Parenting Stress Index among Mothers of Conduct Disorder Children

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Abstract:

The objective is to study the parenting stress among mothers of children with conduct disorder and to highlight the possible risk factors attributed to the co-occurring stress. A case control study was conducted on 30 mothers of conduct children and a matched control group. Both groups underwent the following: semi-structured clinical interview and parenting stress index. Conduct children were diagnosed according to the ICD-10 and underwent the following: semi-structured clinical interview and a revised-behavior problem checklist. Mothers of conduct children experienced a significantly higher parenting stress score than the control and international scores, including total, parent and child domains scores. The maternal distress is experienced in all dimensions of the parent's functioning including parent's sense of competence, restriction of role, social isolation, and parental attachment relationship with spouse, parental health and parent depression and the distress is also predicted by the presence of inattention, hyperactivity, psychotic behavior, anxiety withdrawal, duration of the illness, delay to start treatment, age of the child and mother's education.

Introduction:

Conduct disorder (CD), as defined in the DSM-IV, is characterized by a pervasive and persistent pattern of aggressive, deceptive and destructive behavior that usually begins in childhood or adolescence. CD symptoms are the primary presenting problems for psychiatric referral among children and adolescents in the US, and youth diagnosed with CD report higher levels of distress and impairment in almost all domains of living compared with youth with other mental disorders. Moreover, prior prospective studies have shown that conduct problems during childhood or adolescence are associated with significantly increased risk of other mental disorders, legal problems, and premature mortality ***(Nock et al. 2006).***

Several prior studies have used DSM-IV criteria to evaluate the prevalence of CD in other countries or in selective samples within the US, but these data are of limited use in estimating the prevalence of CD in the general US population. Based on these prior studies, the lifetime prevalence of CD has been estimated at between 6% and 16% for males and 2% and 9% for females in the US. However, in addition to limitations in the sampling procedures used, these estimates are based on DSM-III and DSM-III-R criteria. Given that even minor changes in the diagnostic criteria of CD have been shown to result in major differences in prevalence, these estimates are unlikely to represent the prevalence of DSM-IV CD accurately ***(Maughan et al. 2004).***

Examination of the collaboration of personal, family, components provides information on the complex of CD as well as an avenue for providing interventions. Personal characteristics and features, such as irritability, aggressiveness, and cognitive difficulties, are crucial for identifying

markers for the onset of antisocial behavior. The perpetuation of these characteristics is mitigated by experiences with parents. Each of these components can intensify or minimize the extent to which antisocial behaviors are developed. Parent and family effects can range from familial stress to member criminality or psychopathology to discipline practices. Additionally, the quality of parent-child interactions can create, inadvertently encourage, or negate antisocial behavior. This is often a common area of change employed in interventions and a primary area of prevention ***(Jimerson et al.2002)***.

ADHD when becomes comorbid with conduct disorder in children is commonly associated with disturbances in family and marital functioning, disrupted parent-child relationships and increased level of parenting stress and parental psychopathology ***(Johnston and March, 2001).***

Researchers studying the impact of raising a child with disruptive behavior on parents have emphasized that increased caretaking demands exist for parents throughout childhood and adolescence that could have adverse impact on parents with increased parenting related stress that they will experience. Some of these studies were done on parents of ADHD children showing more parenting related stress than other parents ***(Biederman, 2003).***

A study compared the levels of perceived stress on several dimensions of parenting in mothers and fathers of conduct disorder, autistic, Down syndrome, and normal children. Results showed that mothers and fathers report very similar levels of stress when parenting exceptional children, although their patterns of stress change as a function of the child's difficulties. Parents of conduct disorder children are most stressed, closely followed by parents of autistic children, while parents of Down syndrome children closely resemble and, in some respects, appear less stressed than parents of normal children ***(Noh et al. 1989)***.

The aim of this work is to study the parenting stress among mothers of Conduct disorder children, to highlight the possible risk factors attributed to the co-occurring stress.

Subjects and methods:

This case control study was done on 15 mothers of conduct disorder children who were diagnosed according to the ICD-10 diagnostic criteria. They were recruited from the Child Psychiatry Clinic, Institute of Psychiatry, Ain Shams University. The control group is the hospital workers mothers of healthy children matched for age, sex, and socioeconomic status with mother of conduct disorder children.

