHD,^{6,7} support for managing financial challenges was not a theme identified in the current study. Future studies should expand conversations around the definition of psychosocial functioning, including financial stability. The current study represented an ethnically and socioeconomically diverse group, however, family structures were limited in their diversity. More research is needed to understand treatment targets relevant to same-sex parents and extended family caregivers. Future research should also examine how the broad themes identified in this study can be individualized in their implementation to meet the needs of specific subgroups, such as non-English speaking parents.

Formalized, individualized, and continuous psychosocial care may help to reduce stress and mitigate the impact of parental anxiety and depression on child outcomes. Engagement of parent stakeholders is critical to the design and evaluation of psychosocial intervention programs for parents of children with critical illness.

Acknowledgments

Supported by the Mend a Heart Foundation and the National Institute of General Medical Sciences of the National Institutes of Health (U54-GM104941 [PI: Binder-Macleod]). The study sponsor was not involved in the study design, the collection, analysis, and interpretation of data, the writing of the report, or the decision to submit the paper for publication. The authors declare no conflicts of interest.

Abbreviations

CHD	Congenital heart disease
NICU	Neonatal intensive care unit

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Figure 1.

Preferences for (A), intervention timing (B), number of meetings (C), intervention format and (D), program leaders. *Note.* Percentage of parents endorsing intervention following prenatal diagnosis based only on parents who received a prenatal diagnosis (Mothers: $n = 8$; Fathers: $n = 5$).

Table 1,

Online Only. Psychosocial Program Descriptions

Goals		Structure
Sample Program 1	To help parents <i>handle stress and use healthy coping strategies</i> during the hospitalization	• Small group format (2–3 families at a time)
		• During any hospitalization for heart surgery
		• Three 45–60 minute meetings in the early evening
		• Located in a meeting room on or near the hospital unit
		• Led by a psychologist or counselor
		• Families watch short video clips of other parents talking about their experiences and discuss program topics
Sample Program 2	To support building strong <i>parent-infant relationships and promote parental involvement in care</i> during the hospitalization	• Individual format (one family at a time)
		• During the <u>first</u> hospitalization for heart surgery (for families of newborns and younger infants)
		• Three 45–60 minute meetings at a time that works best for the family
		• Located at the baby's bedside
		• Co-led by the baby's nurse and a psychologist or counselor
		• Families read personal stories written by other parents and discuss program topics
Sample Program 3	To support families after leaving the hospital in <i>understanding and preparing for common challenges</i> of parenting a child with heart problems	• Larger group format (5–8 families at a time)
		• Within six months after the baby's first heart surgery
		• One, 2–3 hour meeting (weekend and weekday options available)
		• Located in the outpatient clinic where the baby receives follow up care
		• Co-led by the parent of an older child with CHD and a psychologist or counselor
		• Families meet others who have had similar experiences and are given time to talk with each other as well as discuss program topics

Table 2,**Online Only. Card Sort Options**

Program Goals	Ways to handle and reduce stress
	How to soothe the baby and respond to baby's cues
	Ways to promote healthy child development
	Importance of accepting help from family and friends
	How to maintain good communication with family members
	Ways to be involved in baby's care even when baby is very sick
	Ways that family members can support one another
	Importance of taking care of self (sleeping, eating, getting outside)
	How to maintain good communication with medical team
	Discuss challenges often faced by families after hospitalization
	How stress and depression can impact how we think and act
Program Structure	Timing of Program
	Before baby is born (prenatal care)
	During first hospitalization
	During any hospitalization
	After leaving the hospital
	Involvement of Providers or Parents
	Psychologist or counselor
	Nurse
	Doctor
	Parents of older children with heart problems
	Number of Meetings
	One meeting (two to three hours)
	Two to three meetings (about one hour each)
	Four to five meetings (about one hour each)
	Size of Program
	Individual (one family at a time)
	Small group (two to three families at a time)
	Large group (five to eight families at a time)
	Where the Program Takes Place
	At the baby's bedside
	In a meeting room at the hospital
	In the outpatient clinic
	Skype/Face Time
	Parent Contact
	Talking with other parents about their experiences
	Watching videos of other parents talking about their experiences
	Reading stories written by other parents about their experiences
	Time of Day
	Weekday morning

Weekday afternoon

Weekday evening

Weekend day

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Table 3,
Online Only. Sociodemographic and Clinical Characteristics

	<i>Frequency (%)</i>
Parent Sociodemographic Characteristics (N = 34)	
Single Parent (All Female)	5 (15)
Parent Race/Ethnicity	
Non-Hispanic White ^a	13 (38)
Black or African-American	8 (24)
Hispanic/Latino ^b	10 (29)
Asian	3 (9)
Parent Education Level	
Middle School/Partial High School	8 (24)
High School Degree	10 (29)
Partial College	6 (18)
College Degree or Higher	10 (29)
Annual Household Income	
<\$30,000	13 (38)
\$30,000 – \$60,000	9 (26)
>\$60,000	12 (35)
Child Clinical Characteristics (N = 21)	
Prenatal CHD Diagnosis	8 (38)
Down Syndrome	3 (9)
Age at First Cardiac Surgery	
<1 week	9 (43)
1 week – 1 month	5 (24)
2–4 months	7 (33)
Norwood Procedure	5 (24)
Multiple Cardiac Surgeries (>1)	8 (38)
Discharged with Feeding Tube	6 (29)
Age at Time of Interview	
12–23 months	8 (38)
24–35 months	7 (33)
36–47 months	6 (29)

Note.

