

## **Effect of Psycho-Educational Program on Emotional Distress and Psychological Wellbeing for Parents of Children with Conduct Disorder**

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**Background:** Conduct disorder is among the most serious and complex complications in school-aged children. It is considered the leading cause of parental emotional and psychological problems affecting their psychological wellbeing. **Purpose:** Evaluate the effect of psycho-educational program on emotional distress and psychological wellbeing for parents of children with conduct disorders. **Research design:** A quasi-experimental research design two groups (study and control group pre/ posttest) was used to achieve the purpose of the study. **Setting:** The study was conducted at out-patient psychiatric clinic at Menoufia University Hospitals, in Shebin El-Kom City, Menoufia Governorate. **Sample:** A convenience sample consisted of 100 parents from the above mentioned setting who fulfilled the inclusion criteria of the study. **Instruments:** (1): Socio-demographic structured interview questionnaire. (2) The emotional distress scale. (3) Scale of psychological wellbeing. **Results:** The results revealed that there was a highly statistically significant difference between study and control group in the total emotional distress and psychological wellbeing level post psycho-educational intervention. **Conclusion:** It was concluded that the psycho-educational intervention has a positive effect on reducing emotional distress and improving psychological wellbeing among parents having conduct disorder children. **Recommendations:** counseling, family therapy, free workshops for parents because they are really in need. Furthermore, raising the awareness of nurses and healthcare professionals about parents' experiences of parenting a child with Conduct disorder has the potential to guide practice and provide appropriate support for these mothers, thus minimizing the possible negative impact on their family life.

**Keywords:** *Psycho-education, Emotional Distress, Psychological Wellbeing, Children with Conduct Disorder, Parents*

## **Introduction**

Conduct disorder (CD) is a major public health concern. The worldwide prevalence of conduct disorder could range between 2% to 10%, 2–5% in children between 5–12 years and 5–9% in adolescents between 13–18 years. Boys are more likely to present with symptoms of conduct disorder than girls. Boys are four times more likely to be diagnosed with conduct disorder than girls, and the ratio could range from 4:1 as much as 12:1. Around 3.6% is for males and 1.5% for females (Gatej et al., 2019).

Emotional distress has been found to be associated with adverse behavioral and emotional outcomes in children; and regardless of parent gender; parents' mental health has been found to relate to emotional symptoms in younger children and abnormal behavior relationship stress related to difficulties associated with imposing a daily routine and discipline on the conduct disorder child (Fritzsche et al., 2020).

Emotional distress is a problem experienced not only in a low-income country, but in high income countries as well (Mauramo et al., 2019). Ambikile, & Outwater, (2022) argued that emotional experience of sadness, and inner pain or bitterness associated with having a CD child differs from a previous study in the United States, where emotional strain was expressed by mothers as having fears, frustrations, and guilt in dealing with the child's behavior and attitude. Having conduct disorder child affects several aspects of parent /caregiver's

life negatively including poor physical and emotional state.

Conduct disorder led to more social and emotional problems. Arab parents share the same fear, than those with a set of different cultures, norms and beliefs. Parents having conduct disorder children induced emotional distress problems in light of depression, anxiety, and stress problems (Reeves & Krause, 2019). Depression is often underestimated among parents having conduct disorder children due to a child's difficult temperament. Furthermore, others reject the child, leading to their reduced opportunities. In fact, the lifetime prevalence of major depressive disorder may be higher in the parents of children with CD than parents of children without CD (Matthys & Lochman, 2017).

The parents of children with conduct disorder are at risk for severe depression, aggression, and negative attitudes. Mothers with more severe depression reported higher extrinsic symptoms in their children; specifically, attention problems, hyperactivity, disobedience, aggression, and crime are more frequent in this group. Maternal depression could impact child aggression; however, it has a dual effect on this condition (Sajadi et al., 2020).

Anxiety is among psychological changes resulting from having CD children that can have adverse effects on parents' mental health. Parents, especially mothers having CD children, displayed higher levels of

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anxiety. Anxious parents tended to be withdrawn, bad-tempered and had less engagement with their children. Anxious mothers displayed significantly less positive affection towards their children. Therefore, anxiety in mothers having CD children can be one of the consequences of dealing with the problems of these children and, in turn, can exacerbate their behavioral challenges, making family environment more stressful (Leijten et al., 2019).

Parents having CD children experienced more parental stress than mothers and fathers of children without CD symptoms; the higher CD symptom severity, the more parenting stress. It is also due to the different problems comorbid with CD children, such as oppositional defiant disorder or learning disabilities that may negatively impact parent-child relationships and result in higher levels of parenting stress. Also, the age of the children may affect the course of the stress disorder and how it is perceived by parents or could change between boys and girls. Also, higher levels of parental stress are founded for women and men who report lower satisfaction with their couple or greater restriction in their social activities affecting their psychological well-being (Hintsanen et al., 2019).

Psychological well-being has a negative relationship with emotional distress. Psychological well-being is thus defined as the absence of indicators of emotional distress. Over half of parents of children with conduct disorders have decreased their leisure time. Over third of those parents were

reluctant to invite friends into their houses because they feel much more burden and stigma as a result to their children behaviors (Hernandez et al., 2018).

Parents having children with conduct disorder may benefit from psycho educational programs that are formed to increase understanding and knowledge about conduct disorder and associated issues as opposed to learning techniques to reduce depression, anxiety and cope with stress, which is the main focus of most psychosocial interventions. The psycho education enabled the parents to make sense of their major problems and recognize their feelings about these problems and thus supported metalizing these experiences. Psycho education helps one to stay in a certain state and understand that state meaningfully and become aware of feelings, which are the goals of many dynamic therapies (Emmanuel, 2020).

While early prevention of serious childhood conduct disorder is the most effective strategy in reducing the scope of their emotional distress in the parents (i.e., “nipping it in the bud”), interventions during the pre-adolescent and adolescent period present a unique opportunity to: intervene with youth and families with a longstanding history of CD with the goal of risk reduction and minimization of risk escalation during adolescent development; and prevent adolescent onset CD (Dahl et al., 2020).

In addition, parent education with activities such as advice on self-management strategies and/or counseling. The few psycho-

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educational interventions that focused on parents having CD children delivered in multi sessions via group, face-to-face, and/or video formats data showed positive effects on outcomes, such as depression anxiety, stress, and quality of life (Imamura et al., 2022). Moreover, in light of parents' self-care and improving their psychological wellbeing, the nurse should teach the parents to develop consistent self-care activities such as eating a healthy diet, getting optimal amounts of sleep, doing regular exercise, practicing good hygiene, taking time to do things they enjoy, treating themselves well every day and making their living space somewhere they enjoy to be. The nurse should ensure safety for parents/caregivers, their children, and other family members that should be number one priority. Prevention efforts to improve emotional distress involved and promoting well-being (Robert et al., 2018).

