INTERNATIONAL JOURNAL OF ADVANCE RESEARCH, IDEAS AND INNOVATIONS IN TECHNOLOGY

ISSN: 2454-132X
Impact Factor: 6.078

(Volume 8, Issue 5 - V8I5-1200)
Available online at: https://www.ijariit.com

Parental explanatory model and perceived burden of child and adolescent psychiatric disorder

Devaki B.
devaki.b@cmcvellore.ac.in
College of Nursing, Christian Medical College, Vellore, Tamil Nadu

Helen Sujatha Charles
helen@cmcvellore.ac.in
College of Nursing, Christian Medical College , Vellore, Tamil Nadu

Paul Russel
russell@cmcvellore.ac.in
College of Nursing, Christian Medical College , Vellore, Tamil Nadu

ABSTRACT

An observation study to assess the explanatory model and perceived burden of child and adolescent psychiatric disorders among the primary care givers. To assess the explanatory model and perceived burden of child and adolescent psychiatric disorder and to study the relationship between them. Observation design was used. Computerized simple random technique was used to recruit 200 subjects after consent. Short explanatory model interview (SEMI) was used to assess the explanatory model and the family intervention burden scale was used to rate the burden of primary care givers. Among 200 subjects, 53.5% and 50.5% have medical model and non medical model respectively. Among the medical model 46.5% have allopathic perspective and 54.5% have complementary and alternative medicine model. Mean burden of primary care giver was 18.86 with SD ±11.08. There is a significant relationship between explanatory model and perceived burden of primary care givers (P=0.025). Assessing and understanding the influence of explanatory model on burden helps in intervening with burden of the primary care givers. Education and support are an essential part of nursing care. It is an effective method for improving the knowledge as well as decreasing burden of child and adolescent psychiatric disorders among primary care givers and will help in increasing adherence to therapeutic regimen.

Keywords: *Belief, Perception, Child and Adolescent Psychiatry, Explanatory Model, Care Givers Burden*

1. INTRODUCTION

Assessing the explanatory model of care giver helps the health team improve the understanding of the care giver, and compliance with the treatment. It outlines the problems and circumstances of care giver thus helping the health team members to plan problem-based interventions. Further it helps in recognition of divergence of models between health team and care givers and to negotiate a treatment plan acceptable for both.

Explanatory models of illness contribute to patient satisfaction with treatment and relationships with health team members (McCabe & Priebe, 2004). Influencing the dynamics of explanatory model and perspectives of care may decrease the burden and problems of care givers. Nonmedical psychological interventions such as counseling, religion, help with social and occupational problems, social support, psychological help using a variety of 'native treatments has a powerful impact on illness awareness, course, treatment, and outcome.

About 90 % of the care givers are unaware of psychiatric disorders in children, this as a negative effect on health seeking behavior. They had a positive attitude towards the same when adequate information is given ("Health seeking behavior regarding psychiatric disorders in mothers of children of an urban slum," 2004.).

Environmental risk factors such as lack of services and negative attitudes can also have an adverse influence on the prognosis of the child with disability. Negative attitude and burden significantly changes with the social adjustment of the parents (Ravindranadan & Raju, 2007). It is also found that the parents of children with disabilities perceive more problems in themselves and their family (Chandorkar & Chakraborty, 2000).

Assessing the explanatory model of care giver helps the nurse improve the understanding of the care giver, and compliance with the treatment. It outlines the problems and circumstance of them helping the health team members to plan problem-based intervention. Assists in recognition of divergence of models between nurse and care givers necessarily imply to negotiate a treatment plan acceptable for both.

Explanatory models of illness contribute to patient satisfaction with treatment and relationships with health team members(McCabe & Priebe, 2004). Influencing the dynamic explanatory model and perspectives of care will significantly decrease the burden and problems of care givers. Non medical psychological intervention such as counseling, religion, help with social and occupational problems, social support, psychological help using a variety of 'native treatments has a powerful impact on illness awareness, course, treatment and outcome.

Susan (1986) emphasized "that nurses are in a position to correct public misconception about people who are mentally handicapped. They can work to gain greater acceptance of individuals who are mentally handicapped, in whatever setting they reside". The nurse can be instrumental in promoting a positive attitude toward the mentally handicapped among care givers and the public which in turn change the view of society. The nurse will be able to understand and help parent to overcome their perceived burden.

