

Comparison of the Epidemiological Prevalence of Mental Disorders in Mothers of Children with Mental Disorders and Physical Illness

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Abstract

Introduction: The prevalence of mental disorders is increasing worldwide, and the epidemiology of mental disorders plays an important role in the current state of mental health in society and in estimating the facilities needed at any point in time. Therefore, this study aimed to compare the epidemiological prevalence of mental disorders in mothers of children with mental disorders and physical illnesses in centers under 14 years of age.

Research Method: This descriptive study was conducted on 200 mothers (100 with children with mental disorders, 100 with physical illnesses) in Hamedan welfare centers in 2024. The research tool included the Drogatis checklist for symptoms of mental disorders. To analyze the findings, an independent groups t-test (comparison of means) was used using SPSS version 25 software.

Results: The results showed that the variable of physical complaints was higher in mothers with children with mental disorders than in mothers with children with physical illness, and in mothers with physical illness, due to social stigma, sensitivity in interpersonal relationships was higher than in mothers with mental disorders. In both groups, mothers had depression/

Conclusion: According to the results of this study, it is suggested that targeted interventions in the field of children's psyche and body should be accompanied by support for mothers' mental health in schools and health centers.

Keywords: Disability, Epidemiology, Mental Disorders, Physical Illness

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Introduction:

Illness not only causes dysfunction in the affected individual but also severely affects their families and disrupts their functioning. This impact is visible in various dimensions, such as mental health and social functioning, and reduces the well-being of the family and imposes great pressure on it (1). When a family member becomes ill, all family members are somehow involved in the illness and its consequences, and great pressure is imposed on them (2). And being in a family with a sick member often imposes major objective and mental pressure on other family members (3). The extent of this pressure depends on several factors, including the age and gender of the patient's relatives, the quality of their pre-illness relationship with the patient, the nature of the patient's problems, the coping strategies used by the relatives, the relatives' assessment of the situation and how they perceive the illness, the emotional and practical support available to the family, and cultural and ethnic variables (4).

Much research evidence suggests that mothers feel excessive guilt and responsibility for their children's illness, which in turn leads to illness in mothers (5). Mothers of children with a psychiatric disorder experience increased parenting stress and anxiety compared with mothers of children with normal development (6). However, this effect varies depending on the nature of the child's disorder and some family variables (7). Acute-onset disorders have a different impact on family life than chronic disorders, and a disorder may present different challenges to the family at different times (1). In addition to families of patients with mental disorders, families of children with physical illness are also under great pressure and stress, and this pressure and stress are related to the severity of the disability and the type of problem of the child (8). Physical illness is a crisis that anyone may face in their life course, and as a result, they may find themselves in a different situation than before or different from others (9). Physical illness does not have a single definition (10), in fact, it can be physical, sensory, or mental and may affect daily life and personal and social development as well as an individual's education (11) and arises from the incompatibility of interpersonal and environmental experiences that can accelerate functional limitations (12).

Physical illness is not only present in the body of individuals, but also in their mindsets and attitudes, and those around them. Those who suffer from some kind of chronic physical illness experience a painful loss that is of great importance. Physical barriers make it impossible for an individual to participate in the general process of human activities, and more importantly, some barriers exist in the individual's psychological and social environments. These individuals are mostly isolated in adulthood. Such negative attitudes and psychosocial barriers cause them to have lower self-esteem and self-confidence than other people (13).

The impact of illness is not limited to children but also affects the family and their members under stress (14). A sick child has a significant impact on family functioning. Families with sick children are exposed to greater stress than other families (15). Parents of these children report feelings such as helplessness, low self-esteem, and anger (16). There are also many disparities among families with sick children, with some feeling helpless when dealing with their children's mild illness, while others can manage severe illnesses without difficulty (15). The presence of a sick child causes anxiety, physical and mental stress on the family, especially the mother, and parents of children with developmental disabilities experience great stress (16).

Epidemiology is a branch of behavioral science that studies the distribution of a disorder in a society. Mental health is the ability to communicate harmoniously with others, adjust to the environment, and resolve conflicts (17). Mental illness has existed since the beginning of humanity, and no group is immune to it (18). Since about 10% of the world's population suffers from some form of illness (19), and this illness also affects the lives of family members, the rate of mental disorders due to acute and chronic conditions and the burden of care is lower than normal (20). Some studies, based on the fact that some disabilities are more severe than others and considering the level of developmental functioning (20) or the frequency of behavioral disorders and problems in children (21), and other studies, based on parents' perceptions of the child's condition (22), showed that the level of mental disorders, parenting pressure, and stress is highly correlated with the severity of the child's disability (23). Therefore, given that the situation of families with sick children varies according to their functioning, the present study was conducted to compare the epidemiological prevalence of mental disorders in mothers of children with mental illness and physical illness.

