



# Effect of Life Skill Training on Quality of Life Among Caregivers of Children with Behavioral Disorders: A Study Protocol

**Anita Paul Samanta,**

Research Scholar, Faculty of Nursing, Siksha 'O' Anusandhan (Deemed to be) University, Bhubaneswar, India, Odisha 751030.

**Dr. Sasmita Das,**

Associate Dean, Faculty of Nursing, SUM Nursing College, Siksha 'O' Anusandhan (DTU), Bhubaneswar, India, Odisha 751030.

**Dr. Saswati Nath,**

Professor, and Head of the Department, Dept. Of Psychiatry, Bankura Sammilani Medical College and Hospital, Kenduadihi, Bankura, West Bengal 722102.

**Dr. Surjeet Sahoo,**

Professor and Head of the department, Department of Psychiatry, Institute of Medical Sciences and Sum Hospital, Odisha 751003.

## Corresponding Author

**Anita Paul Samanta,**

Research Scholar, Faculty of Nursing, Siksha 'O' Anusandhan (Deemed to be) University, Bhubaneswar, India, Odisha 751030.

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### KEYWORDS

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### ABSTRACT

**Introduction:** Mental health related issues in children are the alarming health problems of the younger generation; below 15 years of age represent approximately one third of the world's population and 5 to 15% of them are crippled with behavioural disorders. The emotional and behavioural issues range from 6.33% to 43.1% in Indian setting. Childhood behavioural disorders like ADHD, CD and ODD not only impacted their development it has impact on the family caregivers' quality of life in day to day life.

**Aims:** To determine the level of quality of life before administration of life skill training among caregivers and find out the effect of life skill training on quality of life among caregivers.

**Materials and methods:** This trial was interventional in nature, the current investigation was a parallel group trial with repeated measurement, randomized and prospective in design. Caregivers: Parents who are in charge of raising children with behavioural issues are referred to as caregivers. Four domains of life skill training administered in sessions among 24 participants and outcome variable measured by PedSQL Family Impact module.

**Result:** In Experimental Group, the mean Health Related quality of life score (20 items) (mean $\pm$  S.D.) of caregivers was 63.69 $\pm$  8.505. In Control group, the mean Health Related quality of life score (20 items) (mean $\pm$  s.d.) of caregivers was 63.39 $\pm$  7.442. Distribution of mean Health Related quality of life score (20 items) with Group was not statistically significant ( $p=0.721$ ). Whereas the changes of mean between experimental and control group is statistically significant in all three post intervention at 0.01 and 0.001 level.

**Conclusion:** Selective life skill training for caregivers of children with behavioural disorders positively impacts their quality of life by enhancing coping mechanisms, reducing stress, and improving overall well-being. Integrating such interventions into existing support systems may contribute to better outcomes for caregivers.

## INTRODUCTION

Mental health related issues in children are the alarming health problems of the younger generation; below 15 years of age represent approximately one third of the

world's population and 5 to 15% of them are crippled with behavioral disorders. The emotional and behavioural issues range from 6.33% to 43.1% in Indian setting. [1]



The prevalence of attention deficit hyperactivity disorder (ADHD); 1.30% to 28.9%, oppositional defiant disorder (ODD) and conduct disorder (CD) range of 4 and 16%. Behavioral problem; 84.30% of children under parental care and 48.70% out of parental care (Kolkata). [2]

The family caregivers play multiple roles in caring and managing them. They showed high level of stress (mean 33.31; Mousavi et al, 2019; anxiety 35%; Thomas KS et al) poor quality of life, financial, social and care giving burden, losing of self-efficacy, interruption at work and role dissatisfaction irrespective of the subtypes.[3] ; has impacts on the outcome of the behaviour of the children. Earlier studies are limited to descriptive and cross sectional, ADHD caregivers. Very few Interventional; psycho-education, problem solving, coping, stress management and quality of life. There is a dearth of literature in Eastern India and West Bengal too.