Both Conduct disordered children and healthy children were subjected to the following:

1) Semi-structured psychiatric interview according to ICD-10:

The patients were interviewed guided by a psychiatric history-taking sheet designed at the Institute of Psychiatry, Ain Shams University. It includes detailed personal, family, medical and past history records.

2) Revised Behavior Problem Checklist (R-BPC) (Quay and Peterson 1987):

This questionnaire was translated to Arabic by ***Abou EL Ela, et al., 1998***. The questionnaire was applied to the mother of every child to answer all the items. The number of the items is 99. The questions consist of groups which are finally collected

to give a score for a specific behavior. The scales are:

i) Conduct disorder scale concerned with the misconduct of the child.

ii) Socialized aggression scale concerned with group aggressive behavior of the child.

iii) Anxiety withdrawal scale concerned with anxious mood and withdrawal reaction of the child.

iv) Attention scale concerned with the inattention and distractibility of the child.

v) Motor excess scale concerned with the hyperkinetic behavior of the child.

vi) Psychotic behavior scale concerned with the bizarre and psychotic behavior.

The mothers of both the Conduct disordered and healthy children were subjected to the followings:

1) Semi-structured psychiatric interview:

It was designed at the Institute of Psychiatry, Ain Shams University; it includes detailed personal, family and medical information.

2) Parenting stress index (PSI):

Parenting stress index was constructed in 1976. It is a screening and diagnostic assessment technique designed to yield a measure of the relative magnitude of stress in the parent child system ***(Abidin, 1990).*** This revised form is subdivided into child domain comparing 47 items constituting 6 subscales, parent domain comparing 54 items constituting 7 subscales, and 19 items constituting the optional life stress scale.

The test includes the following subscales:

I- Child Domain Subscales:

i) Adaptability:

It addresses the issue of how well a child handles change and transitions. High score makes mothering task more difficult by virtue of the child's inability to adjust in his or her physical or social environment.

ii) Acceptability of the child by parent:

This variable addresses the issue of how close the child is to the parents' idealized or hoped for the child. High score means the child possesses physical, intellectual and emotional characteristics which do not match the parents' hope for the child.

iii) Child demandingness:

This refers to the direct pressure the child places on the parent. High scores are produced when the parent experiences the child as placing many demands upon him or her.

iv) Child mood:

Child characteristic stresses associated with mood are primarily related to excessive crying, withdrawal and depression. High scores are associated with children whose affective functioning shows evidence of dysfunction.

v) Child distractibility/hyperactivity:

This indicates that child distractibility and hyperactivity stresses result in a continuous drain on the parents' energy requiring not only active parental management but sustained high states of vigilance.

vi) Child reinforces parent:

It represents the degree to which the parent child interaction results in a positive affective response in the parents. Parents who earn high scores on this subscale do not experience the child as a source of positive reinforcement. Child characteristic domain score as a sum of the previously mentioned 6 subscales is also considered.

High scores = 122 or above are associated with children who display qualities that make it difficult for parents to fulfill the parenting process.

II- Parent Domain Subscales:

i) Parent depression:

It assesses the extent to which the parents' emotional availability to the child is impaired and the extent to which the parents' emotional and physical energy is compromised. The scale also captures to some degree the punishing impact of guilt upon the parent.

ii) Parent attachment:

This scale was designed to assess the intrinsic investment the parent has in the role of parent.

iii) Restriction of role:

It addresses the impact of parenthood on the parents' personal freedom and other life roles. The scale assesses primarily the negative impact, losses, and sense of resentment associated with the parents' perceptions of loss of important life roles.

iv) Parent sense of competence:

This subscale is related to depression subscale, in assessing the extent to which the parents' emotional availability to the child is impaired.

v) Social isolation:

Parents who earn high scores in this subscale are under considerable stress and it is necessary to establish an intervention program as soon as possible.

vi) Relationship with spouse:

Parents who earn high scores on this subscale are those who are lacking the emotional and active support of the other parent in the area of child management.

vii) Parental Health:

This is suggestive of deterioration in parental health which may be either the result of parenting stress or may be an additional independent stress in the parent child system.

