Original article / *Araştırma*

Psychiatric disorders and family functioning in mothers of children admitting to the child psychiatry clinic with temper tantrum

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ABSTRACT

Objective: *The aim of this study is to investigate the family functioning and frequency of psychiatric disorders in mothers of pre-school children (between ages 2 and 6) who referred to child and adolescent psychiatry outpatient clinic for anger, mischievousness, unruliness, temper tantrum complaints and who were not diagnosed any psychiatric disorder.* ***Methods:*** *Sixty-two children aged between 2 and 6 years and their mothers were included in the study. The control group consisted of 55 mothers of children who were not admitted to psychiatry clinic and without any psychiatric disorders. Diagnostic interviews of the parents were conducted with Structured Clinical Interview for Axis-I Disorders (SCID-I). Family functioning was evaluated with McMaster Family Assessment Device.* ***Results:*** *The frequency of psychopathology was higher in the mothers of children referred to child psychiatry outpatient clinic with anger, mischievousness, unruliness, and temper tantrum complaints than the controls. At least one psychiatric disorder was diagnosed in 51.6% of mothers of study group, meanwhile this ratio was 26.8% in the control group. More frequent psychiatric disorders were major depressive disorder (27.4%), generalized anxiety disorder (19.4%), and obsessive compulsive disorder (17.7%). Similarly, family functioning perceived by mothers in the study group was poorer than the controls.* ***Conclusion:*** *The results of this study suggested that half of the mothers who brought their children for the behavioral problems to the outpatient clinic were suffering from a psychiatric disorder. The mothers of children, who referred to the child psychiatry outpatient clinic with these complaints, need to be screened for psychiatric symptoms and guide for a psychiatric assistance if necessary.* ***(Anatolian Journal of Psychiatry 2017; 18(4):387-394)***

Keywords: *Anger, mother-child relations, family functioning, maternal psychopathology, temper tantrum*

Çocuk psikiyatri kliniğine öfke patlaması yakınmalarıyla başvuran çocukların annelerinde psikiyatrik bozukluklar ve aile işlevselliği

ÖZ

Amaç: *Bu çalışmanın amacı çocuk psikiyatri polikliniğine sinirlilik, öfke patlamaları, söz dinlememe ve yaramazlık yakınmaları ile başvuran ve herhangi bir ruhsal bozukluk saptanmayan okul öncesi çağdaki (2-6 yaşları arasındaki) çocukların annelerinde psikiyatrik bozuklukların sıklığını ve aile işlevselliğini araştırmaktır.* ***Yöntem:*** *Çalışmaya 2-6 yaşları arasındaki 62 çocuk ve anneleri alınmıştır. Çocuk psikiyatri polikliniğine başvuru öyküsü olmayan ve herhangi bir psikiyatrik bozukluğu olmayan 55 çocuk ve annesi ise kontrol grubunu oluşturmuştur. Tanı görüşmeleri Structured Clinical Interview for DSM Axis-I Disorders (SCID-I) Türkçe örneği ile yapılmıştır. Aile işlevselliği ise Aile Değerlendirme Ölçeği (ADÖ) ile değerlendirilmiştir.* ***Sonuçlar:*** *Sinirlilik, öfke patlamaları, söz dinlememe ve yaramazlık yakınmalarıyla polikliniğe başvuran çocukların annelerinde psikopatoloji sıklığı kontrol grubundan daha*

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yüksekti. Çalışma grubu annelerin %51.6'sında en az bir psikiyatrik bozukluk saptanırken, kontrol grubunda bu oran %26.8'di. En sık konulan psikiyatrik tanılar majör depresyon (%27.4), yaygın anksiyete bozukluğu (%19.4) ve obsesif kompulsif bozukluktu (%17.7). Benzer şekilde, çalışma grubu annelerinin kontrol grubuna göre algıladıkları aile işlevlerinin daha sağlıksız olduğu saptanmıştır. ***Tartışma:*** *Çalışmamızın bulguları çocuk psikiyatri polikliniğine bazı sorunlu davranışlarla başvuran annelerin yarısında psikiyatrik bir bozukluk bulunduğunu göstermektedir. Bu yakınmalarla polikliniğe başvuran çocuklarla birlikte annelerin de değerlendirilmesi ve gerektiğinde psikiyatrik yardım almaya yönlendirilmesi uygun olacaktır.* ***(Anadolu Psikiyatri Derg 2017; 18(4):387-394)***