One of the most stressful experiences for any family is handling a child with a disability or chronic illness [4]. The parents of a disabled child experience complicated and different feelings Birth of a disabled neonate usually comes as a shock to the family at first. It sometimes leads to feelings of guilt, grief and desperation and parents experience mental distress this changes the status of the family as a social unit in many ways [5] The mother is the first person who can directly communicate with the child. Faced with her disabled child, the mother's natural function will be undermined due to the special circumstances including stereotypes, language difficulties, struggling and lack of self-care skills and mobility problems [6]. According to the fundamental role of the mother in raising, and stabilizing the family, giving support to the parents of disabled children, will noticeably reduce their mental problems such as depression, stress and anger.

Down syndrome is the most common genetic cause of mental retardation [7] The incidence of this syndrome is one per 800 - 900 live births, and is considered as one of the most common congenital abnormalities with varying degrees of mental retardation from moderate to severe. Although the number of problems in children with Down syndrome compared with other disabilities is less, children with Down syndrome compared to normal children are faced with more difficulties [8] These children may have adaptive behavior, social development, memory, language, and emotional problems. Due to the problems such as accepting having a child with disabilities, care-related fatigue, leisure time problems, financial problems, health issues, education and rehabilitation, mothers of children with Down

syndrome are under mental pressure, stress and anxiety and they feel more impotent towards their children [9] These daily challenges and pressures of raising a disabled child may have a negative impact on the quality of life in mothers. Several studies showed that the quality of life in mothers with disabled children is lower than the quality of life in mothers with normal children [10]. According to the World Health Organization definition, the quality of life includes a person's perception of their position in life and in the structure of cultural-value system which they live in. Quality of life is a broad concept that includes concepts such as individual physical health, psychological state, level of independence, social relationships or communicating with outstanding environmental aspects. Environmental factors not only affect the individual's participation in society, but also have impact on quality of life; this is far more important in individuals with disability rather than the normal population [11]. Quality of life is related to disease and conditions that endanger the health and on the other hand, having a disabled child in a family can be a challenging and unpleasant event causing physical and psychological stress in the family, especially the mother [12].

## MATERIALS AND METHODS

**Study Type:** Interventional study. Prospective in nature.

**Study Design:** Randomized, Parallel Group Trial.

Pre-test post-test control group design with repeated measurement.

**Population of the study:** All caregivers of children with behavioural disorders. Caregivers; Refers to the parent who are responsible for the caring of the children with behavioural disorders.

**Sampling and Sample size:** A systematic random sampling technique is to be adopted and 120 sample considered  $[n=2(Z\alpha+Z\beta)^2 S^2/d^2]$ . Where  $z_\alpha = 1.96$  and  $z_\beta=0.84$ ,  $S$  = population standard deviation. With the reference of previous study (Mousavi [13] et al 2019, Standard deviation of stress score of the intervention group is 2.39 and control group is 3.54 at the end point of intervention.  $n_1=n_2=35$ , mean; 49.2 and 52.7. Power 80% at 0.05 level of significance. Desired mean difference =5. So total sample is  $52 \times 2 = 104$ . Possibility of loss to follow up can be assumed at 15%. Adjusting the power in 80% sample size is  $104 + 16 = 120$ .

Sample considered in the result section is 24 (experimental group 12 and control group 12)

**Inclusion criteria**

- Caregiver of the children with diagnosed behavioural disorders with or without Borderline Mental Retardation
- Children receiving standard mental health care
- Primary caregiver of children aged upto 15 years (completed).
- Providing care at least 3 months with the diagnosis
- Willing to participate in the study.
- Able to communicate in local languages

**Exclusion criteria**

- Caregivers diagnosed with severe mental health illness like severe depression, acute psychosis and schizophrenia.
  - Children with psychological disorders, co morbid medical, surgical or neurological illnesses.
  - Missed one session of interventions
  - Taking care of seriously ill parent or family members.
  - Attended life skill training programme before one month
- Study participants: Caregivers of children with behavioural disorders attending outpatient department of psychiatry.