**Significance of the study**

Conduct disorder is more common worldwide. It can present commonly during childhood and early adolescent periods. Conduct disorder is more common in boys than girls, and the ratio could range from 4:1. The prevalence of CD has been estimated among different countries globally, from 35.6% for high- income countries to 1.6% of low- income or middle-income countries. The prevalence of conduct disorder was reported from 1 to 29.9% for females and from 3.3 to 34.6% for males. Early onset of conduct disorder in childhood years

could lead to the worse prognosis of the condition (Thomson et al., 2019).

In Egypt, the total prevalence of CD among the adolescents was 19.5%, the prevalence of CD among males was 25%, while among females, it was 13.2% with a ratio of 1.9: 1, The prevalence of CD in males of the technical schools was (25.8%) which is higher than that in the general schools (22%). The percent of adolescent onset type was (78.2%) and that of childhood onset type was (21.8%). Male to female ratio is higher in childhood onset type than with adolescent onset type (2.7: 1 compared to 2: 1) (El Sayed et al., 2014).

In Menoufia Governorate, CD represented 8 and 6.9%. It is significantly higher among boys than among girls (89.5% vs. 10.5%). It was correlated with single-parent family, low family socioeconomic status, parental substance abuse, age from middle childhood into adolescence, parental mental illness, parent-child conflict, and inter-parental conflict (Farahat et al., 2017).

Parents having children with conduct disorder experience pressure in their life. Increased emotional distress has been demonstrated in parents having children with conduct disorder concerning depression, anxiety and stress -particularly female parents- in comparison to parents of children with other developmental disorders. About 64% of the parents were noted to have depression symptoms. It is a strong indication to anxiety and stress changes that is more likely to be apparent in Arab/Islamic population

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than other psychological variables (Lu et al., 2018).

Psychological well-being has a negative relationship with emotional distress. Over half of parents of children with conduct disorders have decreased their leisure time. Over third of those parents were reluctant to invite friends into their houses because they feel much more burden and stigma as a result to their children behaviors (Hernandez et al., 2018). So this study aimed to evaluate the effect of psycho-educational program on emotional distress and psychological wellbeing for parents having children with conduct disorder.

### **Purpose of the study**

Evaluate the effect of psycho-educational program on emotional distress and psychological wellbeing for parents having children with conduct disorder.

### **Research hypotheses**

- 1) The parents who will participate in psycho-educational program (study) will have lower mean scores of emotional distress (depression, anxiety, and stress) than parents who will not receive the program sessions (control).
- 2) The parents who will participate in psycho-educational program (study group) will have high mean scores of psychological wellbeing than parents who will not receive the program (control).

### **Methods**

#### **Research Design**

A quasi experimental design, two groups (study and control group pre/

posttest) was used to achieve the purpose of the study.

#### **Research Setting**

This study was conducted at outpatient psychiatric clinics Menoufia University Hospitals.

#### **Sample**

A convenience sample of (100) parents who attending outpatient psychiatric clinic at Menoufia University Hospitals. The researchers divided (100 parents) randomly into two groups; study group (50 parents) who received psycho-educational program sessions and control group (50 parents) who did not receive psycho-educational program sessions.

#### **Inclusion Criteria**

- 1) Parents who follow up treatment for their children through six months after at least one month of their children's diagnosis with conduct disorders.
- 2) Parents having conduct disorder children aged from 4-11 years old.
- 3) Parents able to communicate relevantly and willingly and agree to participate in the study.

#### **Exclusion criteria:**

Parents who having children with any other psychiatric disorder.

#### **Instruments of the Study**

##### **First instrument: Socio-demographic structured interview questionnaire:**

This questionnaire was developed by the researchers based on pertinent literature and guidance of her supervisors to assess socio demographic characteristics of the

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parents as age, education, marital status and income ..... etc ; and clinical data for their conduct disorder children such as the child age, conduct disorder subtype, early risk factor present, ...etc.

**Second instrument: The emotional distress scale (DASS -21)**

This scale was originally developed by Lovibond & Lovibond, (1995) to assess emotional distress on three sub-scales (depression, anxiety and stress). This scale includes 21 items. Psychological structures of depression, anxiety and stress were evaluated by 7 different items for each subscale. Each question demonstrated a feeling in the participant.

**Scoring system: The rating scale was as follows:**

- 0 = Did not apply to me at all.
- 1 = Applied to me to some degree, or some of the time.
- 2 = Applied to me to a considerable degree or a good part of time.
- 3 = Applied to me very much or most of the time.

**Total score of emotional distress:**

The scale was evaluated giving a score of 0 - 63. The total score of each parent was categorized arbitrary into No ED, if his/her total score was 0 – 30, mild ED, if the total score was 31– 40, moderate ED if the total score was 41 – 51, severe ED if the total score was 52 – 63.

**Third instrument: Scale of psychological wellbeing (SPWB)**

This scale was developed by Ryff & Keyes, (1995). It was composed of 18 items on six sub-scales in accordance with the six factors of positive functioning namely autonomy, environmental mastery, personal growth, purpose in life, positive relations with others and self-acceptance.

**Scoring system:**

The rating scale was as follows:

- 1 = strongly agree.
- 2 = somewhat agree
- 3= somewhat disagree
- 4 = strongly disagree

**Scoring system:**

Higher scores mean higher levels of psychological well-being.

**Total score of psychological wellbeing:**

The total score of each parent was summed and converted into percentage and categorized into : low PSWB when he/she achieved less than or equal  $\leq 50\%$  of the total score i:e ( $< 36$ ), intermediate PSWB when the he/she achieved  $>50$  to  $75\%$  of the total score - i:e ( $<37 - 54$ ) , and high PSWB when the he/she achieved more than  $> 75\%$  of the total score i:e ( $55 - 72$ ).

**Instruments validity**

The study instruments were tested for content validity by a jury of five experts in the field specialty of psychiatric mental health nursing, and psychiatric medicine. Following the

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judgment of the experts, the required modifications were done accordingly to ascertain the relevance, coverage of the content and clarity of the questions. Then they conclude a high degree of agreement on the best form to be implemented and the tools were approved to be valid following the judgment of the experts.

### **Instruments reliability**

It was measured by test-re-test for testing the internal consistency of all tools of the study; it was applied by the researcher. The tools were applied to the same subjects (10 parents) under similar conditions two times, fifteen days apart. The subjects' answers from the repeated testing were compared (test - retest reliability). The internal consistency the questionnaire was calculated using Cronbach's alpha coefficients. The reliability of the tools was done and proved to be strongly reliable, instrument 2 was reliable at 0.81 and instrument 3 was reliable at 0.84.

