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European Psychiatry

journal homepage: <http://www.europsy-journal.com>

Original article

Coping with information style and family burden: Possible roles of self-stigma and hope among parents of children in a psychiatric inpatient unit

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ARTICLE INFO

Article history:

Received 27 October 2016

Received in revised form 27 November 2016

Accepted 28 November 2016

Available online 12 December 2016

ABSTRACT

Objective: Parents of children who are hospitalized in inpatient psychiatric units must cope with significant challenges. One of these challenges relates to the way in which they cope with illness-related information. The current study examined the relationship between two such coping styles – monitoring and blunting – and family burden among parents of children in a psychiatric inpatient unit. Moreover, the possible moderating roles played by hope and self-stigma in these associations were also examined. **Methods:** Questionnaires regarding coping with information style, self-stigma, hope and family burden were administered to 70 parents.

Results: A main positive effect of hope and a main negative effect of self-stigma were uncovered. An interaction between self-stigma and monitoring was also revealed, suggesting that for parents with high self-stigma, compared to those with low self-stigma, more monitoring was related to more burden.

Conclusions: Tailoring family interventions according to coping style and self-stigma is highly recommended as a mean to reduce the family burden of parents whose child is hospitalized in a psychiatric inpatient unit.

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1. Introduction

The mental health problems of children and adolescents greatly impact the social, familial, educational and leisure domains of their parents' lives, creating challenges and burden for them [1,2]. Many studies have in fact shown that parents of children with psychiatric disorders experience both objective and subjective burden [3]. The objective burden refers to the disrupted daily life routines of the family, and to the limitations on the social, occupational, and familial domains of quality of life, which arise as a result of the child's disorder. The subjective burden refers to the relatives' various psychological reactions, such as anxiety, frustration and depression [4]. It should be noted that the parents' emotional reactions could affect the child's symptomatology, which can in turn increase the parents' emotional experience [5].

Previous studies have shown that objective and subjective aspects of family burden are correlated with patient characteristics,

such as severity of symptoms and number of hospitalizations [5,6] and with family environment and support [4]. In addition, variables related to illness perception, such as insight into the illness and internalization of the stigma by parents were also found to be positively associated with the family burden experienced by parents of both adolescents and adults with psychiatric disorders [7,8].

Parents' perceptions of their child's psychiatric illness are based on the knowledge that was already in their possession prior to its onset (i.e., knowledge they may have picked up "on the streets", often with negative and stigmatizing connotations; or via acquaintances they have with persons with serious mental illness), and on the information that they are either provided with or actively seek out from professionals, or from informal sources, after receiving their child's diagnosis. These perceptions – or mental representations of the illness – are also related to the way these parents process and cope with their knowledge of their child's illness.

In general, the literature distinguishes between two ways in which people tend to cope with threatening information: monitoring and blunting. Monitoring is expressed by seeking

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threat-relevant information, whereas blunting is expressed by avoiding it [9]. Although there has been some criticism of the making of a distinction between approaching and avoiding the stressor, due to the multidimensionality of both approaching and avoiding (i.e., integrating dimensions, such as activeness, being emotionally constructive and stressor-oriented) [10], it seems that in health-related situations the monitoring and blunting distinction can uniquely illuminate the experience of coping with information [11,12]. Notably, coping that is related to either approaching or avoiding is seen as being neither “good” nor “bad”, per se; rather, the relative “goodness” or “badness” of types of coping are determined based on their consequences and their subjective experience [10].

The effects of monitoring versus blunting have been studied in different contexts. For example, two studies have shown the benefits and positive aspects of monitoring among soldiers who participated in a war [13], and among individuals in the process of rehabilitation from cancer [14]. In contrast to these positive effects, monitoring has also been found to be related to insomnia, whereas blunting has been associated with high sleep quality [15]. High monitoring has also been found to be associated with more distress among persons whose genetic testing for cancer revealed either indeterminate or positive results [16], whereas blunting has been associated with optimism and well-being among cardiac patients [17].

Several variables – including parents’ personal characteristics – may moderate the association between coping style and outcome. This idea is consistent with studies that have shown that self-efficacy moderates the association between blunting and outcome among cardiac patients [17], and with studies showing that the interaction between coping style and type of intervention are important in determining outcome [11].

