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Life Skill Training and Self Efficacy of The Caregivers with Behavioural Disorder Children

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ABSTRACT

Background: Psychological health of the primary caregivers has an impact on the outcome of the behaviour of the children with ADHD, CD and ODD. Parents and caregivers often faced conflict between family members, high irritability and poor self-efficacy. The reviewed literature indicated that parent mediated intervention helps in balancing their wellbeing.

Objectives: This study aimed to investigate the impact of life skill training on self –efficacy of the caregivers with behavioral disorder children.

Methods: A randomized control trial was conducted in the year 2022 to 2023 at two tertiary care hospital, Kolkata, West Bengal. Hypothesis was tested at 0.05 level of significance. One hundred and twenty caregivers attending Child guidance clinic of psychiatric outpatient department of the tertiary care hospitals were recruited in a single blind randomized control trial and randomly allocated in experimental and control group. Life skill training (LST) administered to 60 caregivers in 4 sessions at an interval of two weeks along with standard mental health care. Each session consisted of 2 hours. Control group received the available standard mental health care services. The outcome variable is measured by translated and validated standardized general self –efficacy questionnaire at baseline, immediately, 1 months and 2 months after the completion of intervention respectively.

Result: Among the caregiver's majority of them belonged to 31 – 40 years age group. In experimental and control group, 36.65 and 35 percentages of them had secondary education respectively. Majority of them are female and home makers. 50 % of the children belongs to age group of 8-11 yrs in experimental group and 46.67 % of the control group belongs to 8-11 yrs age group. Majority of them diagnosed with ADHD. Mean self –efficacy of the experimental group is 23.01(±3.58) and control group is 22.9 (±5.24) at baseline. And significantly differ from control group at 0.001level of significance after intervention. The improvement of the caregivers self efficacy is sustained in consecutive measurement. So life skill training has positive impact on caregivers' self- efficacy.

Conclusion: Family care givers of the children having behavioural disorder develops inadequate self-efficacy and has impact on their well being. They are in need of guidance and support from the health care providers. Proper education and training on life skill intervention can be the resource of increasing abilities to combat the demand of care giving among care givers and helps in prevention of diseases. Integration of life skill training as a comprehensive approach in multidisciplinary health care services is beneficial for the caregivers.

Keywords: *Life Skill Training, Self-Efficacy, Caregivers and Behavioural disorders.*

1. INTRODUCTION

Caregivers play a critical role in the overall well-being and development of individuals with physical, psychological, or developmental needs. The emotional and behavioural issues range from 6.33% to 43.1% among children in Indian setting. The behavioural complexities diagnosed with ADHD, CD and ODD ranges from 1.30% to 28.9%, 30% to 75% and 4 % to 16% respectively**.** [1,2,3,4] However, the demands of care giving often lead to emotional exhaustion, low confidence, and stress, which may hinder effective care giving. Recent studies have emphasized the importance of life skill training interventions in enhancing caregivers' self-efficacy—the belief in their own ability to handle care giving challenges. Life skills, including emotional regulation, communication, stress management, decision-making, and interpersonal relationships, have been proven to empower caregivers by equipping them with adaptive strategies and practical tools. This training helps to improve cognitive skills, social skills and decision making skills. Evidence shows that such training leads to improved coping mechanisms, reduced caregiver burden, and better mental health outcomes [5], [6], [7].

For instance, structured programs tailored for parents of children with developmental disorders have demonstrated increased confidence and competence post-intervention [8], [9]. Moreover, caregivers of elderly patients with chronic illnesses reported reduced anxiety and enhanced care giving performance following cognitive-behavioral and skills-based workshops [10], [11]. Similar gains in self-efficacy were observed among institutional caregivers after participating in peer support and life skill modules [12], [13], [14]. Interventions grounded in Bandura's self-efficacy theory and resilience frameworks further validate these findings [15], [16]. Importantly, digital and hybrid models of training during and after the COVID-19 pandemic have expanded accessibility and sustained positive outcomes across diverse care giving populations [17], [18], [19].