### **Ethical Considerations**

An approval sheet was obtained from the Ethical Research Committee of the Faculty of Nursing, Menoufia University. An official letter was obtained from the dean of the faculty of nursing and directed to the administrator of the setting to permit data collection and gain their support. Informed consent was taken from every participant after he/she was being informed about purpose, procedure, benefits and nature of the study. All participants were informed that the information they provided during the study would be kept

confidential and used only for statistical purpose and after finishing the study.

### **Pilot study**

A pilot study was carried out on 10% of the total sample (10 parents) to test the feasibility, clarity, and applicability of the instruments. No modifications were done, so the pilot study sample wasn't excluded from the study.

### **Procedure of data collection:**

- Before starting the study, an administrative approval was obtained from directors the dean of Faculty of Nursing Menoufia University, then send to the head of the department of out-patient clinics Menoufia University after explanation of the purpose of the study to get the permission.
- The psycho-educational program sessions were constructed after reviewing the related literature, electronic dissertation, available books, articles, and ideas from external sources and periodicals and were prepared by the researcher, reviewed by a jury and was being ready to be given finally in a form of booklet.
- They started data collection by introducing themselves to the participants and a brief description of the purpose, nature of the study and the type of the questionnaire required to fill were given to each participant to gain his/ her cooperation and sharing in the study.
- After an explanation about the program sessions, parents who fulfilled the inclusion criteria were invited to participate in the study.

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- An informed oral consent was obtained by the researcher from every parent who accepts to participate in the study and fulfills the inclusion criteria, the researchers answered all related questions, and data collection was done through interviews with the parents at the waiting hall of the outpatient psychiatric clinic of Menoufia University Hospital using the instruments of data collection (pre-test).
- All parents who had emotional distress and met the inclusion criteria were included in the study and divided into two groups randomly (study and control group), 50 parents for each group.
- Then the study group arranged in three subgroups (each group contains 16 to 17 parents) and informed that every subgroup would attend 10 nursing program sessions within two days/ week until the end of the sessions and the control group took the routine care.
- The researchers collected data and implemented the psycho educational program sessions during the morning at two days/ week on Saturday and Sunday. Those two days were available to the parents because they attend for medical follow up and continue their children's treatment plan.
- The three subgroups attend the nursing psych educational program from 11 am to 12 am for the first group, from 12 am to 1pm for the second group and from 1pm to 2 pm for the third one, every Saturday and Sunday for ten sessions.
- Every parent received ten sessions, lasts for almost one month and a week at a rate of two sessions per week, every session lasted for 45-60 minutes depending on the parents' response and each session had specific objectives.
- The methods of teaching that were used while implementing the sessions were booklet, lectures, discussions, brainstorming, demonstration and re-demonstration, real-life situations and role playing. Data show presentation, videos, pictures and the booklet were used as a media.
- Summery, feedback, further clarifications were done for vague items and homework was given at the end of each session. The process of data collection, assessment, and implementation of the psycho educational program sessions carried out from September to December 2022. The implementation of the study passed into four phases (assessment, planning, implementation, and post assessment phase).

**Phase (1): Assessment phase:**

Once the permission was obtained to continue this study, orientation was done about the researcher's name, purpose, significance, content of the study. The researcher met the parents within two days \weekly from 10am to 1am in the waiting hall for 100 parents and through the interview technique the parents were asked individually to fill the pre-test assessment questionnaire.

Assessment was done using the emotional distress scale (DASS, 21), and psychological wellbeing scale (PSWB). The researcher contacted them for clarification of the scales. The pre-test results revealed that all of the 100 parents had emotional distress and disturbed levels of psychological wellbeing then the researcher divided

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them into two groups ,control group (50 parents) who didn't receive psycho-educational program and study group (50 parents) who received psycho-educational program.

**Phase (2): planning**

In this phase setting goals/ outcomes of the psycho-educational program sessions were done. The general objective was stated that the participant parents would be able to overcome the problem of emotional distress and improve their psychological wellbeing. This aim was achieved through specific objectives. As the participant, parents would be able to identify the concept of conduct disorder. List conducts disorder types. identifying risk factors for conduct disorder and conduct disorder management, identifying the concept of emotional distress, list the main types of emotional distress and its symptoms, demonstrate how to reduce emotional distress, practice measures to overcome emotional distress, and identifying relaxation technique kit, praise the importance of relaxation techniques, demonstrate types of relaxation techniques, and practice types of relaxation techniques. Moreover, identify the concept of emotional distress, identify dimensions of psychological well-being, knowing theories of psychological wellbeing, praise the importance of psychological wellbeing, and demonstrate measures to improve their psychological wellbeing and practice measures to improve psychological wellbeing.

**Phase (3): Implementation Phase (for the study group only)**

The researchers implemented according to the following steps:

- The first step: The participants of the study group who met the inclusion criteria were included in the study

and the researcher reintroduced herself to them and explained the rules and regulations.

- The second step: The researcher divided the participants of the study group into three equal subgroups. Every subgroup was nearly 16:17 parents, each subgroup attended ten consecutive psycho-educational sessions, every session took about 45:60 minutes within two days / week from 11am to 2 pm. The study was carried out in the period that started from September 2022 to December 2022 including the assessment and the implementation of the sessions.
- The sessions were designed to meet specific objectives, including the main aim of the session, revision of the previous session, and feedback teaching methods and the media used during the sessions, finally conclusion about the session and given homework.
- The researchers distributed the content of each session after explanation and discussion of the content with them and homework was given. At the beginning of each session, the researcher was asked about the homework, application and how they used the content.

**Psycho-educational intervention program:**

It was designed by the researcher focused on the following sessions:

- Session 1: Introduction, orientation, and overview of the sessions
- Session 2: Information about conduct disorder
- Session 3: how to deal with conduct disorders
- Session 4: information about emotional distress
- Session 5: Management of emotional distress

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- Session 6: Relaxation techniques as a way to improve emotional distress; its definition, aims, when to use or not to use and its stages,
- Session 7: different types of relaxation techniques
- Session 8: Information about psychological wellbeing; its definition, dimensions and the characteristics of a person who has psychological wellbeing.
- Session 9: General tips for improving psychological wellbeing.
- Session 10: Final session, the closing of the psycho-educational program

**Phase (4): post assessment phase**

**(Evaluation):**

During this phase, the participants were encouraged to ask any questions or demand clarifications they needed and the researchers assessed the achievement of the aim of the study through reintroducing the research instruments (Emotional distress Scale, and psychological wellbeing scale) (Post-Test) for both study and control group to evaluate the effectiveness of the psycho educational program sessions.

After obtaining the results for an ethical purpose, the nursing program sessions were given to the control group also.

**Statistical Analysis**

Data were coded and transformed into specially designed form to be suitable for computer entry process. Data were collected, tabulated, statistically analyzed using an IBM personal computer with Statistical Package of Social Science (SPSS) version 20 where the following statistics were applied.

**A.** Descriptive statistics: in which quantitative data were presented in the form of mean ( $\bar{X}$ ), standard

deviation (SD), and qualitative data were presented in the form of numbers and percentages.