**Setting :** Outpatient department of psychiatry (Child Guidance and adolescent clinic) at Medical College and Hospital, Kolkata, West Bengal, Outpatient department of psychiatry (Child guidance and adolescent clinic) at R. G. Kar Medical College and Hospital, Kolkata & Outpatient Department of Psychiatry (Child guidance and adolescent clinic) at NRS MCH, Kolkata.

**Intervention:** Four domains of life skill training is considered and administered in two weeks interval after assessment of baseline data. The Outcome variable is measured immediately after the intervention, one month after and two months after the intervention.

**Tool:** Translated and validated J.W.Varni's PedSQL Family Impact Module is to be used for the assessment of quality life of the caregivers.

Assessor will assess the outcome variable and she will be blinded.

**Ethical consideration:** Ascertained recommendations from the institutional ethics committees and Control Trial registration Society of India. CTRI (ICMR-NIMS): REF/2022/04/053166; Reg. No: CTRI/2022/05/042455

**RESULT****Table 01. Distribution of caregivers sample characteristics****n=24 (n<sub>1</sub>=12, n<sub>2</sub>=12)**

Sample Characteristics		Experimental [Frequency (%) ]	Control [Frequency (%) ]	Total [Frequency (%) ]	P-value
Age in year	25-≤30	03 ( 25)	02 (16.7)	05 ( 20.8)	0.8786
	31-40	08 ( 66.5)	09(70.8)	17( 70.8)	
	>40-45	01 ( 8.3)	01 ( 8.3)	2 ( 8.3)	
Gender	Male	01( 8.33)	02 ( 16.7)	03 ( 12.5)	0.537
	Female	11( 91.66)	10 ( 83.33)	21(87.5)	
Education	Class IV- IX	07 ( 58.33)	07( 58.33)	14 (58.33 )	0.881
	Secondary education	02 (16.96 )	02 (16.96)	04 (16.66 )	
	Higher secondary	01 (8.33)	02 (16.66 )	03 ( 12.5)	
	Graduation	02 ( 8.33)	01 (8.33 )	03 ( 12.5)	
Marital status	Married	10 ( 83.33)	11 (91.66 )	21 (87.50)	0.3843
	Widower	01 (8.33 )	0	01( 4.16)	
	Widowed	0	01 ( 8.33 )	01( 4.16)	
	Divorce	01 (8.33 )	0	01( 4.16)	
Occupation	Housewife	08 (66.66)	07 ( 58.33)	15 ( 62.5)	0.3618
	Self employed	02 (16.66)	01 ( 8.33)	03 ( 12.5)	
	Job	01 (8.33)	04 ( 33.33)	05 ( 20.83)	
	Cultivation	01( 8.33)	0	01 ( 4.17)	
Family income	≤10000	07 (58.33)	06 (50)	13(54.16)	0.67
	11000-20000	03 (25)	04 (33.33)	07(29.16)	
	21000-30000	01(8.33)	02(16.66)	03(12.5)	
	>30000	01(8.33)	0	01(4.16)	
Type of family	Extended	02 ( 16.66)	01 (8.33)	03 (12.5)	0.8145
	Joint	06 (50)	07( 58.33)	13( 54.16)	



	<b>Nuclear</b>	04 ( 33.33)	04 ( 33.33)	08 (33.33)	
<b>Duration of care giving in moth</b>	<b>≤12</b>	09 (75)	06 (50)	15 (62.5)	0.2537
	<b>13-24</b>	03 (25)	04 (33)	12(50)	
	<b>&gt;24</b>	0	02(16.66)	02 ( 8.33)	
<b>Habitat</b>	<b>Rural</b>	07(58.33)	09 (75)	16 (66.66)	0.5352
	<b>Urban</b>	03 (25)	01(8.33)	04(16.66)	
	<b>Urban slum</b>	02 (16.66)	02 (16.66)	04(16.66)	