Studies have also highlighted improvements in problem-solving abilities, emotional intelligence, and reduced burnout symptoms among caregivers who completed life skill training interventions [20], [21], [22]. Community-based models, involving group sessions and participatory learning, showed consistent improvement in interpersonal functioning and stress tolerance [23], [24]. Training tailored to caregivers' specific needs (e.g., caring for children with autism, dementia patients, or individuals with psychiatric conditions) was especially effective [25], [26], [27]. Additionally, long-term follow-up evaluations showed that life skill interventions had a sustained impact on caregiver efficacy and quality of life [28], [29].

Recent randomized control trials and qualitative assessments reaffirm that the integration of life skill modules into caregiver support services leads to improved emotional resilience, self-care practices, and perceived competence [30], [31]. Culturally sensitive and linguistically appropriate training materials were also found to be vital in maximizing impact [32], [33]. Overall, life skill training is now recognized as a vital psychosocial intervention for enhancing caregiver self-efficacy, empowering them to manage care giving demands with confidence and competence [34]. Present study taken into consideration as there is a dearth of evidence of life skill training intervention for the parent as caregiver responsibilities for the children diagnosed with ADHD, ODD and CD.

2. MATERIALS AND METHODS

Study Design: A randomized controlled trial (RCT) was conducted.

Study Duration: The study was carried out from 2022 to 2023.

Study Setting: The research was conducted at:

- R. G. Kar Medical College and Hospital, Kolkata, West Bengal
- Nil Ratan Sircar (NRS) Medical College and Hospital, Kolkata, West Bengal

Study Participants

- Total Sample Size: 120 caregivers
- Participants were selected from the Child Guidance Clinics of the psychiatric outpatient departments.

Group Allocation

- Participants were randomly assigned into:
  - **Intervention Group** ($n_1 = 60$): Received Life Skill Training (LST) and standard mental health care.
  - **Control Group** ($n_2 = 60$): Received standard mental health care.

Inclusion Criteria:

a. Caregiver of the children with diagnosed behavioral disorders as ADHD, CD & ODD with or without borderline Mental Retardation
b. Children receiving standard mental health care
c. Primary caregiver of children aged up to 15 years (completed).
d. Providing care at least 3 months period with the diagnosis

Exclusion criteria:

i. Willing to participate in the study and attend the setting at 2 -4 weeks interval
ii. Able to communicate in Bengali, English and Hindi.
iii. Caregivers diagnosed with severe mental health illness like severe depression, acute psychosis and schizophrenia.
iv. Children with psychological disorders, co morbid medical, surgical or neurological illnesses.
v. Missed two sessions of intervention.
vi. Taking care of seriously ill parent or family members.
vii. Attended life skill training programme before one month and participate in other study

Study Parameters:

1. **Sociodemographic Variables**
   - Age
   - Gender
   - Education level
   - Employment status
   - Family type (nuclear/joint)
   - Relationship to the child
   - Duration of care giving
2. **Child-Related Variables**
   - Age and gender of the child
   - Education
   - Diagnosis
   - Duration of illness
3. **Outcome variable:** Self- efficacy: Measured by using standardized general self efficacy questionnaire.
4. **Attendance and Participation in Life Skill Training**
   - Number of sessions attended
   - Participation level (active/passive, based on trainer observation or feedback forms)
5. **Satisfaction with Life Skill Training**
   - Measured using a post-intervention feedback form

Tools of the study: demographic characteristics were measured by semi structured interview scheduled. The self-efficacy was assessed by the assessor using translated and validated standardized general self efficacy questionnaire developed by R. Schwarzer & Jerusalem (1995).

Intervention: Developed and validated life skill training intervention based on WHO life skill training module consisted of 4 domains administered to the participants of the experimental group in 4 (four) session at an interval of two weeks after measuring the base line data. Parents of the children participated as a caregiver. Both the groups received standard mental health care services for the children. The control group is also received one session on understanding behavioural disorder.

3. STATISTICAL ANALYSIS

Data were initially entered into Microsoft Excel and subsequently analyzed using SPSS (version 27.0; SPSS Inc., Chicago, IL, USA) and Graph Pad Prism (version 5). Numerical variables were summarized as means and standard deviations, while

categorical variables were presented as frequencies and percentages. Mann –Whitney U –tests and Friedman test were used **to** test the significance differences. Categorical data were analyzed using the Chi-square test or Fisher's exact test, as appropriate for sample size. A p-value of ≤ 0.05 was considered statistically significant.