**B.** Analytical statistics: used to find out the possible association between studied factors and the targeted disease. The used tests of significance included:

\*Chi-square test ( $\chi^2$ ): was used to study association between two qualitative variables.

\*Pearson correlation (r): is a test used to measure the association between two quantitative variables.

\*Correlation coefficient test (r-test): Results may be positive or negative correlation.

- P value of  $>0.05$  was considered statistically non-significant.

- P-value  $<0.05$  was considered statistically significant.

- P value  $< 0.001$  was considered statistically highly significant.

\*McNemar's test: To assess the significance of the difference between two correlated proportions.

\*T- test: This is a test of significance used for comparison between means of two groups having quantitative data.

**Results**

**Figure 1:** Highlighted the efficacy of the psycho-educational nursing intervention program for the levels of total score of emotional distress as well as its three subscales. Concerning study group, Pre-program assessment revealed that (44%) had no emotional distress which increased to (100%) post intervention, (26%) suffered from mild emotional distress which decreased to (0%) post intervention, (26%) suffer from moderate emotional distress symptoms which decreased to (0%) post intervention and (4%) suffered from severe emotional distress which decreased to (0%) post

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intervention with statistically significant difference at ( $p$  value  $>0.001$ ). Concerning control group, Pre-program assessment revealed that (20%) had no emotional distress which converted to (30%) post intervention, (42%) suffered from mild emotional distress compared to (66%) post intervention, (36%) suffer from moderate emotional distress which decreased to (4%) post intervention and (2%) suffered from severe emotional distress which decreased to (0%) post intervention. This result approved current study first hypothesis.

**Figure 2:** Demonstrated grand total psychological wellbeing among study and control groups pre/post intervention ( $N=50$ ) for each. This graph demonstrated the efficacy of the psycho-educational program psychological wellbeing as well as its three subscales. Concerning study group, pre-program assessment revealed that (4%) had low psychological wellbeing which converted to (0%) post intervention, (76%) had intermediate psychological wellbeing which decreased to (8%) post intervention, and (20%) had psychological wellbeing levels which increased to (92%) post intervention with statistically significant difference at ( $p$  value  $>0.001$ ). Concerning control group, pre-program assessment revealed that (4%) had low psychological wellbeing which converted to (0%) post intervention, (88%) had intermediate psychological wellbeing pre intervention life which increased to (90%) post intervention, and (8%) had high psychological

wellbeing levels compared to (10%) post intervention.

This result approved current study second hypothesis.

**Table 1:** Showed the relation between post intervention level of emotional distress and level of psychological wellbeing among study and control groups. Post -intervention program revealed a highly significant improvement in the grand total ED levels as well as grand total psychological wellbeing levels among study group than control group ( $p<0.0001$ ). Post intervention, all study group participants were normal level of ED (100%) whose 92% of them showed high level of grand total psychological wellbeing, and 8% of them showed intermediate level of grand total psychological wellbeing. On the other hand, 30% of control participants showed normal level of ED, only 26.7% of these control participants showed high level of grand total psychological wellbeing, and 73.3% of them showed intermediate level of grand total psychological wellbeing.

**Figure 3:** Illustrated correlation coefficient between grand total emotional distress and their psychological wellbeing post intervention among study group ( $n=50$ ). This graph represented a high negative significant correlation between post intervention grand total ED and grand total psychological wellbeing.

**Table 2:** Demonstrated relation between ED and psychological wellbeing pre and post intervention among study group ( $N=50$ ). The table

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showed that, there were statistically significant differences between parents' levels of emotional distress and total score of their Psychological wellbeing pre intervention ( $p < 0.02$  for each). However, concerning post intervention no statistics are computed because there are fewer than two groups for the variable grand total psychological wellbeing. This represented the efficacy of the psycho educational program in improving their psychological wellbeing.

**Table (3 A-B ):** Highlighted the relation between the parents' sociodemographic characteristics and the levels of their emotional distress. The table showed that, there were no statistically significant differences between parents' sociodemographic characteristics and levels of total score of their emotional distress. ( $p > 0.05$  for each) except in three items: their gender, education, and maternal occupation status, which had statistically significant differences ( $p < 0.01$ ,  $< 0.001$  and  $< 0.003$  respectively). While male parents showed a higher percentage of mild ED (37% vs. 13%) and moderate ED levels (29.6% vs. 21.7%) than female parents, female parents showed higher statistically significant normal ED than male parents (65.2% vs 25.9%). In addition, Illiterate / parents showed a higher percentage of moderate ED compared with those had either diploma or high education (66.7% vs 33.3% and 0 % respectively). Opposite

pattern was observed in normal ED where High education & postgraduate parents showed the highest percentage than both illiterate and diploma education parents (73.3% vs. 0% and 40.7% respectively), this difference was highly significant statistically ( $P < 0.001$ ). Concerning parental working, parents who work as employee showed a highest percentage of "normal ED" than all others (85.7% vs. 18.5%, 66.7%, & 50%), and the difference was highly significant statistically ( $P < 0.003$ ).

**Table 4:** Demonstrated relation between clinical data and levels of emotional distress pre intervention among study group ( $N=50$ ). This table showed that there was a statistical significant deference between conduct disorder children age and levels of emotional distress ( $p < 0.01$ ), conduct disorder subtype ( $p < 0.009$ ) for each subtype, and onset of beginning the diagnosis of conduct disorder ( $p < 0.008$ ).

**Table 5:** Showed the relation between clinical data and levels of psychological wellbeing post intervention among study group ( $N=50$ ). This table showed that there was no association between total psychological wellbeing levels and each of clinical data ( $P > 0.05$  for each). This non-significant result may be due to the small sample size of parents within the intermediate level of psychological wellbeing (only 4 parents).