Table 02. Distribution of the children by their sample characteristics

n=24 (n<sub>1</sub>=12, n<sub>2</sub>=12)

Characteristics of the child		Experimental [Frequency (%)]	Control [Frequency (%)]	Total [Frequency (%)]	P-value
<b>Age in year</b>	<b>≤10</b>	09 (75)	07( 58.33)	16(66.66)	0.3864
	<b>&gt;10</b>	03(25)	05(41.66)	08( 33.33)	
<b>Gender</b>	<b>Male</b>	09( 75)	08( 66.66)	17( 70.83)	0.6534
	<b>Female</b>	03( 25)	04( 33.33)	07( 29.16)	
<b>Diagnosis</b>	<b>ADHD</b>	06( 50)	06 (50)	1 2(50)	0.5439
	<b>CD</b>	04 (33.33)	03 (25)	07(29.16)	
	<b>ODD</b>	01(8.33)	0	01(4.16)	
	<b>ADHD with CD</b>	01(8.33)	03 (25)	04(16.66)	
<b>Co-morbid illness</b>	<b>Borderline mental retardation</b>	0	02 (16.66)	02 (8.33)	0.1573

Table 03. Distribution of pre-test PedsQL score for experimental group and control group

n=24 (n<sub>1</sub>=12, n<sub>2</sub>=12)

Variable	Group	Mean	SD	Minimum	Maximum	Median	p-value	't' Value
<b>PedsQL total Score (36 item)</b>	<b>Experimental Group</b>	64.1	4.358	57.1	71.6	64.75	0.604	0.392
	<b>Control Group</b>	63.19	4.09	57.8	69.6	62.8		
<b>Health Related Quality of life score (20 items)</b>	<b>Experimental Group</b>	63.69	8.505	53.54	79.89	62	0.721	0.374
	<b>Control Group</b>	63.39	7.442	53.33	77.08	61.87		
<b>Family functioning (8 items)</b>	<b>Experimental Group</b>	63.4	8.42	47.5	77.5	64.58	0.627	0.426
	<b>Control Group</b>	61.38	13.04	40	83.33	63.33		

Table 4 Unpaired 't' test showing comparison of PedsQL score between experimental and control group before, immediately after, one month after and 2 months after the intervention

n=24 (n<sub>1</sub>=12, n<sub>2</sub>=12)

Variable	Group	Mean	SD	Minimum	Maximum	Median	p-value	't' Value
<b>PedsQL Score (36 item) Pre test</b>	<b>Experimental Group</b>	64.1	4.36	57.1	71.6	64.75	0.604	0.392
	<b>Control Group</b>	63.19	4.09	57.8	69.6	62.8		
<b>Post-test-1 Immediately after</b>	<b>Experimental Group</b>	72.59	3.89	67.604	79.11	73.2	<0.0001	8.052
	<b>Control Group</b>	64.25	1.85	61.51	67.96	63.828		



Post-test 2 One month after	Experimental Group	75.55	3.26	70.416	80.416	76.01	<0.0001	9.262
	Control Group	65.58	1.82	62.5	68.854	65.59		
Post-test 3 Two months after	Experimental Group	78.73	3.01	73.43	84.73	78.09	<0.0001	12.13
	Control Group	66.51	1.76	63.64	69.37	66.77		