2. OBJECTIVES

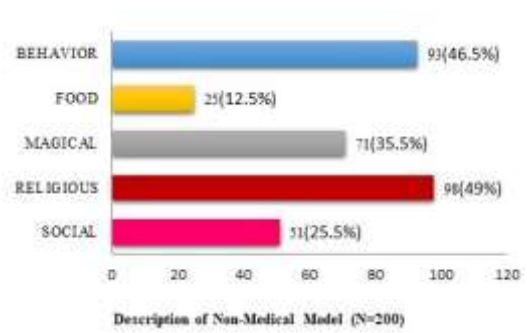
- To assess the beliefs of the primary care givers on child and adolescent psychiatric disorders using the explanatory model.
- To assess the perceived burden of child and adolescent psychiatric disorder among the primary care givers.
- To identify the relationship between the parental explanatory model and perceived burden among the primary care givers of children affected with child and adolescent psychiatric disorders
- To identify the association between explanatory model and selected demographic and clinical variables.

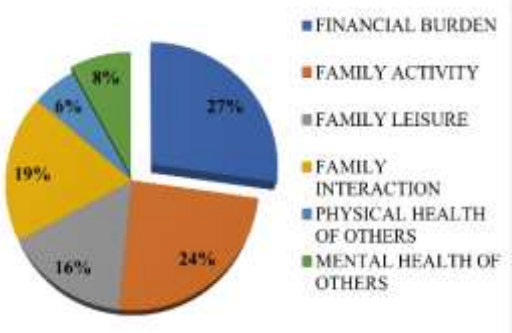
3. METHODOLOGY

A descriptive study design was used to document the parental explanatory model and perceived burden of Child and Adolescent psychiatric disorders among primary care givers. This study was conducted in, child and adolescent psychiatric (CAP) unit in a tertiary mental health center located in South India. Children who fulfilled the inclusion criteria were identified from the data base. The investigator then explained about the study and its implication those the parents of the identified children. Parents who consented were recruited for the study. Using computerized random sampling technique, 200 parents were chosen and interviewed based a standardized interview tool. The instruments used to collect data are short explanatory model interview (SEMI- Jacob et.al. 1998) and The Family Burden Interview schedule, which is a self-rated Likert Scale. (Pai and Kapur, 1981). The qualitative data generated by SEMI was quantifies using numeric codes. These data were analyzed using descriptive and inferential statistics.

4. RESULTS

- 50.5% of the participants were from a rural setting.
- Majority of the participant's children were males and were diagnosed with Emotional and Behavioral disorders and were between the ages of 13 & 19 years.
- The study revealed that 53.5% of the primary care givers believe in medical model for child and adolescent psychiatric disorders and 50.5% of them believe in nonmedical model. The overlap of beilef among the primary care giver is the reason for the total being more than 100%.
- Among the medical model 54.5% of the participants believed in complementary and alternative medicine such as ayruveda, unani, siddha, homeopathy, yoga, physiotherapy, occupation therapy and meditation.
- The nonmedical perspectives of the primary care givers included behavior, food, magic, religion, and social aspects. It was found that 49% of the participants expressed that the disorder is caused by god's punishment and karma.
- The mean burden among the primary care givers of children with child and adolescent psychiatric disorder was found to be 18.86 with SD ±11.08. Out of the many contributing factors assessed 27% of the primary care givers expressed Finance to be the highest perceived burden.
- Participants believing in medical model showed 4 times less burden as compared with those who believed in non-medical model which was statistically significant. (p=0.0512).
- Among the participants, those who believed in complementary and alternative medicine showed 5 times less burden compared with others. (p=0.0014)
- Female primary care givers were found to have 5 times more burden than male (P=0.0142)
- Care givers of female children believed twice more on nonmedical model as those caring for adolescents.