Research Method:

The method of this study was the accessible method. The statistical population consisted of all mothers of children with mental disorders and mothers of children with physical illness (disability) who were admitted to the daily welfare centers and clinics of the city of Hamadan in 1403. The research sample consisted of 100 families with children with mental disorders and 100 families with children with physical illness (disability) who met the inclusion criteria for the study. These criteria were: (1) families with a child with a mental disorder or physical illness; (2) admission to daily welfare centers under the age of 14.

The exclusion criteria were: 1) patients with mental disorders requiring medication; 2) people with substance abuse disorders; 3) patients who were undergoing medication at the time of selection; 4) divorced women; 5) Women who have recently been bereaved.

The measurement tools were: the Symptom Checklist Revised Form 90 (SCL-90-R). This tool was developed to measure those physical and mental disorders that respondents have recently experienced, and its purpose is to measure the extent and severity of symptoms of mental disorders in individuals, both normal and abnormal. This measurement is based on the report that individuals provide themselves. Its development has a long history. Its initial form had 58 symptoms of illness, including five subscales, and later, due to the problems that existed in the initial form, this scale was expanded and expanded to 90 symptoms of illness, and the number of its subscales was increased from 5 to 9 items (24). This scale was later revised by Drokitis in 1976. This questionnaire has 9 dimensions and 3 scales. The 9 dimensions of this test are: physical complaints, obsessions and compulsions, interpersonal sensitivity, depression, anxiety, aggression, morbid fear, paranoid thoughts, and psychosis. 3 general indices of distress indicate the depth and severity of mental problems in the individual. These indices are: 1- General illness index. The score of this index is the average score of all test questions. 2- Number of positive symptoms: the number of questions that the subject reports positively (fluctuates in the range from zero to ninety). 3- Severity of positive symptoms: the average number of questions that the subject reports positively (fluctuates in the range from zero to four). In this questionnaire, for each item of the five-choice questionnaire, there

is none (score zero) to very severe (score four) (25). In Iran, the SCL-90-R scale is a valid and widely used test that has been translated and used for many years, and the cutoff point is 0.04, the reliability coefficient is 0.97, the sensitivity is 0.94, the specificity is 0.98, and the efficiency is 0.96 (26).

To analyze the findings, the independent groups t-test (comparison of means) was used using SPSS version 25 software.

Findings:

A total of 100 mothers with children with mental disorders and 100 mothers with children with physical illnesses (disabilities) were studied, and their characteristics in terms of education, age range, and employment status are given in Table 1. According to the data in Table (1), it can be seen that in terms of education, the highest frequency in the mental disorders and physical Illness groups with 53 and 57 percent are at the diploma level and below the diploma level, and in terms of employment status, the highest frequency in both groups is related to housewives, and the highest average age of participants with mental disorders is in the ages of 40-49 with 42 percent and in participants with physical Illness in the ages of 30-39 with 46 percent.

Table 1. Demographic characteristics of the study population

Feature		Mental disorders Prevalence (%)	Physical illness Prevalence (%)
Education Level	Diploma and below	53 (0.53)	57 (0.57)
	Higher than a diploma	47 (0.47)	43 (0.43)
Employment Status	Housewife	89 (0.89)	92 (0.92)
	Employee	11 (0.11)	8 (0.8)
Age Group	19-29	27 (0.27)	24 (0.24)
	30-39	31 (0.31)	46 (0.46)
	40-49	42 (0.42)	30 (0.30)

In this study, descriptive statistical methods, including frequency test, mean, and standard deviation of scores, were used to compare the subscales of the questionnaire.

According to Table (2), the highest mean used in the checklist of mental disorders in the family of patients is physical complaints, which is 42.49 out of 48 points in the family of patients with mental disorders and 45.35 in the family of patients with physical Illness, and sensitivity in mutual relationships in the family of patients with mental disorders is 31.03 out of 36 points higher than in the family of patients with physical Illness. In the depression scale, both groups had a high mean, 47.06 out of 52 points in the family of patients with mental disorders and 47.52 in the family of patients with physical Illness, and in the psychoticism scale, 35.36 in the family of patients with physical Illness.