In experimental, 03 (25%) caregivers were 25-≤30 years of age, 08 (66.5%) were 31-40 years of age and 01 (8.3%) belongs to >40-45 years of age. In Control, 02 (16.7%) caregivers were 25-≤30 years of age, 09(70.8%) belongs to 31-40 years of age and 01 (8.3%) were >40-45 years of age. Association of age in years with sample characteristics was not statistically significant ( $p=0.8786$ ). In Experimental, 01(8.33%) caregivers were male and 11(91.66%) were female. In Control, 02 (16.7%) parents were female and 10 (83.33%) were male. Association of sex with group was not statistically significant ( $p=0.5370$ ). In Experimental, 10 (83.33%) caregivers staying with spouse (were married), 01 (8.33%) were widower and 01(8.33) were divorced. In Control, 11 (91.66%) were married and 01 (8.33%) were widower. Association of Marital status with Group was not statistically significant ( $p=0.3843$ ). In Experimental, 08 (66.66%) caregivers were housewife, 02 (16.66%) were self-employed, In Control, 08 (66.66%) caregivers were housewife, 02 (16.66%) were Self-employed, 01 (8.33%) caregivers. Association of occupation with group was not statistically significant ( $p=0.3618$ ).

In Experimental, 07 (58.33%) caregivers' family income is ≤10000, 03 (25%) and 01(8.33%) caregivers had family income >30000. In Control, 06 (50%) caregiver's family income ≤10000 and 02(16.66%) caregivers had family income 21000-30000. Association of family income with group was not statistically significant ( $p=0.6700$ ). In experimental, 02 (16.66%) parents belong to extended family, 06 (50%) were from joint family and 04(33.33%) represents nuclear family. In Control, 01 (8.33%) parent belong to extended family, 07 (58.33%) parents were from Joint family and 04(33.33%) belongs to nuclear family. Association of type of family with group was not statistically significant ( $p=0.8145$ ). In Experimental, 09(75%) respondents had duration of care giving in month ≤12 and 03 (25%) had duration of care giving in month 13-24. In control, 06 (50%) of them had duration of care giving in month ≤12, 04 (33%) had duration of care giving in month 13-24 and 02(16.66%) had duration of care giving in month >24.

Association of duration of care giving in month with group was not statistically significant ( $p=0.2537$ ).

In experimental, 07(58.33%) caregivers habituated to live in rural area, 01(8.33%) caregivers were habituated to live in urban area. In control, 09 (75.0%) caregivers were habituated to live in rural area, 03 (25%) habituated to live in urban area and 02 (16.66%). Association of habitat with group was not statistically significant ( $p=0.5352$ ). In experimental, majority (58.33%) parent faced family conflict, 03(25%). Whereas in control, half of them [06(50%)] faced family conflict, Association of Problem faced with group was not statistically significant ( $p=0.3068$ ). In Experimental, 11(91.66%) caregivers were mother and 01(8.33%) were father. Whereas in control, 08 (66.66%) were mother and 04 (33.33%) were father. Association of relationship with sick child with group was not statistically significant ( $p=0.6534$ ).

In Experimental, 09(75%) children with behavioural disorder were ≤10 years of age and 03(25%) belongs to >10 years of age. In control, 07(58.33%) children were ≤10 years of age and 05(41.66%) belongs to >10 years of age. Association of age in year with group was not statistically significant ( $p=0.3864$ ). In experimental, 09(75%) children were male and 03(25%) were female. In Control, 08 (66.66%) children were male and 04 (33.33%) were female. Association of gender of the sick child with group was not statistically significant ( $p=0.6534$ ). In Experimental, 06(50%) caregivers had ADHD, 04 (33.33%) caregivers had CD, 01(8.33%) Caregivers had ODD and 01(8.33%) caregivers had ADHD with CD. In Control, 06(50%) caregivers had ADHD, 03 (25%) caregivers had CD and 03 (25%) caregivers had ADHD with CD. Association of diagnosis with group was not statistically significant ( $p=0.5439$ ). In Control, 02 (16.66%) caregivers had Co-morbid illness. Association of Co-morbid illness with group was not statistically significant ( $p=0.1573$ ). In experimental Group, the mean PedsQL Score (36 item) ( $\text{mean} \pm \text{s.d.}$ ) of caregivers was  $64.1 \pm 4.358$ . In control group, the mean PedsQL Score (36 item) ( $\text{mean} \pm \text{s.d.}$ ) was  $63.19 \pm 4.09$ . Distribution of





mean PedsQL Score (36 item) with group was not statistically significant ( $p=0.604$ ).

