

Original Article

Assessment of burden, coping skills & depression in parents of children with psychiatric morbidity

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Mental illness in children affects more than just the children - it impacts the entire family specially the parents resulting in stress and depression in them. A positive and effective coping may help to overcome the situation. Our purpose was to compare perceived burden, coping skills and depressive symptoms in parents of children with mental retardation (MR) and attention deficit and hyperkinetic disorder (ADHD) and to compare the same between mothers and fathers of children with different psychiatric morbidity. We also assessed relation between different coping skills with depressive symptoms and burden score. Willing parents of children with psychiatric morbidity with education above 5th standard were assessed for depressive symptoms, perceived burden and different coping skills. Results were analyzed statistically. Both mothers and fathers are found to be similarly depressed. Perceived stress and use of coping mechanism were similar in both groups. Education or income had no effect on depression or perceived burden. Increased use of family coping mechanism helped to reduce stress. Parental distress needs to be assessed by mental health professionals in order to comprehensively address needs of both the child with mental health problems and his or her parent. To improve the condition enhancing coping strategies may help.

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Key words : Parents, burden, depression, coping skill, children, psychiatric morbidity.

Mental illness in children affects more than just the children - it impacts the entire family. Parent caregivers of children with mental illness struggle to meet the needs of their entire family by balancing the needs of their child, other family members, and themselves. They may face challenges such as financial burden, sibling rivalry, stigma, self-doubt and blame, marital stress, and difficulty accessing services, in addition to dealing with the symptoms their child is experiencing¹. Family caregivers have been described as stressed, with the potential of having more problems than the persons for whom they care². Many studies have found that caring for a child with a disability can be a stressful job for parents^{3,4}.

Caregivers' burden has been assumed as an overall term to describe the physical, emotional, and economic consequence of providing care⁵. Care giving is a demanding task that places both burden and stress on the caregiver. While stress is a short term response to the pressures of care giving, burden refers to the long-term effects of providing care to a family member. Developmental disabilities have always been an important but largely yet to be addressed

public health problem for children in developing countries^{6,7}.

Due to the influence of a child's disability, it is important that families adopt appropriate and effective coping methods in adjusting to their child's condition(s). A study by McCubbin and colleagues (1983) suggested that exercising family integration, support, and a positive definition of the situation, in addition to maintaining self-esteem, psychological stability, and social support most effectively helped parents adapt to the stress of managing a household with the addition of a child with an illness⁸.

There are Indian studies which showed psychological stress and coping strategies in parents with mentally challenged children⁹. However we conducted a study in our outdoor setting with following objectives:

Objectives :

- To compare perceived burden , coping skills & depressive symptoms in parents of children with mental retardation (MR) and attention deficit and hyperkinetic disorder (ADHD).
- To compare the same between mothers & fathers of children with different psychiatric morbidity.
- To assess relation between different coping skills with depressive symptoms and burden score.

MATERIALS AND METHODS

(1) BDI (Beck depressive inventory, Bengali version)¹⁰

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self-rated 21 item scale. This widely used instrument consists of 21 symptoms or attitudes commonly seen in patients suffering from depression (eg, sadness, negative self-concept, sleep and appetite disturbances). The symptoms are rated from '0' to '3' in intensity. The internal consistency for non-psychiatric subjects has yielded a mean coefficient α of 0.81, and the mean correlation of BDI with clinical ratings on the Hamilton Psychiatric Rating Scale for Depression has been found to be 0.74^{11,12} suggested caution with regard to the use of the term depression from a single-administration BDI classification and recommend that the term depression should only be used when individuals score above 20 on the BDI. The following cut-off points of depressive symptomatology were used when interpreting the results in the present study¹²: the range of scores from 0 to 9 indicates no depression, 10-20 dysphoria and over 20 depression. Depression scores above 9 are referred to as elevated depression scores. In large samples, the mean BDI score usually falls between 4 and 6, with women usually scoring two points higher than men^{11,12}. Cronbach's α for internal consistency in the present study was 0.90.

(2) CHIP (Coping health inventory for parents) — (McCubbin, McCubbin, Patterson & Cauble, 1983) was used to assess parental coping styles and perceptions of the helpfulness of certain strategies. The scale uses a four-point Likert-type scale, ranging from 'not helpful' (0) to 'extremely helpful' (3). Forty-five items are divided into three sub-scales; family (maintaining family integration, co-operation and optimistic definition of the situation), support (maintaining social support, self-esteem and psychological stability), and medical (understanding the medical situation through communication with other parents and professionals)⁸.

