



E-ISSN: 2706-9575
P-ISSN: 2706-9567
IJARM 2021; 3(2): 15-17
Received: 09-05-2021
Accepted: 12-06-2021

Dr. Gaurishankar
Assistant Professor,
Department of Psychiatry
Chhattisgarh Institute of
Medical Sciences, Bilaspur,
Chhattisgarh, India

Evaluation of maternal stress in mothers of adolescents with bipolar disorder

Dr. Gaurishankar

DOI: <https://doi.org/10.22271/27069567.2021.v3.i2a.209>

Abstract

Background: Caring of a child with bipolar disorder (BPAD) is a challenging job because of numerous illness-related and non-illness related factors – “securing appropriate treatment on long-term basis. The present study was conducted to evaluate maternal stress in mothers of adolescents with BPAD.

Materials & Methods: 68 mothers of adolescent with bipolar disorder of both genders were included. The GHQ-12 was applied on mothers of bipolar disorder adolescent (Group I) and the mothers of normal adolescents (Group II). The Parenting Stress Index, Brief COPE Scale was recorded.

Results: Adolescent age in group I was 15.2 years and in group II was 13.1 years, mother age was 38.4 years in group I and 36.2 years in group II and family size was 6.1 in group I and 5.5 in group II. The parental distress (PD) in group I was 41.4 and in group II was 35.2, parent child dysfunctional interaction (PCDI) in group I was 42.6 and in group II was 31.6, difficult child (DC) was 41.2 in group I and 31.8 in group II and total score was 125.2 in group I and 98.6 in group II. The difference was significant ($P < 0.05$).

Conclusion: Mothers of the adolescents with BPAD tend to perceive high level of stress and they also have significantly higher level of dysfunctional relationship with their children.

Keywords: Adolescents, bipolar disorder, parental distress

Introduction

Caring of a child with bipolar disorder (BPAD) is a challenging job because of numerous illness-related and non-illness related factors – “securing appropriate treatment on long-term basis,” “ensuring adherence to the treatment,” “dealing with the psychopathology of bipolar illness at home and in community,” and most significantly “dealing with stigma, prejudices, and stereotypes associated with the illness.”^[1] Many of them have feelings such as “being cursed,” “sense of shame and guilt,” and their “misfortune”^[2].

Symptoms of early onset BPAD do not have substantial similarity with adult BPAD. They have an ongoing, generalized mood disturbance that combines symptoms of both mania and depression^[3]. These symptoms can lead to negative consequences such as “disruption of psychosocial and family functioning,” “difficulty to interact with peers,” “academic problems,” “poor relationship among siblings,” and “poor parent-child relationships”^[4].

Bipolar disorder (BD) is a lifelong condition that highly impairs functioning and quality of life and increases the risk of a range of psychiatric and somatic comorbidities. For a long time, BD was rarely diagnosed in pediatric populations. However, studies have shown that approximately 30%–60% of individuals diagnosed with BD as adults retrospectively report an onset of illness prior to 20 years of age. Furthermore, 16%–27% of bipolar adults report that their first mood episode occurred prior to 13 years of age^[5].

Despite these findings, the diagnosis of BD may be delayed by up to 16 years if the first symptoms occurred in childhood and by 11 years in cases with adolescent onset^[6]. Childhood onset is also associated with a more difficult disease course and with several severe conditions, including substance abuse, suicidal behavior, and a greater number of mood episodes. Studying the initial stages of BD may therefore improve clinical practices regarding early detection of the illness and avoidance of diagnostic omissions or iatrogenic harm^[7]. The present study was conducted to evaluate maternal stress in mothers of adolescents with BPAD.

Corresponding Author:
Dr. Gaurishankar
Assistant Professor,
Department of Psychiatry
Chhattisgarh Institute of
Medical Sciences, Bilaspur,
Chhattisgarh, India

Materials and Methods

The present study consisted of 68 mothers of adolescent with bipolar disorder of both genders. They were selected after they agreed to participate in the study. Inclusion criteria was adolescents with the diagnosis of BPAD and the duration of illness ≥ 2 years, must have at least two episodes of illness in the past 2 years, no history of any other medical and/or psychiatric illness and/or substance addiction and/or disability and mothers actively involved in patient care for at least 2 year and living in the same household with the adolescents.