Two characteristics of parents are examined as possible moderators of the association between coping with threatening information and family burden in the current study: hope and self-stigma. Whereas hope refers to a general attitude one has toward life, self-stigma refers to the mental representations one has with regard to illness. More specifically, hope is defined as a positive and realistic goal-oriented attitude toward the future [18,19], which acts as an important resource for individuals when they are coping with daily demands as well as with crises [20,21]. Hope has been found to be an important factor in the outcome of relatives of children and adults who have both physical and psychiatric illnesses [22–24].

Another factor that plays an important role in family burden is self-stigma, which is defined as the internalization of stigmatizing views held by members of the community (e.g., seeing the individual with mental illness as dangerous and incompetent; or, from the perspective of the parents of persons with mental illness, viewing one’s self as being responsible for the child’s illness) [25–28]. Studies on parents of persons with serious mental illness have examined parents’ self-stigma [7,28] and showed the negative consequences it had on family burden and parental stress [7,8]. Family members’ stigmatizing views seem to stem from their perception of the family as being an extension of the individual family member’s deviation and as perhaps being responsible for it [29]. The internalization of this perception refers to the parents’ self-stigma.

Parents’ self-stigma was found to mediate the relationship between their insight into the disorder (i.e., their awareness of the illness and its implications) and their sense of burden and distress [7,8]. In addition, parents’ opinions, perceptions and attitudes toward the illness were found to be related to the outcomes of both relatives and patients [30]. Parents’ concerns regarding disclosure of their child’s illness, due to the resultant stigma, were also found to be related to the self-stigma of children with psychiatric

disorders [31], highlighting the importance of confronting the issue of stigma in the management of these illnesses.

The current study explored the possible moderating roles played by hope and self-stigma in the relationship between style of coping with threatening information (i.e., monitoring or blunting) and family burden, among parents of children in a psychiatric inpatient unit. We expected that blunting would be effective for parents with high levels of self-stigma, whereas monitoring would be more helpful for parents with low levels of self-stigma. We hypothesized that self-stigma would moderate the relationship between coping style and family burden; we also hypothesized that blunting would be associated with better outcomes in parents with high levels of self-stigma, and monitoring would be associated with better outcomes in parents with low levels of self-stigma. In addition, we tested in an exploratory fashion interactions between coping and hope, and coping and self-stigma, in order to trace the conditions under which monitoring or blunting would be most beneficial in reducing family burden.

2. Method

2.1. Participants

Eighty-three parents of children (mean age of the children = 10.30, SD = 2.18) who were hospitalized in a psychiatric inpatient unit were invited to participate in the study. Thirteen parents declined to participate as a result of being overwhelmed with the situation, of being afraid of emotional disclosure, or of not trusting that the collected information would be anonymous. All of the parents who declined to participate were fathers who were in the same age range as the fathers who did choose to participate. Additional information on non-participants was not available. The final sample consisted of 70 parents (65% of whom were women, 90% of whom were married, 74% of whom the child’s gender was male; mean age = 43.28, SD = 2.76; mean year of education = 4, SD = 2.68). Of the hospitalized children, 54.3% had a behavioral disorder; 34.3% had a serious mental illness, such as schizophrenia, bipolar disorder or major depression; and 11.4% had a communication disorder. Inclusion criteria were: inclusion criteria were 1) that this was the child’s first psychiatric hospitalization; 2) that participants were fluent in Hebrew; and 3) that participants signed informed consent forms. Exclusion criteria included having an organic or psychotic disorder.

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The inpatient unit in this facility is staffed by an interdisciplinary team working together with families. Treatment includes a weekly guidance session with parents and routine meetings with the psychiatrist and with the on-site school counselor. Parents are also required to visit their children twice a week and, in addition, the children return home either every weekend or every other weekend, depending on clinical considerations. The children are provided with psychotherapy, individually adapted school programs, and additional services during their transition back into the community, such as the involvement of a social worker when needed.

2.2. Instruments

2.2.1. Parental self-stigma scale

This is an adapted 26-item version [7] of the Internalized Stigma of Mental Illness Scale [32]. The scale was adapted for use

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