The parent domain score as a sum of the previously mentioned 7 subscales is also considered. High score: = 153 or above suggests that the sources of stress and potential dysfunction of the parent - child system may be related to dimensions of the parent functioning.

III- Life Stress Optional Scale:

Parents who earn raw scores of 17 or above find themselves in stressful situational circumstances, which they consider beyond their control. In effects, high life stress scores tend to intensify the total stress the parent is experiencing.

Statistical Analysis:

Qualitative variables were described in number and percentages and mean ± standard deviation (SD) if quantitative. Student t and ANOVA tests were used when comparing quantitative data between 2 or more than 2 groups respectively. Pearson correlation coefficient was used as an indicator of correlation between 2 quantitative variables. P value was always set at 0.05. All data manipulation and statistical analyses were performed using SPSS (Statistical Package for Social Sciences) version 11.

Results:

Thirty children fulfilling criteria for conduct disorder according to DSM IV with

there biological mothers were enrolled into the study.

Table (1) describes their main sociodemographic characteristics.

40% of the children were younger than 10 years and 60% older than 10 years. Nearly two thirds of the mothers (64.3%) were younger than 35 years and either illiterate or have a low level of education. Only 4 mothers (14%) were working for cash. Regarding fathers' age (53.3%) was older than 40 years. the total number of sibs in the family did not exceed 4 in (73.3%) of the sample.

Table (3) presents the correlation between the (R-BPC) items and PSI main domains and subscales and life stress index. Only 2 items on R-BPC correlated positively and significantly with the parent domain of PSI namely conduct scale which correlated with social isolation ($r=0.531$, $P<0.05$) and anxiety withdrawal which correlated with depression ($r=0.609$, $P<0.05$). Regarding correlation with the child's domain on the PSI, conduct scale and psychotic behavior as well as motor excess all correlated positively and significantly with distractibility ($r= 0.707, 0.607, 0.576$ respectively $P<0.05$) and acceptability ($r= 0.513, 0.610, 0.530$ respectively $P<0.05$). Attention problem with adaptability and mood ($r= 0.630, 0.605$ respectively $P<0.05$), anxiety withdrawal with demandingness ($r= 0.568$ $P<0.05$). The total child domain scores correlated positively and significantly with conduct scale (0.691, $P<0.05$), attention problem (0.581, $P<0.05$), psychotic behavior (0.723, $P<0.05$) as well as motor excess (0.601, $P<0.05$).

As shown in table (4) demandingness on the child domain correlated positively and significantly with all the parent domain scales except social isolation and relation to spouse. Acceptability correlated in the same way with parental attachment, restricted roles, depression and sense of competence. Both adaptability and reinforcement correlated positively and significantly with parental attachment and restricted roles. Mood on the other hand correlated similarly with parental attachment and restricted roles and with health in addition. Distractibility did not correlate with any of the parent subscales. It is worth noting that demandingness, mood and acceptability all correlated positively ands significantly with total parent score.

It was found that the higher the score in the parent domain the younger the age of the child at onset of treatment ($r= -0.595$, $P<0.05$). Health subscale was the most responsible ($r= -0.59$, $P<0.05$). It is worth mentioning that within the parent domain subscales, social isolation correlated positively and significantly with duration of illness ($r= 0.636$, $P<0.05$) and that relation to spouse correlated negatively and significantly with duration of treatment ($r= -0.590$, $P<0.05$).

Regarding total child domain scores, it was found that the higher the scores, the younger the age of the mother ($r= -0.562$, $P<0.05$) and the earlier the age of marriage ($r= -0.577$, $P<0.05$)

Individual child domain subscales summarized in table (5) showed:

Reinforcement correlated positively and significantly with age of the child and age in the study and his age at onset of treatment and negatively and very significantly with age of father and age of mother.

Demandingness correlated negatively and significantly with age of mother at marriage.

Adaptability correlated negatively and very significantly with age of mother in the study and at marriage.