5. DISCUSSION

Many people in India continue to hold on to magical and religious beliefs as an explanation for mental illness. The religious belief changes their attitude towards the illness (Ravindranadan & Raju, 2007). A farmer expressed that his deeds are assessed by God and he gives life according to the karma, even treatment is possible only if God is willing to help through doctors and nurses. Daley et.al, 2002, strongly suggest that psychiatrists should have culture-bound treatment strategies but make religion as an independent component in the care of patients (Daley, 2002; Kendler, 2008). According to Huguelet, Mohr, Gilliéron, Brandt, & Borras, the magical or religious belief regarding mental illness can change in a long run according to their experiences with illness. To this day, magician seem to dominate the belief system of the parents. One of the children was brought to the mental health center, after a magician directed them. He used beetle leaves and kajal for guide them to this center for treatment and cure of their sick child. This gives evidence that irrespective of education, locality, diagnosis, and treatment regimen people hold a magical explanation for all problems and treatment.

The highest burden among the care givers was financial crisis. A lecturer said, "In spite of my financial crisis, I am unable to go for job because of my disabled child, and I am always in tears when I think of the child's future." One fourth of primary care givers find it difficult to perform household duties. A housewife from a joint family expressed that she is unable to contribute or help in any family activity which was causing a lot of problem within the family members. This findings is supported by a study conducted regarding burden among the care givers of intellectually disabled children reports 87% of financial burden, 72% of family interaction, and 69% of physical health of the member (Datta, Russell, & Gopalakrishna, 2002).

Primary care givers believing complementary and alternative medicines have 5 units less burden score ($p=0.0014$) than other perspectives of child and adolescent psychiatric disorder. This can be due to availability of native medicine, increased trust, and familiarity with practitioners as they are one among them in the community and treatment strategies are basically symptomatic.

It is interesting to know that the association between nonmedical models and perceived burden. Subjects with religious perspectives such as God's punishment, karma etc have nearly 5 units more burden than all other models. This is due to culture and societal norms in the community and the belief that God has ultimate power over all the action and counter action of everyone. Majority believe nothing happens without his knowledge.

6. CONCLUSION

It is well understood and documented that, interventions to change the explanatory model and to decrease the burden of child and adolescent psychiatric disorders among the primary care givers needs a multi-disciplinary approach. Since nurses are the major part takers of this multidisciplinary approach, it implies the need for specialized training of nurses in this area also. Nurse administrators should encourage their staff and students to be sensitive to the care givers perspectives of illness and prepare the nurses working in the mental health services and community to educate the public about the biomedical model of illness and to remove myths prevailing in the society. Also provide interventions to decrease their burden.

7. REFERENCES

[1] Baca-Garcia, E., Perez-Rodriguez, M. M., Basurte-Villamor, I., Quintero-Gutierrez, F. J., Sevilla-Vicente, J., Martinez-Vigo, M., Artes-Rodriguez, A., et al. (2008). Patterns of mental health service utilization in a general hospital and outpatient mental health facilities: analysis of 365,262 psychiatric consultations. European Archives of Psychiatry and Clinical Neuroscience, 258(2), 117–123. doi:10.1007/s00406-007-0763-x

[2] Chandorkar, H., & Chakraborty, P. K. (2000). PSYCHOLOGICAL MORBIDITY OF PARENTS OF MENTALLY RETARDED CHILDREN. Indian J Psychiatry, 42(3), 271–274.

[3] Daley, T. C. (2002). The need for cross-cultural research on the pervasive developmental disorders. Transcultural psychiatry, 39(4), 531.

[4] Datta, S. S., Russell, P. S. S., & Gopalakrishna, S. C. (2002). Burden among the Caregivers of Children with Intellectual Disability. Journal of Intellectual Disabilities, 6(4), 337 –350. doi:10.1177/146900470200600401

[5] Halliburton, M. (2004). Finding a fit: psychiatric pluralism in south India and its implications for WHO studies of mental disorder. Transcultural Psychiatry, 41(1), 80–98.

[6] Health seeking behavior regarding psychiatric disorders in mothers of children of an urban slum. (n.d.). Retrieved from http://medind.nic.in/ibl/t04/i3/iblt04i3p121g.pdf

[7] Huguelet, P., Mohr, S., Gilliéron, C., Brandt, P.-Y., & Borras, L. (2010). Religious explanatory models in patients with psychosis: a three-year follow-up study. Psychopathology, 43(4), 230–239. doi:10.1159/000313521

[8] Jacob, Ks. (2010). The assessment of insight across cultures. Indian Journal of Psychiatry, 52, 373. doi:10.4103/0019-5545.74316

[9] Jacob, KS. (2002). Mental disorders and systems of medicine. Indian journal of psychiatry, 44(4), 397.