4. RESULT

Table: 1. Demographic Characteristic of Caregivers by their age

n=120 (n_1=60, n_2=60)

Parameter		Number of caregivers	Mean ± SD	p-value
Mean age (years)	Experimental Group	60	35.35 ± 6.26	0.12
	Control Group	60	33.57 ± 5.08	

Table: 2. Comparison of Caregiver Demographic Characteristics Between Experimental and Control Groups

n=120 (n_1=60, n_2=60)

Parameter		Experimental Group	Control Group	df	p-value
Education Level	IV–IX	19	23	3	0.32
	Secondary	22	21		
	Higher Secondary	10	05		
	Graduation and above	09	11		
Duration of care giving in month	≤15	26 (43.33)	19 (31.66)	1	0.3
	>15	34 (56.67)	41(68.67)		

n=120 (n_1=60, n2=60)

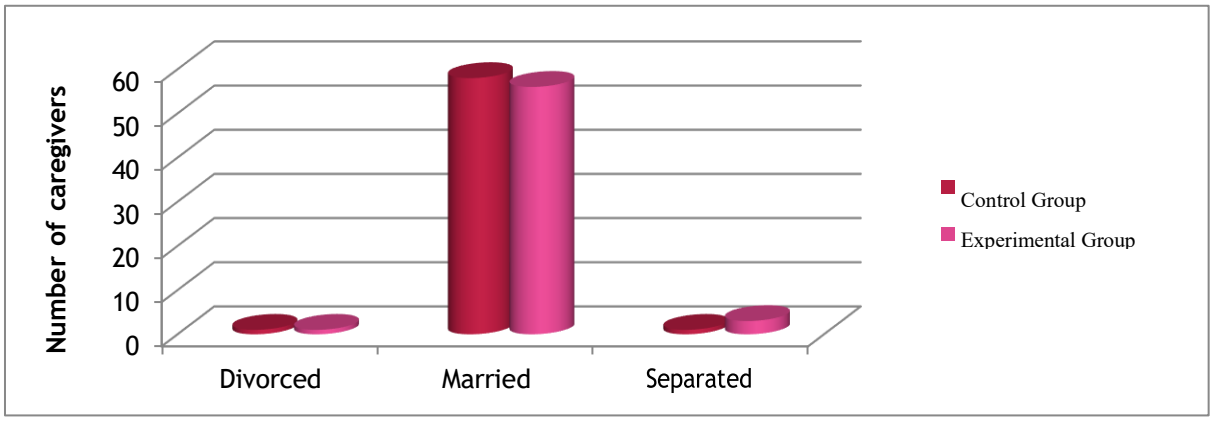

Figure 1: Frequency and percentage distribution of caregiver's marital status in both groups

Table: 3. Distribution of the children by their sample characteristics

n=120 (n_1=60, n_2=60)

Sample characteristics		Experimental group	Control group	Total
		Frequency (%)	Frequency (%)	Frequency (%)
Age in year	4-7	13 (21.67)	20 (33.33)	33 (27.5)
	8-11	30 (50)	28 (46.67)	58 (48.33)
	12-15	17 (28.33)	12 (20.00%)	29 (24.17)
Gender	Male	43 (71.66)	42 (70)	85 (70.83)
	Female	17 (28.33)	18 (30)	35 (29.17)
Diagnosis of the child	ADHD	32 (53.33)	30 (50)	62 (51.66)
	ADHD with CD	04 (6.67)	08(13.33)	12 ((10)
	CD	10 (16.67)	09 (15)	19 (15.87)
	ODD	08 (13.33)	05 (8.34)	13 (10.8)
	ADHD with BMR	06 (10)	08 (13.33)	14 (11.67)

Table: 4. Distribution of baseline self-efficacy of caregivers in experimental group and control group

n=120 (n_1=60, n_2=60)