Distractibility correlated positively and significantly with duration of illness and duration of treatment On the other hand life stress subscale correlated negatively and significantly with each of age of the child (r= -0.727, P<0.05), age of mother (r= -0.571, P<0.05), age of onset of illness (r=-0.505, P<0.05), age of child at onset of treatment (r= -0.674, P<0.05) and number of sibs (r= -0.490, P<0.01)

Table (1): Child and Parents Characteristics of the Studied Sample

Characteristics	Number (%)
Child's Age	
- <10	12 (40.0)
- 10+	18 (60.0)
Mother's Age	
- < 35 years	18 (64.3)
- 35+	10 (35.7)
Father's Age	
- <40 years	14 (46.7)
- 40+	16 (53.3)
Education of the Mother	
- Illiterate	12 (42.9)
- Prim/Prep	6 (21.4)
- Secondary	4 (14.3)
- High education	6 (21.4)
Working Mothers	4 (14.3)
Number of sibs	
- < 4	22 (73.3)
- 4+	8 (26.7)
Age of Mother at Marriage	
- <= 18 years	14 (50.0)
- >18	14 (50.0)

As shown in table (2), mean age of onset was 6.8 ± 3.5SD, mean duration of illness 2.5 ± 1.8SD, mean age at start of treatment 8.5±4.2, with a mean of 2.0 years' delay ±1.8SD.

Table (2): Conduct Disorder History of Illness

Characteristics	Number (%)
Age of Onset	
=< 4 years	4 (13.3)
4 –5	4 (13.3)
5 +	22 (73.3)
Mean±SD	6.8±3.5
Duration of Illness	
Mean±SD	2.7±1.8
Age at start of Treatment	
Mean±SD	8.5±4.2
Delay from onset to treatment	
- At Onset	4 (13.3)
- =< 1 year----	12 (40.0)
- > 1 yr ---	4 (13.3)
- 3 years---	6 (20.0)
- 5 years+	4 (13.3)
Mean±SD	2.0±1.8

Figure (1) shows the percentages of behavioral problems according to revised behavior problem checklist (R-BPC). Socialized aggression was the most frequently met (60%) followed by conduct scale (53.3%). On the other hand, anxiety withdrawal was the least frequently met (13.3%).

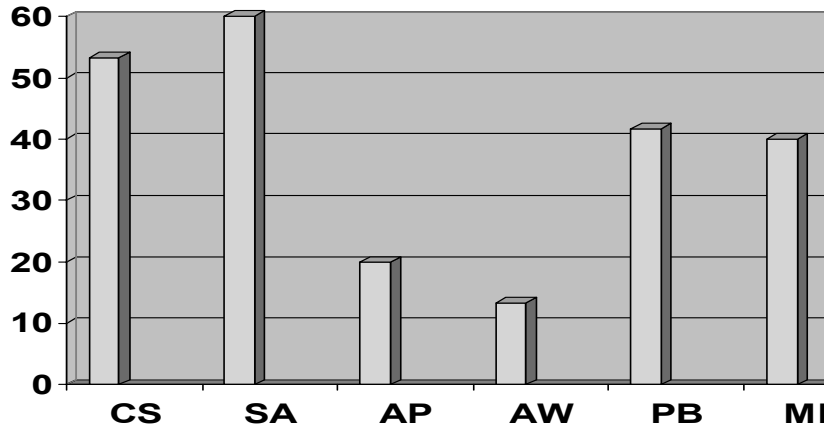
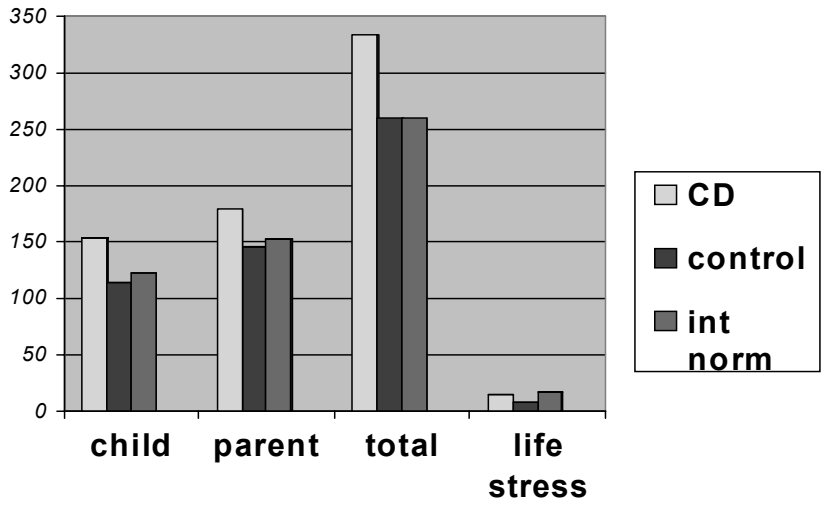
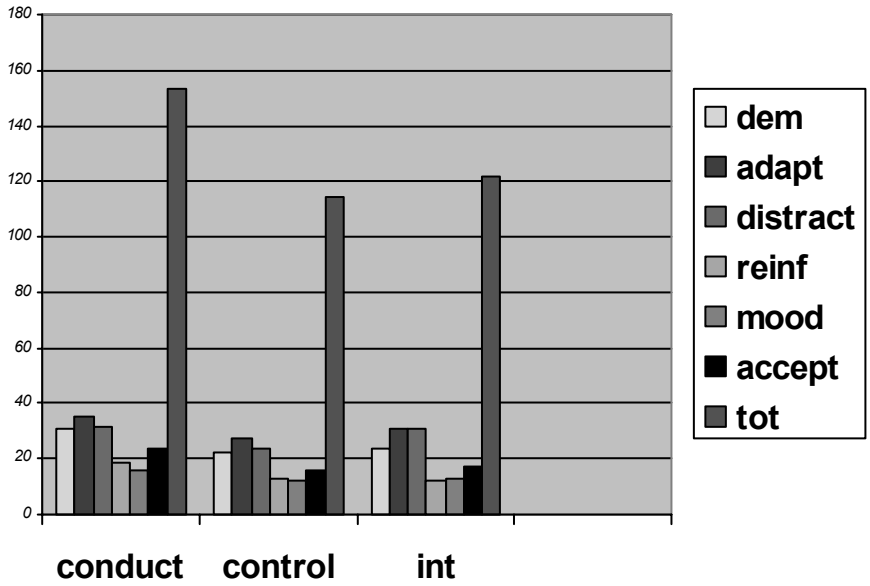