In experimental group, the mean health related quality of life score (20 items) (mean $\pm$  s.d.) of parent was  $63.69\pm 8.505$ . In control group, the mean Health Related quality of life score (20 items) (mean $\pm$  s.d.) of parent was  $63.39\pm 7.442$ . Distribution of mean Health Related quality of life score (20 items) with group was not statistically significant ( $p=0.721$ ). In experimental group, the mean family functioning (8 items) (mean $\pm$  s.d.) of caregivers was  $63.4\pm 8.42$ . In control group, the mean family functioning (8 items) (mean $\pm$  s.d.) of parent was  $61.38\pm 13.04$ . Distribution of mean family functioning (8 items) with group was not statistically significant ( $p=0.627$ ). In experimental group, the mean PedsQL Post-test-1 [immediately after intervention] (mean $\pm$  s.d.) of parent was  $72.59\pm 3.89$ . In Control group, the mean Post-test-1 immediately after (mean $\pm$  s.d.) of parent was  $64.25\pm 1.85$ . Distribution of mean Post-test-1 immediately after with Group was statistically significant ( $p<0.0001$ ).

In Experimental Group, the mean quality of life Post-test 2 score [One month after intervention (mean $\pm$  s.d.)] of parent was  $75.55\pm 3.26$ . In Control group, the mean Post-test 2 score [One month after (mean $\pm$  s.d.)] of parent was  $65.58\pm 1.82$ . Distribution of mean Post-test 2 score with group was statistically significant ( $p<0.0001$ ). In experimental group, the mean Post-test 3 [Two months after intervention (mean $\pm$  s.d.)] of parent was  $78.73\pm 1.82$ . In control group, the mean Post-test 3 score (mean $\pm$  s.d.) of caregivers was  $66.51\pm 1.76$ . Distribution of mean Post-test 3 with group was statistically significant ( $p<0.0001$ ).

## DISCUSSION

Pro the current investigation was a parallel group trial with a prospective design that was randomized, making it an interventional trial. Caregivers: Parents who are responsible for raising kids who have behavioral disorder are called caregivers. The Child Guidance and Adolescent Clinic is an outpatient psychiatry program offered by the Medical College and Hospital in Kolkata, West Bengal. There were 24 parents in total in this study. Parallel group trial that is randomized and emphasizes observation. **Rosenzweig JM [14]** found in his study on **2008** that lack of appropriate child care is frequently reported by parents of children with disabilities as a major obstacle to finding and maintaining their employment. Care for children with emotional or behavioral disorders is particularly difficult to locate because child care providers often lack adequate

training. Findings are presented from interviews with 60 parents employed a minimum of 30 hr per week and caring for at least one school-age child with an emotional or behavioral disorder.

**Samanta AP et al [1] (2023)** found his study, the majority (75%) of the participants were parents, and the majority of them were female. The participants' mean age was 28 years. A small proportion of them had never received any life skill training. The knowledge questionnaire shows a statistically significant mean difference.

A majority of ninety-five (95.39%) expressed full agreement to learn about this particular LST intervention.

A cent of them expressed satisfaction with the training sessions. A hundred percent of them said they would wholeheartedly recommend this kind of session to others.

The intervention had a positive effect on the caregivers' perception of stress, as evidenced by the mean post-test PSS score reduction. However, in our study, 17 (70.8%) of the 24 caregivers were aged 31 to 40 years, which was not statistically significant ( $p=0.8786$ ).

The majority of the pediatric caregivers in our study [16 (66.66%)] were under the age of 10. But, at  $p = 0.3864$ , this was not statistically significant.

We discovered that there were more male children [17 (70.83%)] than female children [07 (29.16%)].