Anahtar sözcükler: *Sinirlilik, anne-çocuk ilişkisi, aile işlevleri, anne psikopatolojisi, öfke patlamaları*

INTRODUCTION

Core features of human behaviors, emotions and thoughts develop especially in the early childhood.[1] Differences with preschool age children's behaviors may emerge because of mother-child relationship in addition to genetics and environmental factors. The child's social and emotional development, regulation of emotions are also affected by the interaction, experienced with parents,[2] the child can discriminate the emotional expressions on the parent's face and soon afterward, can use that expressions.[3] For developing satisfactory and approvable social behaviors, regulation of the emotional responses is essential.[4]

From the first years of the life, emotional expression, which is a way to transmit needs and expectations to others, may change with conditioning and social learning especially the result of mother-child relationship.[5,6] In this period some children show their negative emotions by externalizing symptoms such as hyperactivity, mischievousness, temper tantrums, oppositional defiance, and obstinacy.[7-9] The children with poorer emotional regulation ability are at risk of developing future internalizing (like depression) or externalizing (like aggression) problems.[10]

With the lack of a supporting environment, the risk of serious behavioral problem occurrence could increase in children who cannot express their emotions (like anger and irritation) appropriate for that situation.[11] The attitudes and behaviors of the parents who mostly interact with the child are the most important environmental deterministic of problematic behaviors in this life period.[12]

Familial conflict, unhealthy family functioning, child abuse and neglect; insecure, accusing family environment may cause problems in emotional and behavioral development.[13-15]

Psychiatric disorders of the parents also predict the attitudes and behaviors of parents to child.[16] It is known that the parents with psychiatric disorders usually have a negative relationship with their children, develop an insecure attachment, and their ability to recognize and understand the people surrounding them is also decreases.[16] The lack of communication and perception in mother-child interaction cause the children with problematic behavior to be misunderstood, and to be less supported.[17] Insensitive attitude of mother at early childhood may cause externalizing disorders, intrusive or hostile attitude may cause poorer emotional regulation abilities and disruptive behaviors.[17,18] It is reported that mothers with depressive disorder have a more restricted and insensitive relationship with their children; they have more judgmental and strict attitudes to their children.[19]

Anger, mischievousness, unruliness, temper tantrums are the behaviors that can be seen in every child from time to time. To diagnose a psychiatric disorder because of these symptoms, some criteria have to be fulfilled.[20] In some life periods, in the case of small life style changes they have to adopt or because of parental attitudes, the children present themselves with these problematic behaviors. In these situations if the behaviors do not fulfill the criteria of a psychiatric disorder, the reasons why the child behaves problematically have to be investigated.

This study is conducted to understand the effect of family functioning perceived by the mother and mother's psychiatric disorders, on their complaint about the problematic behaviors of the preschool child (between the ages 2 and 6). Thus, psychiatric diagnoses and family functioning perceptions of the mothers who attended to a Child and Adolescent Psychiatrist due to the child's anger, mischievousness, unruliness, temper tantrums are compared with diagnoses and perceptions of family functioning of healthy children's mothers.

METHODS

Procedures

The study group consisted of 2-6 years old children who were admitted to Konya Education and

Research Hospital Child and Adolescent Psychiatry Clinic with anger, mischievousness, unruliness, temper tantrums complaints in three months.