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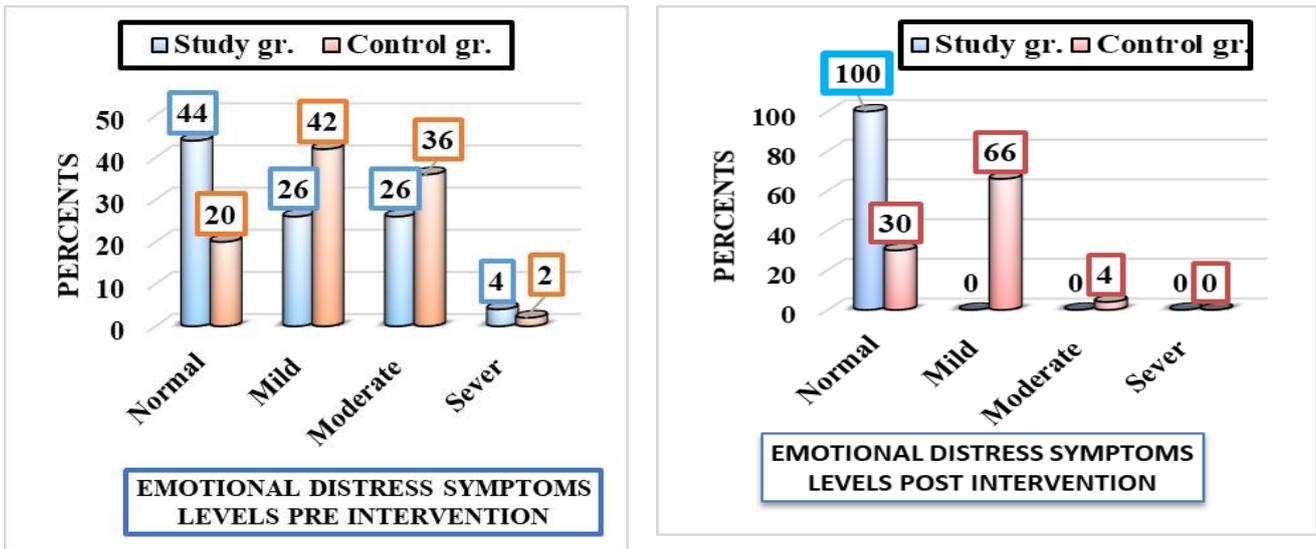


Figure (1): Levels of total emotional distress symptoms among study and control groups pre and post-intervention (N=50) for each group.

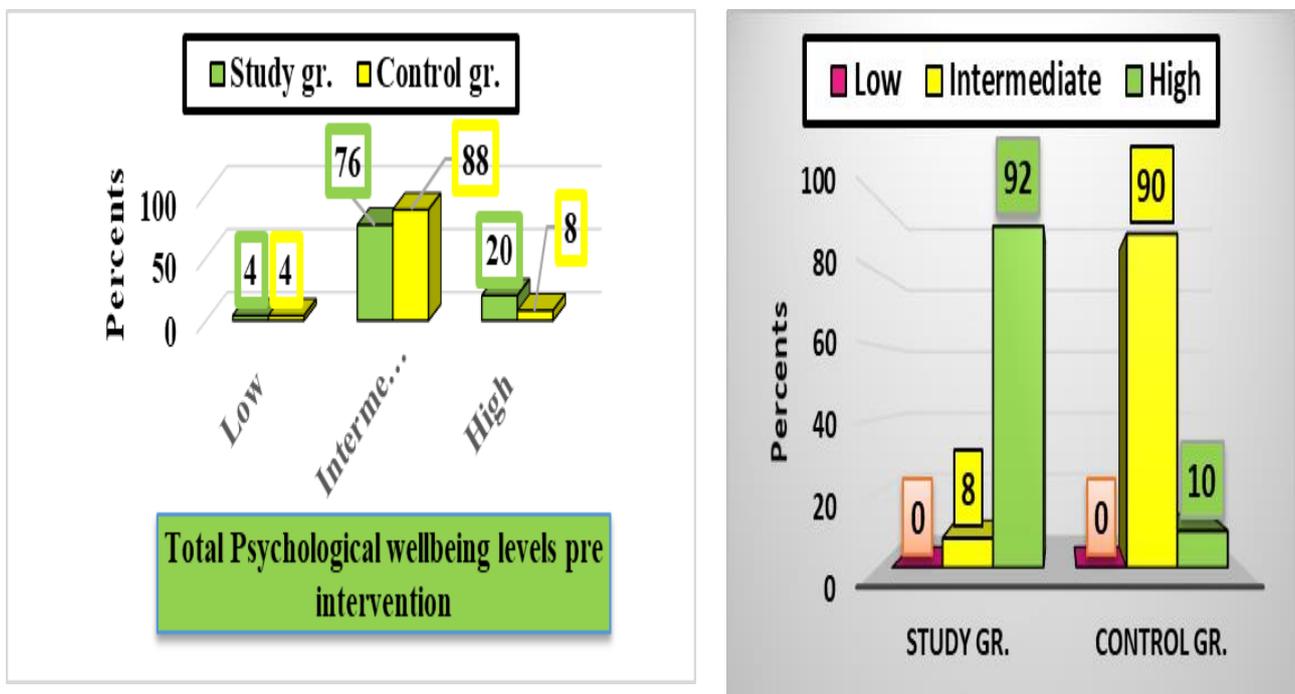


Figure 2: Grand total psychological wellbeing among study and control groups pre/post intervention (N=50) for each.

**Table 1: Relation between level of emotional distress and level of psychological wellbeing among study and control groups post intervention (n=50) for each.**

Emotional Distress levels	Study group							Control group							P3 value
	Psychological wellbeing levels							Psychological wellbeing levels							
	Low		Intermediate		High		P1	Low		Intermediate		High		P2	
	NO	%	NO	%	NO.	%		NO	%	NO	%	NO.	%		
Normal.	0	0	4	8	46	92	NA	0	0	11	73.3	4	26.7	P<0.04	54.3, P<0.0001
Mild ED	0	0	0	0	0	0		0	0	33	100	0	0		
Moderate ED	0	0	0	0	0	0		0	0	2	100	0	0		
Severe ED	0	0	0	0	0	0		0	0	0	0	0	0		
Total	0	0	4	8	46	92		0	0	46	92	4	8		

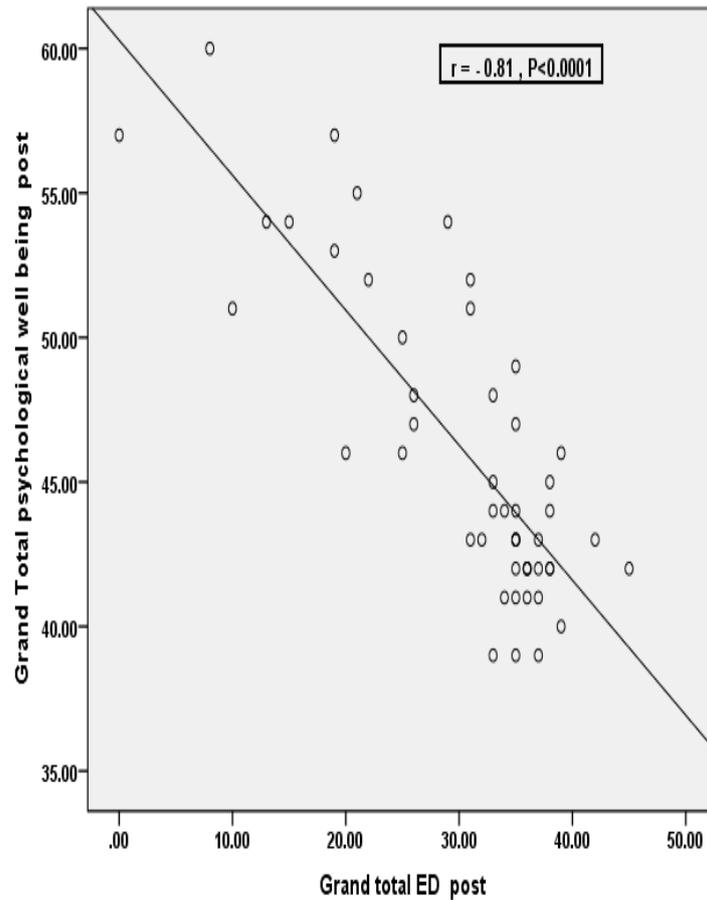
NA= Not applicable. No statistics are computed because Groups of grand total ED post is a constant.