Although the male to female ratio was 2.4:1, was not statistically significant ( $p=0.6534$ ) in a similar study by **Bar S et al [15] (2023)** found that most of these kids were between the ages of 6 and 12 (57.8%), non-Hispanic White (63.3%), and male (74.7%). and also **Asiri F et al [16] (2023)** found that, The QOL of parents of disabled children is impacted by variables like age, gender, and low income.

The population of women was found to be higher [21 (87.5%)] than the population of men [03 (12.5%)]. Although the ratio of men to women was 0.1:1, this did not reach statistical significance ( $p=0.5370$ ). **Gabatzi RI [17] et al 2018** that, to understand the perspective of caregivers about the formation and disruption of bonds with institutionalized children. A qualitative research that used as a theoretical framework the Attachment Theory and the Symbolic Interactionism, and the Grounded Theory as methodological framework. Participating in the study were 15 female caregivers of children aged zero to three years, from a child care institution in the south of Brazil, from April to July 2015. Three categories were elaborated: "Experiencing the formation of bond and attachment"; "Disrupting with the



established bonds and detaching”; “Learning how to work with formation and disruption of bond”. We need to think of ways to minimize the negative effects formation and disruption of bonds. In this sense, active listening and the offer of psychological support favor the sharing of experiences and the emotional strengthening of the female caregivers.

It was discovered that the same number of caregivers in the experimental and control groups were in classes IV–IX [07 (58.33%)]. However, this did not show statistical significance ( $p=0.8810$ ).

According to our research, compared to the experimental group [10 (83.33%)], the control group [11 (91.66%)] had a higher percentage of married parents (living with spouse). Yet, at  $p=0.3843$ , this was not statistically significant.

We found that in the experimental group [08 (66.66%)], there were more housewives than in the control group [07 (58.33%)]. However, this did not show statistical significance ( $p=0.3618$ ).

It was observed that a higher proportion of the caregivers in the experimental group [07 (58.33%)] had family incomes of  $\geq 10000$  than in the control group [06 (50.0%)]. which, at  $p = 0.6700$ , was not statistically significant.

According to our research, the percentage of caregivers with Joint families was marginally higher in the control group [07 (58.33%)] than in the experimental group [06 (50.0%)]. however, at  $p=0.8145$ , this was not statistically significant.

According to our study, compared to the control group [06 (50.0%)], the majority of parent in the experimental group [09 (75.0%)] had  $\leq 12$  months of care given. However ( $p=0.2537$ ), this was not statistically significant.

It was noted that in the control group [25 (50.0%)], a greater proportion of parent were from rural areas than in the experimental group [07 (58.33%)]. However, this did not show statistical significance ( $p=0.5352$ ).

We found that, in comparison to the control group [06 (50.0%)], a higher percentage of parent in the experimental group [07 (58.33%)] experienced family conflicts. which, at  $p=0.3068$ , was not statistically significant.

**Bar S et al [15] (2023)** showed that, There is little data assessing the quality of life (QoL) of caregivers for children with attention deficit-hyperactivity disorder (ADHD) and autism spectrum disorder (ASD), despite the fact that caregivers of these children experience higher levels of stress than caregivers of typically developing children. The purpose of this study was to

describe how caregiver quality of life is related to children who have ASD or ADHD. Caregivers with ASD and/or ADHD who visited a single pediatric specialty clinic between September 2018 and August 2020 were included in this study. Children with ASD-only, ADHD-only, or youth with both conditions (ADHD + ASD) were the three categories of caregivers.

It was discovered that the number of caregivers with ADHD in the Experimental and Control groups was equal [06 (50.0%)]. Still,  $p=0.5439$  did not indicate statistical significance which similar study found by **Gisladottir M in 2017 [18]** that adolescents with ADHD may develop antisocial behaviour and caregiver's group can empower caregiver's supporting role. To evaluate the effectiveness of a Therapeutic Conversation Intervention on caregivers of adolescents with ADHD regarding strengthening the supportive role.