Control group consisted of children who were admitted to pediatric clinic with physical complaints. Case and control groups were matched for age, gender, employment status and socioeconomic level of the family. All of the children were assessed by a child and adolescent psychiatrist. A total number of one hundred and seventeen mothers of the children without a documented psychiatric disorder according to the DSM-IV criteria were included in the study. For all mothers in case (n=62) and control (n=55) group, Structured Clinical Interview for DSM Axis I Disorders (SCID-I) Turkish example was applied by a psychiatrist.[21]

Detailed information about the study was given to the mothers and their written informed consents were obtained. Ethics committee approval of the study was obtained from Selçuk University Ethics Committee.

Assessment tools

All the tools used in this study have explained to the participating mothers, researchers helped to mothers for filling, if necessary.

Sociodemographic Data Collection Form: It has been created by the researchers and includes questions assessing child's family structure and socioeconomic characteristics (mother's age, education, occupation and economic status, child's age and gender).

SCID-I/CV: It is a semi-structured interview tool which is used by the interviewer to diagnose axis I psychiatric disorders according to the DSM-IV. It consists of six modules, which are mood episodes, psychotic and associated symptoms, differential diagnosis of psychotic disorders, mood disorders, alcohol and other substance use disorders, anxiety and the other disorders. This interview instrument developed by First et al.,[22] has found widespread use worldwide and has been adapted for Turkish language and its reliability study has been published.[21]

Family Assessment Device (FAD) To assess the family functioning, FAD was given to mothers. Turkish validity and reliability study of FAD was conducted by Bulut[23] through clinical application of McMaster Model of Family Functioning on families.[24] Device consists of 60 items and 7 subscales as problem-solving (6 items), communication (9 items), roles (11 items), affective responsiveness (6 items), affective involvement (7 items), behavior control (9 items) and general functioning (12 items). Each item receives a score between1-4 (1 point means healthy, 4 points means unhealthy). The mean score for each subscale is taken. Cut-off point for mean scores accepted as 2, and mean scores higher than 2 points predict a tendency towards unhealthy family functioning. Family scores are obtained using the scale individually for each family member over the age of 12 and averaging their scores from each subscale. However, some authors suggest evaluation of perceived family functioning using the same scale on only one family member.[25] FAD has been used only in mothers in this study.

Statistical analysis

SPSS (Statistical Package for the Social Sciences) version 16.0 for Windows software was used in statistical analysis. For comparison of groups, chi-square test was used for categorical variables and Student t test was used continuous variables. In this study, p values less than 0.05 was accepted statistically significant.

RESULTS

Sociodemographic characteristics

Among the children in the study group, 34 (54.8%) were girls and 28 (45.2%) were boys. Their mean age was 3.82±1.07 (range: 2-6). It was determined that 43 of the families in the study group were nuclear families, (69.4%) and 19 of them were extended families (30.6%), and according to the families' own perception, 27 were in low (43.5%), 18 were at medium (29%), and 17 were at high socioeconomic status (27.4%). Sociodemographic characteristics of the study and the control group presented in Table 1. There were no statistically significant difference between case and control groups in terms of gender, family structure and economical status (Table 1).

The mothers' average of age was determined as 28.5±5.9 in the study group, and 29.4±4.2 in the control group. When their level of education was considered, it was observed in the study group that 35 of the mothers were completed the primary education (56.5%), 14 completed high school education (22.6%), and 13 graduated from university (21%). When their employment status was analyzed, on the other hand, it was determined that 42 mothers were housewives (67.7%) and 20 mothers had regular jobs

Table 1. The sociodemographic characteristics of study and control groups

	Study group		Control group		
	n	%	n	%	p
Gender					0.44
Girl	28	45.2	21	38.2	
Boy	34	54.8	34	61.8	
Mother's education status					0.82
Primary school	35	56.4	30	54.5	
Secondary school	14	22.6	15	27.3	
High school	13	21.0	10	18.2	
Mother's job status					0.87
Working	20	32.3	17	30.9	
Housewife	42	67.7	38	69.1	
Economic status					0.86
Low	27	43.5	24	43.6	
Average	18	29	18	32.7	
High	17	27.4	13	23.6	
Family type					0.28
Core	43	69.4	43	78.2	
Traditional	19	30.6	12	21.8	