[10] Kendler, K. S. (2008). Explanatory Models for Psychiatric Illness. Am J Psychiatry, 165(6), 695–702. doi: 10.1176/appi.ajp.2008.07071061

[11] Lehmkuhl, G., Köster, I., & Schubert, I. (2009). [Outpatient care for child and adolescent psychiatric disorders--data from an insuree-related epidemiological study]. Praxis Der Kinderpsychologie Und Kinderpsychiatrie, 58(3), 170–185.

[12] Liu, M., Lambert, C. E., & Lambert, V. A. (2007). Caregiver burden and coping patterns of Chinese parents of a child with a mental illness. International Journal of Mental Health Nursing, 16(2), 86–95. doi:10.1111/j.1447-0349.2007.00451.x

[13] Lloyd, K. R., Jacob, K. S., Patel, V., St Louis, L., Bhugra, D., & Mann, A. H. (1998). The development of the Short Explanatory Model Interview (SEMI) and its use among primary-care attenders with common mental disorders. Psychological Medicine, 28(5), 1231–1237.

[14] Majumdar, M., Da Silva Pereira, Y., & Fernandes, J. (2005). Stress and anxiety in parents of mentally retarded children. Indian Journal of Psychiatry, 47, 144. doi:10.4103/0019-5545.55937
[15] McCabe, R., & Priebe, S. (2004). Explanatory models of illness in schizophrenia: comparison of four ethnic groups. The British Journal of Psychiatry, 185(1), 25 –30. doi:10.1192/bjp.185.1.25
[16] Padencheri, S., & Russell, P. S. S. (2002). Challenging Behaviours among Children with Intellectual Disability. Journal of Intellectual Disabilities, 6(3), 253–261. doi:10.1177/1469004702006003035
[17] Ravindranadan, V., & Raju, S. (2007). Adjustment and attitude of parents of children with mental retardation. Journal of the Indian Academy of Applied Psychology, 33(1), 137–141.
[18] Religion, Spirituality, and Mental Health - Psychiatric Times. (2010, January 10). Retrieved from http://www.psychiatrictimes.com/display/article/10168/1508320
[19] Robinson, K., & Yates, K. (1994). Effects of two caregiver-training programs on burden and attitude toward help* 1. Archives of Psychiatric Nursing, 8(5), 312–319.
[20] Saravanan, B., Jacob, K. S., Johnson, S., Prince, M., Bhugra, D., & David, A. S. (2007). Belief models in first episode schizophrenia in South India. Social Psychiatry and Psychiatric Epidemiology, 42, 446–451. doi:10.1007/s00127-007-0186-z
[21] Shyu, Y.-I. L., Tsai, J.-L., & Tsai, W.-C. (2010). Explaining and selecting treatments for autism: parental explanatory models in Taiwan. Journal of Autism and Developmental Disorders, 40(11), 1323–1331. doi:10.1007/s10803-010-0991-1
[22] SK Nambi, N., J, P., D, S., V, A., A, K., & KS, J. (2002). Explanatory models and common mental disorders among patients with unexplained somatic symptoms attending a primary care facility in Tamil Nadu. The National medical journal of India, 15(6), 331.
[23] Somasundaram, O. (2002). Psychiatric thoughts in the Tamil culture. Indian Journal of Psychiatry, 44(2), 165–169.
[24] Thabet, A. A., El Gammal, H., & Vostanis, P. (2006). Palestinian mothers' perceptions of child mental health problems and services. World Psychiatry, 5(2), 108–112.
[25] Upadhyaya, G., & Havalappanavar, N. (2008). Stress in Parents of the Mentally Challenged. Journal of the Indian Academy of Applied Psychology, 34, 53–59.
[26] Wasserman, S., Weisman de Mamani, A., & Mundy, P. (2010). Parents' criticisms and attributions about their adult children with high functioning autism or schizophrenia. Autism: The International Journal of Research and Practice, 14(2), 127–137. doi:10.1177/1362361309354757