Demographic data was recorded. Mothers' age, education level and the socioeconomic status was recorded. The GHQ-12 was applied on mothers of bipolar disorder adolescent (Group I) and the mothers of normal adolescents (Group II). The Parenting Stress Index, Brief COPE Scale was recorded. Results were statistically analyzed. P value less than 0.05 was considered significant.

Results

Table 1: Sociodemographic profile

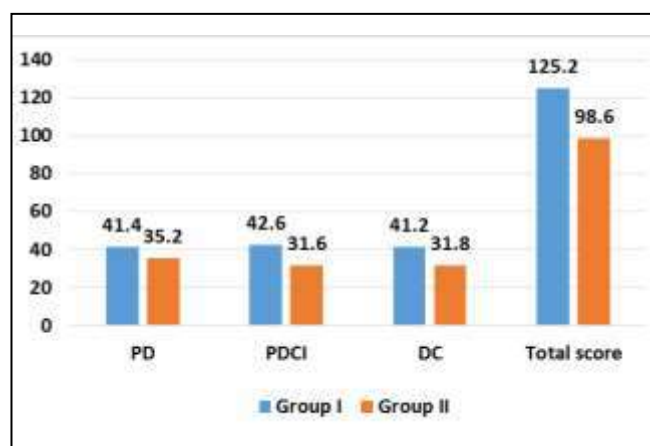
Parameters	Group I	Group II	P value
Adolescent age (years)	15.2	13.1	0.02
Mother age (years)	38.4	36.2	0.12
Family size (number)	6.1	5.5	0.15

Table 1 shows that adolescent age in group I was 15.2 years and in group II was 13.1 years, mother age was 38.4 years in group I and 36.2 years in group II and family size was 6.1 in group I and 5.5 in group II. The difference was non-significant ($P > 0.05$).

Table 2: Comparison of stress between both groups

Parameters	Group I	Group II	P value
PD	41.4	35.2	0.01
PDCI	42.6	31.6	0.02
DC	41.2	31.8	0.15
Total score	125.2	98.6	0.01

Table 2, graph I shows that parental distress (PD) in group I was 41.4 and in group II was 35.2, parent child dysfunctional interaction (PDCI) in group I was 42.6 and in group II was 31.6, difficult child (DC) was 41.2 in group I and 31.8 in group II and total score was 125.2 in group I and 98.6 in group II. The difference was significant ($P < 0.05$).



Graph 1: Comparison of stress between both group

Discussion

The staging model of BD suggests that episodes of minor mood disturbances in late childhood followed by major mood episodes in adolescence precede the onset of mania [8]. Therefore, the early detection of depressive pediatric patients who are at risk for mania is of high clinical importance because it may lead to tailored treatment and prevent iatrogenic harm [9]. Several clinical predictors have been identified in adults, including rapid onset of depressive symptoms, psychomotor retardation, mood-congruent psychotic features, family history of BD, and history of pharmacologically induced hypomania [10]. However, few studies evaluating pediatric populations have been published. Conduct disorders, multigenerational family history of BD, subthreshold BD symptoms, and baseline deficits in emotional regulation have been identified [11]. The present study was conducted to evaluate maternal stress in mothers of adolescents with BPAD.

In present study, adolescent age in group I was 15.2 years and in group II was 13.1 years, mother age was 38.4 years in group I and 36.2 years in group II and family size was 6.1 in group I and 5.5 in group II. Paul *et al.* [12] assessed maternal stress and coping in mothers of adolescents with BPAD. This study was a comparative one and carried out on sixty mothers of adolescents; of which thirty were adolescents with BPAD, and the remaining thirty were the mothers of normal adolescents. Mothers' of the BPAD adolescents reported higher scores in the both PSI/SF and Brief COPE. Mothers of the adolescents with BPAD tend to perceive high level of stress and they also use maladaptive coping more in dealing with stressful situations.