Table 2. Comparison of the mean scores of Family Assessment Device's subscales

	Study group Mean±SD	Control group Mean±SD	p
Problem Solving	2.34±0.82	1.40±0.41	<0.01
Communication	2.30±0.73	1.52±0.44	<0.01
Roles	2.26±0.63	1.63±0.36	<0.01
Emotional responsiveness	2.29±0.80	1.48±0.47	<0.01
Affective involvement	2.31±0.70	1.48±0.41	<0.01
Behavior control	2.20±0.53	1.62±0.33	<0.01
General functioning	2.27±0.78	1.41±0.44	<0.01

(32.4%). The mothers' ages, employment and educational status did not show any statistically significant difference between two groups (Table1).

Family functioning

The results of FAD are shown in Table 2. Mean scores of all subscales of FAD were statistically significantly higher in the case group than the control group (Table 2).

Psychiatric diagnoses of mothers

In the study group 51.6% of mothers (n=32) had at least one psychiatric disorder according to the DSM-IV whereas in the control group this rate was 26.8% (n=15) (p<0.01).

Mood disorders in the study group were distributed as major depression in 17 mothers (27.4%) and dysthymia in three mothers (4.8%). This diagnoses were seen in seven (12.5%) and two (3.6%) mothers respectively in the control group. There were no diagnosis of bipolar disorder in the both case and control groups. The difference between the groups in terms of mood disorders was due to diagnosis of major depression.

Anxiety disorders were diagnosed in 22 of the mothers (35.5%) in the case group and in nine of the mothers (16.1%) in the control group (p=0.01). Anxiety disorders distributed as generalized anxiety disorder (GAD) in 12 of the mothers (19.4%) and obsessive compulsive disorder (OCD) in 11 of the mothers (17.7%) in the case group while these diagnoses were in three

Table 3. Comparison of study and control group mothers in terms of psychiatric disorders

	Study group		Control group		
	n	%	n	%	p
Any psychiatric disorder	32	51.6	15	26.8	<0.01
Affective disorders	19	30.6	7	12.5	0.01
Dysthymic disorder	3	4.8	2	3.6	0.73
Anxiety disorders	22	35.5	9	16.1	0.01
Generalized anxiety disorder	12	19.4	3	5.4	0.02
Panic disorder	1	1.6	1	1.8	0.94
Obsessive compulsive disorder	11	17.7	1	1.8	<0.01
Social phobia	2	3.2	-	-	0.17
Specific phobia	2	3.2	4	7.1	0.33
Agoraphobia	1	1.6	-	-	0.34
Anxiety disorder-NOS	3	4.8	2	3.6	0.73

(5.4%) and one (1.8%), respectively, in the control group mothers. In terms of other specific anxiety disorders, no difference was observed between two groups (Table 3).

DISCUSSION

In this study, psychiatric diagnoses and family functioning perceptions of the mothers who attended to a child and adolescent psychiatrist due to their children's anger, mischievousness, unruliness, and temper tantrums have been investigated. In previous studies, most common referral reasons to a child psychiatry outpatient clinic between 1 and 6 years were anger, mischievousness, unruliness, and temper tantrums,[26] diagnosing any psychiatric disorder in children between 0 and 6 years of age was 50%.[27] Ticehurst and Henry reported that the parents that bring their children, who are between the ages 1 and 4, because of problematic behaviors, which may be characteristic to that age, to child health professions have more expectations about their children than control group.[28]

The most important result of this study is that there are more psychiatric diagnoses in the mothers that bring their children to child psychiatry outpatient clinics because of behaviors that cannot fulfill the criteria of any psychiatric disorder. Mother's psychiatric disorder may reduce her management capacity of child's problematic behavior that is related to developmental and chronological age. The mother that who cannot cope with her child's problematic behavior may need to receive treatment more than other mothers.[29]