P1=Relation between post intervention Emotional Distress, and Psychological wellbeing levels among study group

P2=Relation between post intervention Emotional Distress, and Psychological wellbeing levels among control group

P3= Comparison between post intervention Emotional Distress, and Psychological wellbeing levels among study and control groups

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**Figure 3: Correlation coefficient between grand total emotional distress and their psychological wellbeing post intervention among study group (n=50).**

**Table 2: Relation between ED and psychological wellbeing pre and post intervention among study group (N=50).**

Levels of Emotional Distress	Pre intervention			Post intervention		
	Total Psychological wellbeing			Total Psychological wellbeing		
	Mean ± SD	Test of Sig.	P value	Mean ± SD	Test of Sig.	P value
Low	56.8±4.6	F=3.5	<0.02	60.4 ±6.6	NA*	NA*
Mild	47.2±6.2			0		
Moderate	46.5±5.8			0		
Severe	40.0±1.2			0		

\*NA= Not Applicable.

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**Table 3A: Relation between study group parents' sociodemographic characteristics and their levels of pre intervention emotional distress (N= 50)**

Emotional Distress		Total	levels of Emotional Distress pre-intervention								Chi-square	
			Low		Moderate		High				X <sup>2</sup>	P-value
			N	%	N	%	N	%	N	%		
Father Age (years)	<30Y	13	7	53.8	1	7.7	5	38.5	0	0	6.9	0.32 NS
	30 – <40 Y	27	11	40.7	8	29.6	6	22.2	0	0		
	40- ≥ 50 Y	10	4	40	4	40	2	20	0	0		
Mother Age (years)	<30Y	23	11	47.8	4	17.4	8	34.8	0	0	10.9	0.09 NS
	30 – <40 Y	21	9	42.9	5	23.8	5	23.8	2	9.5		
	40- 50 Y	6	2	33.3	4	66.7	0	0	0	0		
Gender	Males	27	7	25.9	10	37	8	29.6	2	7.4	12.1	<0.01 S
	Females	23	15	65.2	3	13	5	21.7	0	0		
Education	Illiterate/R&W	6	0	0	2	33.3	4	66.7	0	0	12.6	<0.001 HS
	Basic Edu.	2	0	0	2	100	0	0	0	0		
	Diploma edu.	27	11	40.7	5	18.6	9	33.3	2	4.4		
	High Edu.	15	11	73.3	4	26.7	0	0	0	0		
Marital status	Married	43	12	27.9	11	25.6	2	4.7	0	0	6.4	0.37
	Divorced	4	3	75	1	25	0	0	0	0		
	Widowed	3	1	33.3	0	0	2	66.7	0	0		
Income	Not satisfied	23	9	39.1	6	26.1	8	34.8	0	0	9.7	0.13 NS
	Satisfied	21	9	42.9	7	33.3	3	14.3	2	9.5		
	Satisfied & save	6	4	66.7	0	0	2	33.3	0	0		
parent Occupation	HW*. Not work	27	5	18.5	9	33.3	11	40.7	2	7.4	24.8	<0.003 HS
	Worker	3	2	66.7	0	0	1	33.3	0	0		
	Employee	14	12	85.7	2	14.3	0	0	0	0		
	Others	6	3	50	2	33.3	1	16.7	0	0		

**Table 5: Relation between clinical data and levels of psychological wellbeing post intervention among study group (N=50)**

Clinical data of children with conduct disorder	N	Psychological wellbeing levels				χ <sup>2</sup> / LR	P value
		Intermediate		High			
		NO.	%	NO.	%		
<u>Age groups:</u>							
2- 5 years	13	1	7.7	12	92.3	0.58	0.74 NS
6 - 9 years	31	2	6.5	29	93.5		
> 9 years	6	1	16.7	5	83.3		
<u>Child gender:</u>						0.65	0.79 NS
Male	40	3	7.5	37	92.5		
Female	10	1	10	9	90		
<u>Conduct disorder subtype:</u>						2.4	0.65 NS
Aggressive conduct	13	1	7.7	12	92.3		
Deceitful B behavior	6	1	16.7	5	83.3		
Destructive behavior	11	1	9.1	10	90.9		
Violation of rules	9	1	11.1	8	88.9		
More than one behavior	11	0	0	11	100		
Diagnosis of conduct disorder since:						1.3	0.53 NS
< 1 year	4	0	0	4	100		
1 to 2 years	15	2	13.3	13	86.7		
> 2 years	31	2	6.5	29	93.5		
Follow-up at psychiatric clinics:						0.11	0.94 NS
< 6 months	22	2	9.1	20	90.9		
6 mo. to one year	12	1	8.3	11	91.7		
> one year	16	1	6.3	15	93.7		
<b>Total</b>	<b>50</b>	<b>4</b>	<b>8</b>	<b>46</b>	<b>92</b>		

## **Discussion**

Conduct disorder is among the most serious and complex complications in school-aged children. Raising a child with CD isn't like traditional childrearing. It can become frustrating to cope with some of the behaviors which result from a child diagnosed with CD. CD causes children to be more distractible, aggressive, hyperactive, and impulsive than is normal for their age. As a result, they often act in ways that are difficult for parents to manage (Helleman et al., 2022). Therefore, the purpose of this study was to evaluate the effect of psychoeducational program on emotional distress and psychological wellbeing for parents having children with conduct disorder.

The current study revealed that pre intervention program, a non-significant difference between study and control groups for each of the emotional distress subscales as well as grand total ED arithmetic means ( $P>0.05$  for each). The study and control groups had mild emotional distress pre intervention, (fig., 1). This might be illustrated by lack of adequate professional support to those parents. Parents were in need for receiving help from healthcare professionals already at the stage of diagnosis of their child's problems. Among the multiple factors contributing to this situation, a major cause is the general lack of education about the course of young children's development and its disorders among professionals (including physicians and psychologists), and insufficient

knowledge of symptoms indicating significant behavioral difficulties. Another important issue is the small number of diagnostic and treatment institutions offering specialized services to individuals with CD. Preprogram CD behavior could be the challenging for parents of study and control group, leading to elevated symptoms of parenting stress, depression and anxiety. In turn, distressed parents are at higher risk for providing suboptimal quality of caregiving. As a result, psychoeducational interventions can be effective in reducing emotional distress.