Fig. (1): CS= conduct scale, SA= social aggression, AP= attention problem, AW= anxiety withdrawal, PB= psychotic behavior, ME= motor excess

Figure (2) shows child, parent and total Parental Stress Index (PSI) scores in mothers of patients with conduct disorder in comparison with control group and international norms. In the total PSI scores, the conduct disorder group reported higher scores than the control group and the international norms while the median life stress score was higher internationally (17) than both CD (14.9) and control groups (7.7)



As shown in Figure (3) in all subscales of the child domain, CD group median values exceeded both the control group and the international norms



Regarding median parent domain subscales in the same sample, results are illustrated in figure (4)

For the parent domain subscales median scores were again higher than those of the control group as well as for the international norms.

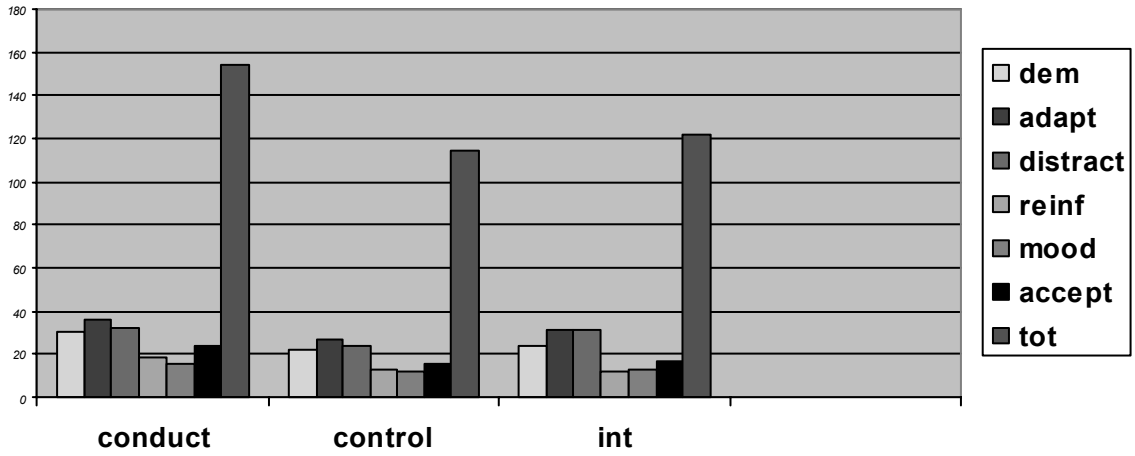


Table (3) Correlation of (R-BPC) with PSI parents and child domains in CD patients:

Parenting Stress Domain Subscales	**CBCL Items**					
	CS	**SA**	**AP**	**AW**	**PB**	**ME**
Parents Domain Subscales						
Health	0.191	-0.176	0.174	0.223	-0.031	0.245
Social Isolation	0.531*	0.445	0.109	0.399	0.249	0.100
Parental Attachment	0.097	-0.001	0.416	0.292	0.305	0.308
Restricted roles	0.463	-0.047	0.326	0.137	0.051	0.084
Depression	0.255	0.047	0.395	0.609*	0.227	0.141
Sense of Competence	0.297	0.466	-0.004	0.407	0.241	0.371
Relation to Spouse	0.103	0.008	-0.025	0.371	-0.142	0.447
Total Parent	0.303	0.086	0.182	0.362	0.242	0.404

Table (3) continue:

Parenting Stress Domain Subscales	CBCL Items					
	CS	SA	AP	AW	PB	ME
Child Domain Subscales						
Demandingless	0.469	0.157	0.486	0.568*	0.280	0.157
Adaptability	0.317	0.020	0.630*	0.109	0.567	0.337
Distractability	0.707*	0.095	0.402	-0.027	0.607*	0.576*
Child reinforces parents	0.340	0.506	0.265	0.267	0.079	-0.139
Mood	0.427	-0.164	0.605*	0.225	0.554	0.426
Acceptability	0.513*	0.243	0.383	0.150	0.610*	0.530*
Total Child	0.691*	0.262	0.581*	0.303	0.723*	0.601*
Life Stress Score	-0.120	-0.309	-0.078	-0.197	0.172	0.251

CD=Conduct Disorder, SA=Social Aggression, AP=Attention Problem, AW=Anxiety Withdrawal, PB=Psychotic Behavior, ME=Motor Excess (*P<0.05)

Table (4): Correlation of PSI parent's domain subscales child domain subscales

Parent Domain Subscales	Child Domain Subscales					
	Dem.	Adapt.	Distrac.	Reinf.	Mood	Accept.
Health	0.702*	0.416	0.205	0.213	0.641*	0.338
Social Isolation	0.472	0.044	0.404	0.434	0.281	0.488
Parental Attachment	0.639*	0.748*	0.259	0.521*	0.569*	0.575*
Restricted roles	0.632*	0.535*	0.429	0.529*	0.582*	0.605*
Depression	0.533*	0.354	0.279	0.349	0.497	0.611*
Sense of Competence	0.658*	0.367	0.339	0.431	0.384	0.578*
Relation to Spouses	0.512	0.204	0.108	0.033	0.448	0.469
Total parent	0.748*	0.509	0.413	0.321	0.609*	0.639*
Life Stress	0.054	0.119	0.135	-0.386	0.108	-0.052

Dem.=Demandingness, Adapt.=Adaptability, Distrac.=Distractability, Reinf.=Reinforcement, Accept.=Acceptability. (*P<0.05)

Table (5): Correlation of PSI Child Domain Subscales with different socio-demographic history of illness variables

	Child Domain					
	Dem.	Adap.	Dist.	Reinf.	Mood	Accep.
Age of Child	-0.106	-0.249	-0.115	0.575*	-0.329	-0.003
Age of Onset	-0.184	-0.239	-0.353	0.396	-0.391	-0.101
Age of Father	-0.306	-0.156	-0.238	-0.447 º	0.053	-0.030
Age of Mother	-0.446	-0.463 º	-0.533*	-0.184	-0.433	-0.294
Age of Mother at Marriage	-0.564*	-0.472 º	-0.279	-0.492 º	-0.250	-0.213
Number of Sibs	-0.090	-0.230	-0.146	0.025	-0.143	0.000
Duration of Illness	0.218	0.102	0.507*	0.177	0.268	0.243
Age of Child on Treatment	-0.512	-0.219	-0.191	0.575*	-0.476	-0.074
Onset to Treatment Duration	-0.181	0.184	0.495 º	0.021	0.190	0.085

* P=<0.05 (Statistically Significant) º P=<0.10

Discussion:

Understanding the genetic basis for behavior has fascinated the field of psychiatry for the past two decades. However, in this decade, it is again becoming apparent that understanding salient social environments, particularly early adverse caregiver/offspring relationships, is also necessary to the understanding of psychiatric disorders.