Only 2 caregivers (16.66%) in the control group in the current study had borderline mental retardation; this difference was not statistically significant ( $p=0.1573$ ). In our investigation, the experimental group's PedsQL Score (36 items) was higher [ $64.1 \pm 4.358$ ] than that of the Control Group [ $63.19 \pm 4.09$ ], but the difference was not statistically significant ( $p=0.604$ ).

We discovered that the experimental group had a higher Health Related Quality of Life score (20 items). Group [ $63.69 \pm 8.505$ ] compared to control group [ $63.39 \pm 7.442$ ] but this was not statistically significant ( $p=0.721$ ).

**Ara JE** showed in his study on **2014 [19]** that, the control group did not receive the psycho-education session and the experimental group received the psycho-education session. During the pretest all measures were administered and in post-test session all measures were re-administered to the experimental group and the control group. During postintervention phase, a significant improvement in caregivers' perceived stress and mental health condition (except severe depression) was noted in the experimental group. But condition of the caregivers of the control group who did not receive psycho-education remained the same for the same variables. Results suggested that psycho-educational intervention is effective in increasing knowledge regarding the condition and in meeting the needs of the caregivers of children with autism spectrum disorders. Family functioning (8 items) showed a higher level in the experimental group in our study. [ $63.4 \pm 8.42$ ] compared to control group [ $61.38 \pm 13.04$ ] but this was not statistically significant ( $p=0.627$ ) at baseline.

**Hedgecock JB et al [20] (2018)** For QOL, use the Pediatric Quality of Life Inventory (PedsQL). The performance was at or below the 16th percentile, as



indicated by the mean VABS-GM of 12.12 (SD = 2.2). The internalizing CBCL t score decreased with increasing VABS-GM after covariate adjustment ( $\beta = -0.64$  SE = 0.12). As VABS-GM increased, so did the total and subscale PedsQL scores ( $\beta = 1.79$  SE = 0.17 for the total score,  $\beta = 0.9-2.66$  SE = 0.17–0.25 for the subscale score). As the PedsQL total score increased, the CBCL internalizing and externalizing t scores declined ( $\beta = -0.39$  SE = 0.01;  $\beta = -0.36$  SE = 0.01). VABSGM significantly altered the relationships between PedsQL and CBCL internalizing or externalizing t scores ( $\beta = -0.026$  SE = 0.005;  $\beta = -0.019$  SE = 0.007). We discovered that the Experimental Group's PedsQL Score (36 item) Pre-test was higher [64.1±4.36] than the Control Group's [63.19±4.09], but this difference was not statistically significant ( $p=0.604$ ).

**Samanta AP et al [1] (2023)** found that, the intervention had an impact on the caregivers' perception of stress, as indicated by the mean post-test PSS score reduction. However, in this study, the experimental group's Post-test-1 score was higher (72.59±3.89) than the Control Group's (64.25±1.85), and this difference was statistically significant ( $p<0.0001$ ).

Current study findings also showed statistically significant difference ( $p<0.0001$ ) between the Experimental Group [75.55±3.26] and the Control Group [65.58±1.82] one month after intervention and two months after the intervention too.

## CONCLUSION

The findings of this study suggest that life skill training significantly improves the quality of life among caregivers of children with behavioral disorders. The most important finding of this study was a significant increase in the total score of quality of life in all the post-test compared to the pre-test in the experimental group, while this difference was not significant in the control group. These results highlight the importance of incorporating life skill training programs into caregiver support initiatives, providing invaluable support to individuals navigating the challenges of caring for children with behavioral disorders. By equipping caregivers with the necessary skills and resources to manage stress and enhance their quality of life, such interventions have the potential to positively impact both caregivers and the children under their care. Further research is warranted to explore the long-term effectiveness and broader implications of life skill training in similar contexts.

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