The result of the current study was in harmony with a study which conducted by (Şipoş, & Predescu, 2017) who studied "The relationship between emotional distress and cognitive coping strategies in adolescents with conduct disorder (CD)" and assumed that the emotional distress is generated among other factors, by the child cognitive individualities, they investigated whether in this population having children diagnosed with conduct disorder, the potential mediators (irrational beliefs and coping strategies) relate statistically significant to the reported emotional distress. They reported that parents having children with conduct disorder reported a low level of emotional distress and negative dysfunctional emotions (depression, anxiety) confirming the lack of a relationship between the symptoms of

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internalization and those of externalization with acts of aggression. Several studies which conducted by (Fredriksen et al., 2019) who studied “parenting stress plays a mediating role in the prediction of early child development from both parents ‘perinatal depressive symptoms’”; they had highlighted a few factors that are associated with parental distress. Besides that, prenatal depressive symptoms also reported to have high influence on parental distress. Furthermore, it indicated that the financial problems as one of the major factors lead to parental distress. Thus, the existing body of research recognizes the importance of addressing parental distress on children ‘s emotional problem.

However, post -intervention program of the current program proved its effectiveness in reduction of the study group emotional distress rather than the control one and revealed a highly significant improvement in the grand total ED means as well as each of its three subscales, among study group (much lower means values) than control group ( $p < 0.0001$ ) for each (fig., 1). This may be due to the effectiveness of the psychoeducational program in increasing understanding and learning of how can deal with of children’s bizarre behavior that can cause positive thoughts and emotions on their parents and the skills they learned during the program sessions.

The result of this study concerning post program was in the same line with a study which conducted by (Zhang et al., 2019) who studied “Parenting stress and mother– child playful

interaction: the role of emotional support” and found that parents who have less social support shows high level of distress compared to the ones receiving adequate amount of social support.

Another study proved the study result of the effectiveness of the psychoeducational program in reducing the parental emotional distress was conducted by (Reczek, & Zhang, 2015) who studied” Parent–Child Relationships and Parent Psychological Distress: How Do Social Support, Strain, Dissatisfaction, and Equity Matter?” and suggested that the parenting group program is feasible, acceptable and has preliminary efficacy in reducing child misbehavior and increasing family functioning and couple functioning and a reduction of psychological distress among low-income, primarily minority families attending a primary care clinic.

The current study demonstrated the efficacy of the psycho-educational nursing intervention program psychological wellbeing which achieved greater improvement in the psychological wellbeing among the study group rather than the control group (Fig., 2). This might be explained by positive benefits for parents as a result of the attendance of the program sessions: decreased tiredness, better support from the researcher, an increase in their own active coping knowledge and compliance with professional advice. This result approved current study second hypothesis which stated “Psychological well-being level will be

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increased among parents of children with conduct disorder who receive psycho-educational nursing program (study group) than parents who don't (Control group)".

These results were in harmony with a study which conducted by (Hauser-Cram et al., 2021) who studied "children with disabilities: a longitudinal study of child development and parent well-being" and found that many mothers (75%) and fathers (67%) perceived themselves as having good or fairly good psychological wellbeing. They found a significant strong association between additional emotional and behavioral problems in children with CD and mental health problems and distress in parents that persisted after controlling for potential confounders.

Concerning correlation between grand total emotional distress and their psychological wellbeing post intervention among study group (Fig., 3), this graph represented a high negative significant correlation between post intervention grand total ED and grand total psychological wellbeing. This might be explained as psychological well-being is thus defined as the absence of indicators of emotional distress and in the current study, post intervention program revealed greater reduction in emotional distress that consequently resulted in an increase in psychological wellbeing. The findings of the current study were in the same line with a study which conducted by (León-Del-Barco et al., 2019) who studied "Parental psychological control and emotional and behavioral disorders among Spanish

adolescents" found psychological wellbeing that was measured among the parents with conduct disorder children concluded that depression, anxiety, and stress negatively affect life satisfaction irrespective of gender and geographical location. Similarly, other evidences show that depression, anxiety, and stress negatively affect well-being in different groups irrespective of race, place, and gender. Another study which conducted by (Lopez et al., 2018) who studied "Compassion for others and self-compassion: Levels, correlates, and relationship with psychological well-being" and confirmed that psychological well-being has a negative relationship with emotional distress. Psychological well-being not only refers to a condition free from psychological problems, but its meaning is much broader, including the ability of individuals to perceive themselves positively related to others, with environmental mastery, independence, and life goals and emotions that lead to healthy development global self-esteem and lack of depressive disorders. However, well-being in general is always associated with psychological distress, both in the form of internalization and externalization problems.

Concerning relation between level of emotional distress and level of psychological wellbeing among study and control groups post intervention (table, 1). Post -intervention program revealed a highly significant improvement in the grand total ED levels as well as grand total psychological wellbeing levels among

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study group than control group ( $p < 0.0001$ ). Post intervention, all study group participants were normal level of ED (100%) whose 92% of them showed high level of grand total psychological wellbeing, and 8% of them showed intermediate level of grand total psychological wellbeing. On the other hand, 30% of control participants showed normal level of ED, only 26.7% of these control participants showed high level of grand total psychological wellbeing, and 73.3% of them showed intermediate level of grand total psychological wellbeing.

This may be explained that emotional distress in the form of anxiety, sadness, irritability, self-consciousness and emotional vulnerability is strongly correlated with physical morbidity, reduced quality and duration of life, and increased use of health services. High levels of stress and depression have also been reported among families of children having CD child. Various difficult emotions have been reported by parents of these children including anger, grief, shock, guilt, reproductive inadequacy, child-rearing inadequacy, and embarrassment that is indicated to high rates of emotional distress.

The findings of the current study were in the same line with a study which conducted by (León-Del-Barco et al., 2019) who studied "Parental psychological control and emotional and behavioral disorders among Spanish adolescents" they found psychological wellbeing that was measured among the parents with conduct disorder children 70 % showed poor

psychological wellbeing. In term of parental stress, 15 % of the subjects presented with high stress, followed by 45 % ( $n=9$ ) with moderate stress and 40 % ( $n=8$ ) with low stress. Comparing the factors that may contribute to the stress, 45% of the subjects associated their level of stress with children characteristics. These types of parents relate their stress with the qualities of the children that make difficult for them to carry out their parenting role. On the other hand, only 5% of the subjects relate their sources of stress and potential dysfunction of the parent-child system to dimensions of the parents' functioning.

Concerning the relation between ED and psychological wellbeing pre and post intervention among study group (table, 2). The table showed that, there were statistically significant differences between parents' levels of emotional distress and total score of their psychological wellbeing pre intervention ( $p < 0.02$  for each). However, concerning post intervention no statistics are computed because there are fewer than two groups for the variable grand total psychological wellbeing. This represented the efficacy of the psychoeducational program in improving their psychological wellbeing. This may be due to emotional distress adversely affects life satisfaction and wellbeing.