Variable	Group	Mean (±SD)	Median (IQR)	Mean rank	Sum rank	Mann - Whitney Test	P value
Self- efficacy	Experimental	23.01 (±3.586)	23 (2)	61.5	3689	1.731E3	0.755
	Control	22.9 (±5.248)	22 (5)	59.5	3571		

Table: 5. Comparison of self -efficacy of caregiver between experimental and control group immediately after, one month after and 2 months after the intervention

n=120 (n_1=60, n_2=60)

Variable	Time period	Group	Mean (±SD)	Median (IQR)	Mean Rank	Sum Rank	Mann Whitney	P - value
Efficacy	Immediately After Intervention (8 Weeks)	Experimental	30.65(±3.29)	31-2	86.29	5177.5	252.5	<0.001
		Control	23.28(±3.54)	23-2	34.71	2082.5		
	One month after intervention (12 weeks)	Experimental	31.88(±2.63)	32-1	90.24	5414.5	15.5	<0.001
		Control	20.73(±3.87)	22-3.5	31.52	1891.5		
	Two months After Intervention (16 weeks)	Experimental	31.65(±2.44)	32-2	90.25	5415	15	<0.001
		Control	19.78(±3.71)	17-4.25	31.48	1889		

Table: 6. Friedman test of analysis related to self-efficacy of the caregivers in groups

n=120 (n_1=60, n_2=60)

Variable	Group	Time period	Mean Rank	Friedman test	df	P Value
Self-efficacy	Experimental	Baseline	1.09	102.03	3	.000
		Immediately after intervention	2.75			
		One month after intervention	3.12			
		Two months after intervention	3.03			
	Control	Baseline	2.75	28.66	3	.000
		Immediately after intervention	3.03			
		One month after intervention	2.32			
		Two months after intervention	1.90			

A total of 120 parents of the children with behavioral disorder participated in this study. Mean age of the caregivers in experimental group was 35.35 (± 6.26) years and in control group was 33.57 (± 5.08) years respectively. Mann Whitney U Test value is 1506 for age of the caregivers at p value 0.12. Distribution of caregivers age with control group and experimental group was not statistically significant.

Data depicted in table shows that in experimental group 50 % of the children belongs to age group of 8-11 years and 46.67 % of the control group belongs to 8-11 years age group. And 71.66 % of the experimental group were male whereas 70% of them were male in control group. In both group majority of them had diagnosed with ADHD.

Association of child age (years) in experimental group with control group was not statistically significant (p=0.30). Association of child gender with group was not statistically significant (p=0.84). Majority of the association are non - significant as p value is > 0.05. Hence this may infer that the data is homogeneous. Kolmogorov-Smirnov test of the self - efficacy score of the caregivers at baseline, immediately after, one month after and two months after LST intervention shows data is non -normally distributed.

Mean self- efficacy score of the participant in experimental group and control group was 23.01 (±3.58) and 22.9 (±5.24) respectively along with median value 23 and 22. Mann –Whitney test shows (1.73 at p=0.75) no significant difference between experimental group and control group before LST intervention.

Data depicted that self- efficacy of the caregivers of experimental group significantly differ from control group at 0.001 level of significance after the intervention. Hence it may infer that life skill training has impact on caregivers' self - efficacy.

Friedman test of analysis related to self- efficacy of the caregivers in groups shows statistically significant at $p< 0.001$ level of significance within (102.03 at df 3) experimental group. Also, statistically significant within (28.66 at df 3) control group at $p< 0.001$ level of significance.

The findings reveal that mean self –efficacy improved from 23.01 (±3.58) at baseline to 30.65 (±3.29), 31.88 (±2.63) and 31.65 (±2.44) in three consecutive measurements after intervention among the participants of experimental group indicating life skill training intervention is effective and sustained. Whereas mean self-efficacy score of the control group changes from 22.9 (±5.24) at baseline to 23.28 (±3.54), 20.73 (±3.87) and 19.78 (±3.71) respectively in three consecutive measurements. As the self –efficacy score significantly reduced in control group after 12 weeks (mean; 20.73 ±3.87, median;22) and 16 weeks (mean 17.78 ±3.71, median; 17). Hence there is enough evidence to conclude that LST intervention is effective to improve the self -efficacy of the caregivers.