We found that parental distress (PD) in group I was 41.4 and in group II was 35.2, parent child dysfunctional interaction (PDCI) in group I was 42.6 and in group II was 31.6, difficult child (DC) was 41.2 in group I and 31.8 in group II and total score was 125.2 in group I and 98.6 in group II. Goentz *et al.* [13] assessed medical records of 46 children and adolescents who were hospitalized for BD at two psychiatric teaching centers in Prague, Czech Republic was performed. The sample represents 0.83% of the total number of inpatients ($n=5,483$) admitted during the study period at both centers. BD often started with depression (56%), followed by hypomania (24%) and mixed episodes (20%). The average age during the first mood episode was 14.9 years (14.6 years for depression and 15.6 years for hypomania). Seven children (15%) experienced their first mood episode before age 13 years (very early onset). Traumatic events, first-degree relatives with mood disorders, and attention deficit hyperactivity disorder were significantly more frequent in the very-early-onset group vs the early-onset group (13–18 years) ($P \leq 0.05$). The offspring of bipolar parents were significantly younger at the onset of the first mood episode (13.2 vs 15.4 years; $P=0.02$) and when experiencing the first mania compared to the offspring of non-BD parents (14.3 vs 15.9 years; $P=0.03$). Anxiety disorders, substance abuse, specific learning disabilities, and attention deficit hyperactivity disorder were the most frequent lifetime comorbid conditions.

Conclusion

Authors found that mothers of the adolescents with BPAD tend to perceive high level of stress and they also have significantly higher level of dysfunctional relationship with their children.

References

1. Hellander M, Sisson DP, Fristad MA. Internet support for parents of children with early-onset bipolar disorder. In: Geller B, DelBello MP, editors. *Bipolar Disorder in Childhood and Early Adolescence*. New York: The Guilford Press; 2003. p. 314-29.
2. Goldberg-Arnold J, Fristad M, Gavazzi S. Family psychoeducation: Giving caregivers what they want and need. *Fam Relat* 1999;48:411-7.
3. Hinshaw SP. The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *J Child Psychol Psychiatry* 2005;46:714-34.
4. Wade J. "Crying alone with my child:" Parenting a school age child diagnosed with bipolar disorder. *Issues Ment Health Nurs* 2006;27:885-903.
5. Wilson L, Crowe M. Parenting with a diagnosis bipolar disorder. *J Adv Nurs* 2009;65:877-84.
6. Pavuluri MN, Brimaher B, Naylor MW. Paediatric bipolar disorder: A review of the past 10 years. *J Am Acad Child Adolesc Psychiatry* 2005;44:846-71.
7. Birmaher B, Axelson D. Course and outcome of bipolar spectrum disorder in children and adolescents: A review of the existing literature. *Dev Psychopathol* 2006;18:1023-35.
8. Bashir M, Russell J, Johnson G. Bipolar affective disorder in adolescence: A 10-year study. *Aust N Z J Psychiatry* 1987;21:36-43.
9. Miller AC, Gordon RM, Daniele RJ, Diller L. Stress, appraisal, and coping in mothers of disabled and nondisabled children. *J Pediatr Psychol* 1992;17:587-605.
10. Dabrowska A, Pisula E. Parenting stress and coping styles in mothers and fathers of pre-school children with autism and Down syndrome. *J Intellect Disabil Res* 2010;54:266-80.
11. McConachie H. Implications of a model of stress and coping for services to families of young disabled children. *Child Care Health Dev* 1994;20:37-46.
12. Paul MS, Bhattacharjee D, Khanande RV, Nizamie SH. Early-onset bipolar disorder, stress, and coping responses of mothers: A comparative study. *Indian J Psychiatry* 2021;63:152-61.
13. Goetz M, Novak T, Vesela M, Hlavka Z, Brunovsky M, Povazan M, Ptacek R, Sebela A. Early stages of pediatric bipolar disorder: retrospective analysis of a Czech inpatient sample. *Neuropsychiatric disease and treatment*. 2015;11:2855.