The results of the current were in harmony with a study which conducted by (Flouri et al., 2019) who studied "Paternal psychological distress and Child Problem Behavior from early childhood to middle adolescence" and

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found that Parents' well-being and psychological distress, the behavior of the child with conduct disorder, and support from the community health services all influence family functioning. Parents with children not medicated for CD seem to be most vulnerable. Parent management training with focus on effective parenting strategies, as well as training in parental cognition for the perception of parental stress, self-esteem, and locus of control, may help these parents in their parenting and help strengthen family functioning. The fathers need support to become engaged in the treatment and follow-up of children with CD to help ease the loads of perceived responsibility in mothers.

Concerning relation between study group parents' sociodemographic characteristics and their levels of pre intervention emotional distress (tables, 3a&3b), the results of the current study showed that, there were no statistically significant differences between parents' sociodemographic characteristics and levels of total score of their Psychological wellbeing ( $p > 0.05$  for each). This table showed that, there were no statistically significant differences between parents' sociodemographic characteristics and levels of total score of their emotional distress ( $p > 0.05$  for each) except in three items: their gender, Education, and Maternal occupation status, which had statistically significant differences ( $p < 0.01$ ,  $< 0.001$  and  $< 0.003$  respectively). This may be due to the

same inclusion and exclusion criteria for the studied parents.

While male parents showed a higher percentage of mild ED (37% vs 13%) and moderate ED levels (29.6% vs 21.7%) than female parents, female parents showed higher statistically significant "normal ED" than male parents (65.2% vs 25.9%). In addition, Illiterate parents showed a higher percentage of "Moderate ED" compared with those had either Diploma or high education (66.7% vs 33.3% and 0 % respectively). Opposite pattern was observed in "Normal ED" where High education & postgraduate parents showed the highest percentage than both illiterate & diploma education parents (73.3% vs 0% and 40.7% respectively), this difference was highly significant statistically ( $P < 0.001$ ). Concerning parental working, parents who work as employee showed a highest percentage of "normal ED" than all others (85.7% vs 18.5%, 66.7%, & 50%), and the difference was highly significant statistically ( $P < 0.003$ ).

The results of the current study seemed to go hand in hand with some other previous studies. In an investigation into parental distress, (Noonan et al., 2018) in their study of "Population Health Family income, maternal psychological distress and child socio-emotional behavior" found factors affecting parents' capacity to promote positive development, in combination with financial hardship, which contributes to variation in behavior and that family and external factors, representing the parental stress and investment frameworks,

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substantially mitigated the effect of income and poverty on children's behavior.

On the same line with the statement aforementioned, (Carreras et al., 2019) who studied "Emotion regulation and parent distress: getting at the heart of sensitive parenting among parents of preschool children Experiencing High Sociodemographic Risk" emphasized that parents from low income families tend to suffer from distress which eventually affects children's emotion and that parents who have financial problems may effect children's emotional problem. — When parents have financial problems, they will think that children are factors causing this issues. The findings of the current study also supported the above mentioned statement where children from poor or families with financial difficulties tend to have emotional problems. This is due to the fact that parents will be more focused and spending more time for the financial stability of the family which subsequently decreases the quality time spend with the children at home. Besides financial difficulties, parent's educational qualifications also one of the family-related matters which lead to parental distress.

This statement supported by (Taylor et al., 2016) "Experience of strain among types of caregivers responsible for children with serious emotional and behavioral disorders" where educated parents indicated higher level of life satisfaction and less likely to have psychological problems. On the other hand, current study also pointed out

that most of the mothers in Selangor have high level of parental distress due to the duty of taking care of their children most of the time compared to their spouse.

Concerning relation between Clinical data and levels of emotional distress pre intervention among study group (table,4). This table showed that there was a statistical significant deference between conduct disorder children age and levels of emotional distress ( $p < 0.01$ ), conduct disorder subtype ( $p < 0.009$ ) for each subtype, and onset of beginning the diagnosis of conduct disorder ( $p < 0.008$ ). This might be explained that parents are the commuter of family who needs to take care of their children most of the time.

Noonan et. al, (2018) in their study of "Population Health Family income , maternal psychological distress and child socio-emotional behavior : Longitudinal findings from the UK Millennium Cohort Study" confirmed that maternal distress has influence on children's emotional problems and highlighted that maternal distress patterns is highly significant with the children's emotional symptoms. These results are consistent with those of (Yoo et al., 2014) who studied "Maternal Distress Influences Young Children's" which emphasized that children's emotional problems are positively associated with long-term maternal distress and reported —if parents are unable to regulate themselves appropriately, they may struggle to respond to their children's own distress in a functional way and model maladaptive regulatory

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strategies. It will make children become frustrated and disappointed where parents does not build relationship with their children.

Regarding the relation between Clinical data and levels of psychological wellbeing post program among study group (table, 5). This table showed that there was no association between total Psychological wellbeing levels and each of clinical data ( $P > 0.05$  for each). This non-significant result may be due to the small sample size of parents within the intermediate level of Psychological wellbeing (only 4 parents).

These results was in contrast with a study which conducted by (Yoo et al., (2014) who studied “Family Representations Through Maternal View of Child Behavior and Parent-Child Interactions” and found that parental psychological wellbeing and child distress expressed through a range of mental health problems are interlinked and often under-pinned by parenting difficulties, interventions need to focus on reducing such distress among both parents and children, as well as enhancing the quality of family relationships.

### **Conclusion**

Based on the findings of the current study and after implementing psychoeducational program sessions, it was concluded that: The psycho-educational program has a positive effect on reducing emotional distress concerning depression, anxiety and stress levels and improving psychological wellbeing among study

group than control group having conduct disorder children. There was a negative significant correlation between emotional distress and psychological wellbeing among parents of children with conduct disorder.

### **Recommendations**

- 1) The importance of increasing the awareness of illness by health care professionals through counseling, family therapy, free workshops for parents because they are really in need.
- 2) Psychological counseling should be integrated as a part of routine nursing intervention for parents / caregivers with conduct disorder children to enhance their psychological wellbeing.
- 3) Raising the awareness of nurses and healthcare professionals about parents’ experiences of parenting a child with CD has the potential to guide practice and provide appropriate support for these parents, thus minimizing the possible negative impact on their family life.
- 4) Preschool child development programmers identifying parents and families at risk and instituting home visits and support.
- 5) Promote coordination between school and child parents to identify any behavior abnormalities in their children as early as possible.
- 6) Orientation programs should be carried out in order to increase public health awareness about CD. Also, prevention programs need to start early and target high-risk groups.
- 7) A respite care for the parent rather than the child, enhancing social

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networks through parent support networks, and encouraging links with self-help organizations for children with similar difficulties.

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