On the other hand, it is claimed that the mothers with psychiatric disorders perceive their children's problematic behavior more intensely than it is.[30,31] Richers reported in his meta analyzes study that mothers with depression interpret their child's behavioral problems wrong, in 17 of 22 studies the mother's report about their child's behaviors are exaggerated.[32]

Major depression is the most common psychiatric diagnose in our study (27.4%), and statistically significantly frequent than the control group. The studies showed that children of depressed mothers have higher risk of occurring behavioral problems.[15,33] Needlman et al. reported that depressed mother's children exhibit three times more temper tantrums than non-depressed mothers' children do.[34] Besides, mother's depressive mood may directly affect the child's mood and make behavioral changes. Also, by damaging the mother child interaction, it may affect the child's behaviors. It is showed that depressed mothers are more judgmental in their interaction with their children, having less confirmative and supportive approaches, and using more strict discipline methods.[35,36] These children cannot develop appropriate anger control mechanisms.[35]

At least one anxiety disorder is diagnosed in 35.5% of the study group mothers, 19.4% is diagnosed generalized anxiety disorder, 17.7% OCD. These diagnoses are significantly higher than control group. Swartz et al. reported that 42% anxiety disorders, 15% GAD in the mothers that referred to a child and adolescent psychiatry clinic.[37] It is reported that the mothers with anxiety disorders are more judgmental and overprotective in their interaction with their children.[38]

FAD used in this study, enables the family

functioning to be assessed in different aspects like problem-solving, communication, roles, affecttive responsiveness, affective involvement, behavior control and general functioning.

The family functioning results in this study show mother's reported complaints about the child may be related to intra familial conflict in addition to mother's psychiatric disorders. It also seems important to assess intra familial conflict in addition to mother's mental health while referring to the child and adolescent psychiatry clinics.

In a ten years follow up study, problematic behaviors at age 3, according to parent's reports, persisted in the half of the children at the beginning of primary school,[39] 67% of the children with ongoing problematic behaviors at age 6, exhibited externalizing behaviors at age 9.[40] The predictors of symptom continuity were the severity at the beginning, ongoing familial conflict and the mother's negative attitudes to the child.[40-42] Thus, for preschoolers, it seems important to assess the mother's mental health and families functioning beside to child's symptoms for prevent future psychopathologies.

There are some limitations in this study. First, the children's referral complaints are asked only to their mothers, the fathers are not interviewed with. When the fact that mothers with mental disorder perceive their child's problematic behavior more severe is considered, it seems important to interview with fathers or somebody else from the family. Secondly, the study has a cross-sectional design. A longitudinal design may help to understand causative relationship between the mother's mental disorder and the child's externalizing problematic behavior. It would be important to monitor the problematic behavior to distinguish the normal and abnormal child behavior. Third limitation of this study is that no inventory was applied to assess the symptom severity of the child.

Despite the limitations, this study shows that the half of the mothers who attended to a Child and Adolescent Psychiatrist due to their children's anger, mischievousness, unruliness, temper tantrums have a psychiatric diagnosis and family functioning perceptions of the mothers are unhealthy. The clinicians' assessment of the mothers psychiatric disorder and manipulate the mother to a psychiatrist if necessary may be favorable. If the externalizing symptom of the child is primarily because of the negative interaction between mothers, the treatment plan may begin with prioritizing the mother's psychiatric treatment. If it is thought that the mother perceives normal childhood behaviors exaggeratedly, and the mother is impatient, it would be influential to inform her about normal behaviors of preschool age children to distinguish normal and abnormal childhood behaviors.

It is considered vitally essential for the child to become a psychologically healthy individual that the destructive behavior, which may emerge as a characteristic of the child's age and developmental period, does not become permanent and being treated in the preschool period.

Yazarların katkıları: *M.Ş.: Konuyu bulma, literatür tarama, planlama, araştırmanın yürütülmesi, makaleyi yazma; C.G.: Konuyu bulma, literatür tarama, planlama, araştırmanın yürütülmesi, istatistik, makaleyi yazma; İ.Ç.İ.: Literatür tarama, araştırmanın yürütülmesi, makaleyi yazma.*

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