5. DISCUSSION

The present study demonstrates a statistically significant improvement in caregivers' self-efficacy following life skill training (LST) intervention, indicating its effectiveness in enhancing coping strategies and confidence among caregivers of children with behavioral disorders. These findings are consistent with those reported by Chandran et al. (2017), who observed significant improvements in caregiver self-efficacy following structured psychosocial interventions, including LST, among parents of children with attention-deficit/hyperactivity disorder (ADHD) in India, with post-intervention scores showing sustained enhancement over time [35]. Similarly, a randomized controlled trial by Akbari et al. (2018) highlighted that life skills-based training significantly increased caregivers' perceived ability to manage caregiving demands in families of individuals with chronic psychiatric disorders, emphasizing the long-term benefits of such interventions [36]. In agreement with our study, a 2020 study by Kumar and George demonstrated that caregiver training programs rooted in cognitive-behavioral and skill-enhancing modules led to marked increases in parental self-efficacy and reduced psychological distress [37]. The current study also aligns with the findings of Navidian and Kermansaravi (2018), who reported that life skills education notably improved psychological outcomes and caregiving competence in caregivers of cancer patients, suggesting the cross-populational effectiveness of such training across different caregiving contexts [38]. Furthermore, a more recent study by Sharma et al. (2022) reported statistically significant gains in parental efficacy following LST among caregivers of children with autism spectrum disorders, underscoring the versatility and scalability of such interventions across neurodevelopmental conditions [39]. Another similar study found by Jiang, D et al [40] SNAP significantly reduced antisocial behaviors (effect sizes: 0.39–0.66), increased prosocial behaviors (effect size: 0.31), and improved parental self-efficacy (effect sizes: 0.14–0.56). Additionally, a negative link was found between child behavior problems and parental self-efficacy—parents of children with more severe behavior issues showed greater improvements and Döpfner M et al [41] Linear mixed models showed that adding WASH+S to treatment-as-usual (TAU) significantly reduced clinician-rated externalizing symptoms at 6 months in both the intention-to-treat and per-protocol (≥25% or ≥40% treatment use) samples. Pairwise comparisons confirmed greater improvement in WASH+S+TAU than WASH+TAU or TAU alone. At 12 months, significant effects persisted only in the PP40 sample. Secondary analyses also found benefits for child functional impairment at 12 months (in all analyses) and for negative parenting behaviours at 6 months (in the PP40 sample), with WASH+S+TAU outperforming TAU in both. Also, Ahmed MG [42] explained his study that all QOL dimensions of the caregivers of ADHD children were markedly deteriorated, if compared to those of non-ADHD children, and two thirds of caregivers of ADHD children suffered from poor level quality of life (QOL). Caregivers of non-ADHD children had fair level of self-competence but a good level of self-liking. Caregiver of ADHD children who had no work or history of medical diseases has a fair level of QOL and self-competence but a good level of self-liking. Overall, these consistent findings across diverse studies corroborate the effectiveness of life skill training in improving self-efficacy and psychological resilience among caregivers. The present study adds to the growing body of evidence supporting the integration of structured LST programs in clinical and community-based support services for the caregivers with ADHD, ODD and CD children.

6. CONCLUSION

The findings of this study clearly demonstrate that life skill training (LST) intervention significantly enhances the self-efficacy of caregivers of children with behavioral disorders. By equipping caregivers with practical skills in problem-solving, emotional regulation, communication, and stress management, the intervention fosters greater confidence and competence in managing caregiving challenges. These improvements not only benefit the caregivers' mental well-being but also contribute to better care and support for the children. Integrating structured life skill training into caregiver support programs is thus recommended as an effective strategy to strengthen caregiver resilience and overall family functioning.

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9. CONFLICT OF INTEREST: There is no conflict among the authors.

10. ETHICAL CONSIDERATION:

This study is approved by the institutional ethics committee of R.G.Kar MCH, Kolkata, Medical College Hospital Kolkata, NRS Medical College Hospital, Kolkata and IMS & SUM Hospital, Bhubaneswar, Odisha. **CTRI (ICMR-NIMS): REF/2022/04/053166; Reg. No: CTRI/2022/05/042455.**

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