Childhood conduct disorder is a top mental health priority (Bethesda, 1998). Evidence from prospective longitudinal data shows that childhood conduct disorder precedes a variety of major axis I psychiatric disorders (Kim-Cohen 2003), suggesting that treating conduct disorder might significantly reduce the burden of adult mental disorder.

According to research cited in Phelps & McClintock (1994), 6% of children in the United States may have conduct disorder. The incidence of the disorder is thought to vary demographically, with some areas being worse than others. For example, in a New York sample, 12% had moderate level conduct disorder and 4% had severe conduct disorder. Since prevalence estimates are based primarily upon referral rates, and since many children and adolescents are never referred for mental health services, the actual incidences may well be higher (Phelps & McClintock, 1994).

Children who exhibit these behaviors should receive a comprehensive evaluation. Many children with a conduct disorder may

have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

High levels of stress and emotional maladjustment are associated with being the parent of a child with a disruptive behavior disorder (Shaw, Winslow, Owens & Hood, 1998). Contextual stressors such as single parenthood (Webster-Stratton, 1985), financial insufficiency, marital conflict and intrapersonal stressors such as anxiety and depression, add to the hardships of rearing a child with behavioral problems. Stress affects parental emotions and behavior, disrupting parent-child interaction and affecting parental perceptions of child behavior (Webster-Stratton, 1990).

Did parents of conduct children manifested any form of stress related to their child's condition? That was the question addressed to be answered by this study. The majority of study children (60%) were above 10 years old and (40%) were below 10 years with mean age of onset 6.8 years and an average of 2 years delay from onset of symptoms till onset of treatment. These results are in agreement with most of the national and international studies (Sayed et al 2005 & Maughan et al 2004).

The prolonged delay in seeking treatment from the onset of symptoms may be attributed to different factors. To start with, parents in Egypt are able to tolerate the child's behavior and usually they consider the symptoms of conduct in their child as a sign of being an active and a smart child. Secondly, parents are always reluctant to seek psychiatric advice for their children because of the stigma of both mental illness and psychiatric treatment. The present results revealed that the majority of conduct children (60%) presented with socialized aggression, followed by conduct scale (53.3%). These findings were consistent with most of the studies, which detected similar frequencies (Conner et al 2006).

Assessment of conduct children's mothers revealed that the majority (about two thirds) were younger than 35 years old, either illiterate or have low level of education, housewives and total number of sibs in the family didn't exceed 4 in (73.3%) of the sample taken. The central finding of the present study is that mothers of conduct children experienced a significantly higher parenting stress more than both control group and international scores, this included the total score and both the child and parents domains. In addition, mothers of conduct children showed higher life stress score than the control group, while the life stress score was higher internationally. These findings are supported by Shaw et al 1998, who mentioned that parents of children with conduct experienced more parenting stress than parents of other children.

Moreover, this study revealed that in all subscales of child domain, the scores of mothers of conduct group exceeded both the mother of the control and international scores. These subscales include the adaptability, acceptability of the child to parent, child demandingness, child mood, child distractibility/hyperactivity, and child

reinforces parent. This means that conduct children display qualities that make it difficult for parents to fulfill the parenting process and have negative impact on parents and with increasing parenting related stress (Shaw et al 1998, Routh et al 1995).

In addition, studying the parent domain subscales revealed that mothers of conduct group exceeded the control group in all subscales. These subscales include parent depression, parent attachment, restriction of role, parent sense of competence, social isolation, relationship with spouse and parental health. The high scores suggest that the sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent's functioning, Wahler and Dumas (1989) have reported that the presence of stressors is associated with diminished parental attention to the child. Stress also leads to disruption of effective monitoring which is thought to be important in the prevention of problem behavior (Dishion & McMahon, 1998).