(3) BASS (Burden assessment scale for schizophrenia) — It aims to assess both subjective and objective burden experienced by primary caregivers of chronic mentally ill patients. Self-rated 40 item scale, marked 1-3. Responses would be 'Not at all, to some extent or very much'. Score-40-120¹³.

Study area — OPD of Dept of Psychiatry, Medical College and Hospital, Kolkata, West Bengal, India.

Study population — Willing parents of children (age <12 years) with psychiatric morbidity with education above 5th standard were taken. Parents with psychotic illness or mental retardation were excluded from the study. Cases were divided into 3 groups according to disorders in their offsprings. 1.MR 2ADHD 3.Others (childhood depression, obsessive compulsive disorder etc). Duration of seeking medical help was more than 1 year.

All 3 scales are given to the parents and scores were analyzed.

Statistical methods — Scores of different groups were compared using t test. Bivariate correlation was carried out to assess correlation between different parameters.

OBSERVATIONS

Demographic profile—Among 61 parents 19 (31.1%) were male and 42 (68.9%) were female of which 36 (59%) came from urban and 25 (41%) from rural background. In 44 (72%) of the study population had school going children. In 15 (24.6%) parents had children with MR, 26 had (42.6%) ADHD and rest 20 (32.8%) had offspring with other disorders. Average per capita monthly income was Rs1955±235. Mean age of parents was 35±4.6 years and mean year of education -9.4±3.2 years

Our finding was 66% of the parents had BDI score more than 9 of which 78% were mothers though the difference was not significant. There was no significant difference in burden score or use of different coping skills between mothers and fathers (Table 1).

Depression and burden are same in parents with MR and ADHD children (Table 2).

Table 1 — BDI & BASS scores in mothers & fathers of affected children

	BDI mean (SD)				BASS mean (SD)			
	T	Degree of	P<(2	T	Degree of	P<(2		
Fathers (n=19)	10.89 (8.67)	statistics	freedom	tailed	66.68 (10.62)	statistics	freedom	P<(2
Mothers (n=42)	15.07 (8.34)	-1.7	59	0.079	67.35 (13.70)	-0.189	59	0.8510

Table 2 — BDI scores in MR & ADHD parents

	BDI mean (SD)				BASS mean (SD)			
	T	Degree of	P<(2	T	Degree of	P<(2		
MR (n=15)	18.13 (10.88)	statistics	freedom	tailed	72.80 (13.64)	statistics	freedom	P<(2
ADHD (n=26)	12.80 (6.93)	1.91	39	0.063	68.73 (11.95)	0.99	39	0.32

More years of formal education or increased income didn't help to reduce perceived burden or depression (Table 3).

Among the three Coping subscales family coping scale helped to reduce both depression & perceived burden (Table 4).

DISCUSSION

Our first important finding was both mothers and fathers had depressive symptoms and they didn't differ in perceiving burden or using coping strategies in dealing

Table 3 — Correlation of BASS or BDI score with education and income

	R (pearson's correlation)	p
Education (in yrs) & BDI	-0.19	0.143
Education (in yrs) & BASS	-0.242	0.060
Income (per capita) & BDI	-0.164	0.207
Income (per capita) & BASS	-0.114	0.381

with the situation. The traditional role of mother is familiar, and the influence of maternal behavior on young children including the influence of children's behavior on mothers is well researched. Knowledge, however, of the comparable role of the father and paternal influences on children's development as well as the child's influence on fatherhood is relatively limited. Father's contributions are often forgotten in the research literature¹⁴ and particularly father's roles with children of abnormal development¹⁵. The very few studies that have included fathers have usually found normal depression scores or reduced symptoms of depression in fathers of children with disabilities than in mothers^{16,17}. Studies of parents with children with disabilities suggest that 35-53% of mothers with children with disabilities pass cut-off scores for depression^{16,18}. However, many of these studies rely on small samples which still make inferences about the prevalence of depression uncertain. Depending on how depression is defined and assessed, lifetime prevalence rates for diagnosable depressive disorders in large population studies range from 2.6% to 12.7% in men, and 7% to 21% in women. There have been a few studies demonstrating both similarities and differences in parenting stress reports between mothers and fathers of children with and without disabilities¹⁶. One robust and consistent finding among the literature has been that of differences between mothers and fathers of children with and without disabilities with respect to parent-related characteristics of parenting stress. Specifically, mothers reported more depression, restrictiveness in the parental role, more problems with their sense of competence, more difficulties with their relationship with their spouse, and more negative effects on their health. Fathers reported significantly more problems with attachment, which has been a fairly consistent finding in the literature^{19,20}. Among Indian studies G Venkatesh Kumar also found that gender of the parents didn't have any impact on psychological stress or coping score⁹.