^aFour non-Hispanic white participants identified as Amish.

^bThree Hispanic/Latino participants spoke only Spanish.

Table 4.

Preferences for Psychosocial Program Goals: Themes and Representative Quotes

Themes (% Mothers, % Fathers)	Representative quotes
Support parents to partner in their child's hospital care (80.0%, 78.6%)	<ul style="list-style-type: none"> How do you actually parent your child...in the state that they're in at the moment?...you feel you can't help, you know? But a lot of this goes back to how much information did you have. <i>Father 7</i> I think [participating in child's care] just makes you feel like you have more of a role in raising your child. Rather than a nurse just coming in and kind of in her or his own way explaining what you can do, having someone who that is their role to teach you that. <i>Mother 20</i>
Promote parental self-care and stress management (95.0%, 64.3%)	<ul style="list-style-type: none"> I think that would be a good idea to know [how to engage in self-care] right away when you get to the hospital. You are kind of in a daze...but you still need to think about some of this stuff. <i>Father 16</i> I'm still going through [stress], and people need to...know that it's okay to have an impact on your mental state. Because it's your baby. <i>Mother 21</i>
Facilitate effective communication between parents and providers (70.0%, 50.0%)	<ul style="list-style-type: none"> There were things that some parents don't know to ask...having that good communication between the family and medical team and how to keep them engaged would help parents better deal with the situation. <i>Father 15</i> There was never, 'this could go wrong, this might not go wrong'...I think that's why I went into denial when he was laid on my chest and looked perfect...even the doctors, when they were doing the ultrasound, didn't talk about it. <i>Mother 14</i>
Prepare parents for common challenges after hospitalization (55.0%, 71.4%)	<ul style="list-style-type: none"> After we left [the hospital] for the first time I was scared because we had no clue what to expect. Have a meeting with the parents [before] going home, let them know what could happen...that would be great. <i>Father 2</i> ...what to expect. So when they checked us out, I knew physically what to do. But I didn't know emotionally how I would be different...and listen, you're gonna be freaked out the first night. <i>Mother 7</i>
Educate parents about child neurodevelopment (65.0%, 50.0%)	<ul style="list-style-type: none"> ...what to expect [with developmental challenges]...And it's going to be a little slower and there's going to be challenges...so that way you're not overwhelmed. <i>Mother 11</i> ...every kid is different, and I think I had a lot of problems with this when...my friends were posting pictures of their babies meeting different milestones before [child's name] did, and then you have to understand, they just went through a lot. <i>Mother 21</i>
Help parents to engage effective social support (75.0%, 50.0%)	<ul style="list-style-type: none"> Everybody wants to know what's going on...If you can communicate to them it would eliminate feeling that...I wish these people would stop calling me, I'm trying to understand what's going on with my child. <i>Father 7</i> The importance of accepting help...because you need help. There's just no getting around it. Even if this is your only child, you need help. <i>Mother 19</i>

Table 5.

Preferences for Psychosocial Program Structure: Themes and Representative Quotes

Themes	Representative quotes
Offer formalized support at each stage of care	<ul style="list-style-type: none"> • Before birth, [learning about] healthy child development, eating properly, sleeping, all of those that are stressors before baby is born, ways to reduce stress, the family development, and accepting help...During first hospitalization, ways to get involved with the baby's care while the baby is very sick. During any hospitalization, caring for yourself is so important. <i>Mother 15</i> • ...Just think it would be healthy...to know certain stuff probably before, or even after, or during [hospitalization]...any information you can get is good because...for everything that you're taught, you can learn something new, something different, or you know, different ways to cope with stuff. <i>Mother 9</i>
Develop brief psychosocial intervention models	<ul style="list-style-type: none"> • Two to three meetings gives you kind of the intro and time to at least have one follow-up to answer questions...It's hard to focus for an hour in general, let alone when...all that is going down. <i>Mother 19</i> • Shorter meetings...like maybe fifteen minutes to a half an hour interval, because...an hour away during hospitalization, I know for myself, I wouldn't be able to focus. <i>Father 7</i>
Provide in-person individualized or small group support	<ul style="list-style-type: none"> • It would be helpful to talk with other parents directly, I don't like the idea of reading stories [about other parents' experiences] because I'm not a reader. And I would rather talk with people in person. <i>Father 17</i> • ...a small group...you feel a little bit more attention from the actual people that are giving you the information...instead of just listening to a speech. <i>Father 10</i> • When you have a larger group it's hard to get everything that they are talking about. If you have a smaller group or one family at a time... everyone gets some time. <i>Mother 16</i>
Engage interdisciplinary providers and peer mentors to provide psychosocial support	<ul style="list-style-type: none"> • In terms of getting people to come up with a plan, coming up with strategies, opening up to acceptance, I think a psychologist is more beneficial...The issues that are about you should eat well and you should sleep...I would have wanted to hear it from a nurse. The parent would be amazing in terms of being able to give feedback on stress reducers, caring for the baby afterwards, this was my experience. <i>Mother 15</i> • I like the fact that the nurse would be included...I like the fact that the people taking care of your child are involved...and they can obviously teach you how to soothe your baby and stuff like that. <i>Mother 2</i> • Just talking to...other parents who went through the experience...it would've been helpful for me. Finding out about others...it would just say, "Oh, look at her. She has her baby and...now the baby is growing up and the same will happen with my baby." Yeah, it would've been useful for me. <i>Mother 6</i>