It is worth mentioning that the scores are even higher on the parent domain than those obtained in a previous study on parents of ADHD patients where total parent score of ADHD=163.45±22.6, while those of CD=180±23.8 especially due to higher scores on social isolation and sense of competence. Whereas, on the child's domain scores were nearly similar being 159.55±16.8 for ADHD as compared to 153.7±25.0 for CD (Sayed et al, 2005). This difference between both samples draws the attention to the weight of stigma and sense of responsibility for the CD child's misbehavior that are indicated by social isolation and sense of competence on parental stress and for the importance of discussing those issues with parents during therapy.

Negative mood and irritability related to mood disorders may also disrupt disciplinary practices (Conger, Patterson and Ge, 1995).The experience of multiple stressors over time leads to the development of disturbed schema of what is appropriate in child behavior. There is an over attribution of negative intent to the child, self-blaming when children do not comply, and feelings of defeat and anger (Stern & Azar, 1998). A number of models have been developed that predict how stress influences parental behavior (Abidin, 1992; Belsky, 1984; Conger et al. 1995; Webster-Stratton, 1990).

This study highlights the risk factors, which could contribute to the parenting stress among mothers of conduct children. Conduct disorder, anxiety withdrawal, psychotic behavior and motor excess were positively correlated to the total child domain score ($P<0.05$). In addition, conduct scale and psychotic behavior as well as motor excess all correlated positively and significantly with distractibility and acceptability while attention problem is correlated positively with adaptability and mood and anxiety withdrawal with demandingness. These findings come to be in agreement with another study that showed also similar correlations but with children having attention deficit hyperactivity disorder (Sayed et al 2005).

Demandingness and acceptability on the child domain correlated positively and significantly with all the parent domains scales except social isolation and relation to spouse. Mood on the other hand correlated similarly with parental attachment

and restricted roles and with health in addition. It is worth noting that demandingness, mood and acceptability all correlated positively and significantly with total parent score.

It is well established that many conduct children have co-occurring ADHD and it is quite possible that these co-occurring behavioral problems, are the reasons for increased stress in parents of children of conduct disorder (Podolski et al 2001).

Social aggression and psychotic behavior were more manifested in conduct children when mother is of low educational level and when she gets married at an earlier age. The above mentioned factors were found to be implicated in the etiology of disruptive behavior in children by other researchers.

Summary and implications:

This study suggests that for mothers, parenting a conduct child is a stressful event that has a great implication on mother's parenting abilities. The maternal distress was experienced in all dimensions of the parent's functioning including parent's sense of competence, restriction of role, social isolation, and parental attachment relationship with spouse, parental health and parent depression. The maternal distress was predicted by the presence of inattention, hyperactivity, psychotic behavior, anxiety withdrawal, duration of the illness, delay to start treatment, age of the child and mother's education. Helping parents of children with oppositional deficit disorder (ODD) to cope more successfully with their disturbed cognitions, brought about by their own mental health problems and stressful lifestyle, may enable them to be more emotionally available and deal more effectively with their children. Based on the above, it was hypothesized that a parenting group that focused more on modifying parental Cognitions, problem solving skills and management of stress, in contrast to discipline and behavior management, would be more effective for clinically-referred children and will improve the treatment outcome in Conduct children .

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الإدراك الناتج عن الأبوية بين أمهات الأطفال المصابين بمرض الاضطراب السلوكي

تم إجراء البحث على عينة من أمهات الأطفال المصابين بمرض الاضطراب السلوكي و تم تقييم الأمهات عن طريق إستبيان التقييم النفسي و مقياس الكرب الناتج عن الأبوية، كما تم تشخيص الأطفال باستخدام التقسيم العاشر للأمراض النفسية و كذلك تقييم المشاكل السلوكية المصاحبة للمرض. و قد أثبتت نتائج هذا البحث أن امهات الأطفال المصابين بمرض الاضطراب السلوكي يعانين من ضيادة الكرب الناتج عن الأبوية، و يشمل ذلك المعدل الكلي، و الشق الخاص بالطفل، و كذلك الشق الخاص بالأبوين. هذا بالإضافة إلى أنه قد تم تحديد بعض العوامل المساعدة في ضيادة نسبة هذا الكرب الناتج عن مرض الاضطراب السلوكي.