Table 4 — Correlation of BASS or BDI score with different coping subscales

BDI & family coping	-0.424	0.001
BDI & support coping	-0.147	0.259
BDI & medical coping	-0.198	0.126
BASS & family coping	-0.352	0.005
BASS & support coping	-0.089	0.497
BASS & medical coping	-0.186	0.151

Our next important finding was parents of children with ADHD and that of MR didn't differ in terms of BDI and BASS score. AP Walker also found that parents of children with ADHD and developmental disabilities did not differ in their perceptions of stress related to the child; however, they did differ with respect to specific child characteristics as measured on the sub-scales of the child domain eg, Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability²¹.

Baker & McCal (1995) also discussed similar results in that parents of ADHD and learning disabled children²².

Another finding was more years of formal education or increased income didn't help to reduce perceived burden or depression in parents. This is in contrast with the finding of G Venkatesh Kumar who found that educational level had significant influence over psychological stress and coping; higher the educational level lesser was the psychological stress and higher coping strategies. Most of the mothers who were educated sought professional help for coping and were also able to provide appropriate and timely treatment for various problems of the child⁹. Like us A P Walker also found that socioeconomic condition was not associated with depression in fathers but lower income was associated with higher depressive symptoms in mothers²¹. McBride (1991) in his study of 54 fathers of pre-school children found the only consistent demographic variable related to paternal stress was family income. Fathers with greater family incomes reported feeling less restricted in their parental roles, more competent as parents, less isolated socially, as having better relationships with their spouses, and considered them to be in better health²³. Hornby (1994) in a study of fathers of school-aged children with Down syndrome found significant inverse relationships between fathers' level of stress and their educational level, as well as their perceived financial adequacy²⁴. Lavee *et al* (1996) looked at the effect children had on parental stress and the parents' marital quality. They found that the economic status of the parents added substantially to both mothers' and fathers' level of distress. Specifically, the lower the economic status the greater level of distress²⁵. Pittman *et al* (1989) demonstrated similar results when they found that lower income was associated with greater parenting difficulties²⁵.

Among the three Coping subscales family coping scale helped to reduce both depression and perceived burden. Greater marital quality predicted lower parenting stress for both mothers and fathers, while greater social support predicted increased parenting efficacy for fathers²⁷. M B Olson in 2001 noted that Single mothers with children with disabilities were more vulnerable to severe depression than mothers living with a partner, which supports the findings by Blacher & Lopez (1997)^{28,29}. This, along with the fact that poorer family functioning is associated with higher stress and depression in families with children with disabilities^{20,30}, supports the suggestion that support for marital and cohabitational relationships, and the prevention of domestic discord may be some of the best ways to promote parental mental health in families with children with disabilities^{31,32}. Gill and Harris (1991) measured the psychological distress of 60 mothers of children diagnosed with Autism to examine the effects of social support and

hardiness. Researchers found a significant negative correlation between mothers who perceived adequate available social support and depressive symptoms, indicating that those mothers who had the most perceived support had the fewest depressive symptoms³³. Jessica Jones et al in their study revealed that coping strategies involving the maintenance of family integration, co-operation and optimism were strongly associated with reduced stress relating to overall family cohesiveness, the parent's perceptions of reward or satisfaction in caring for their child, and their concerns regarding future care of their child and the possibility of institutionalization³⁴. Trute and Hauch (1988) found a strong correlation between family cohesion and coping strategies such that parents reporting active coping skills could discuss and debate alternative choices while maintaining a high commitment and responsibility to one another³⁵.

The main limitation of our study was we were able to include only two groups and there was no control group. We also failed to sub classify these two groups according to severity because of small sample size. We also failed to control the study population as far as medication was concerned because most of our ADHD and few of MR patients were on medication.

However it is evident that raising a child with mental health problem results in parental distress. Distress needs to be assessed by mental health professionals in order to comprehensively address needs of both the child with mental health problems and his or her parent. Furthermore, assessing the amount support available to a caregiver would provide the opportunity to discuss options for increasing supportive resources. Additional support might help to ameliorate the stressful effects of the child behavior problems and prevent a state of continuous distress for these parents³⁶.

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