Table 2. Mean and standard deviation of male and female subjects in terms of the amount of mental disorders in the SCL-90-R.

Dimensions	Mental disorders		Physical illness	
	Mean	SD	Mean	SD
Somatic complaints	42.49	2.06	45.35	1.37
Obsessive-compulsive	31.34	2.35	28.46	2.40
Relationship sensitivity	31.03	3.74	29.25	2.98
Depression	47.06	3.42	47.53	3.48
Anxiety	29.73	1.73	31.69	2.59
Aggression (hostility)	18	3.84	21.47	2.48
Morbid phobia	19.89	2.68	17.14	1.7
Paranoid thoughts	10.62	1.64	18.25	1.47
Dissociative psychosis	31.34	2.37	35.36	2.47
Additional question	24.52	3.14	22.42	2.42

Discussion and Conclusion:

In this descriptive study, the frequency of mental disorders in mothers of children with mental disorders and children with physical illness was examined. In families with mental disorders, physical complaints, sensitivity in interpersonal relationships, depression, aggression, and hostility, and additional questions related to suicidal thoughts are high. Although having a child gives mothers a sense of joy, pride, and personal growth, it also creates challenges and is therefore stressful (27). These challenges can have negative consequences, such that these parents experience higher levels of anxiety and depression than those who do not have children (28). In addition, mothers of children with physical disabilities and special needs are under a lot of pressure and stress. One of the stresses that causes a lot of mental pressure is the stress of having a disabled child, which can have long-term effects and seriously endanger the basic foundations of the individual's family (29).

When a family member suffers from a mental disorder, all family members are somehow involved in the illness and its consequences (1). Children with mental disorders have a chronic onset that, due to its permanence and continuity, degrades the family and family functioning (30) and has various effects on life. In addition, as the child with a mental disorder grows older, his aggressive behaviors become challenging, and bring new issues in the field of social communication when the child enters the adolescent stage (12). Raising these children involves a wide range of physical, psychological, emotional, and social problems that family caregivers, especially mothers of mothers, experience (1). In addition, Rodrigo (30) and Maris (31) showed in their research that mothers of children with mental disorders experience less parental competence, less marital

satisfaction, and more family stress and adjustment problems compared to mothers of normal children. The level of parental stress and marital dissatisfaction experienced appears to be directly related to the severity of the child's conduct disorder (32). Furthermore, genetic studies have shown that siblings of children with mental disorders are more likely to have conduct, mood, and anxiety disorders (33) and are more likely to suffer from subclinical disorders than siblings of healthy children (34). Parents not only face the problem of caring for their children, but also have to care for siblings of sick children, who are more likely to have disorders or subthreshold disorders than others, which creates higher anxiety.

In this study, the frequency of mental disorders in families with physical disabilities was also examined. In families with physical disabilities, physical complaints, aggression and hostility, paranoid thoughts, and additional questions related to suicidal thoughts are high. Previous studies have shown that parents of disabled children report feelings such as helplessness, low self-esteem, and anger (15). On the other hand, trying to be a good parent may lead the family to engage in excessive activities so that they can provide opportunities similar to those of normal children for their disabled children, which causes mental health disorders in the family (13). Disability causes deprivations for the disabled person and reduces or eliminates opportunities to participate in social life. Other studies have also shown that families with a disabled child are usually socially isolated (12).

In such a way that the presence of a disabled child limits the social relations of the family, and the greater the severity of the child's disability, the more limited the free time and the narrower the range of social contacts. A disabled child has a wide impact on the family environment and requires a high level of care, which in some cases may lead to parental divorce or family crises due to the lack of necessary support and other necessary factors (35).

Mothers may feel guilty about going to work or leaving their disabled child with someone else, while fathers may feel guilty about not going to work because of their disabled child. Therefore, if parents act differently in relation to a disabled child, then they are probably not similar in terms of health and well-being (16). Because of the disabled child, parents often describe themselves as very supportive and consider this an obstacle to achieving their goals. Parents unintentionally create dependency by being overly supportive of their disabled children, and this dependency causes physical complaints, aggression, and hostility, which was also observed in this study. In these families, due to the disability of the disabled person and the pressure of caregiving in the family, people shift the problem more than their ability to self-assess and solve it by adapting to the circumstances. The ability to solve problems is a skill that is statistically low in society, and families with disabled children are more involved in communication and emotional problems (15).

On this basis, it can be said that helping to rebuild, grow, and improve the performance of families with children with mental disorders and disabilities, especially supporting the condition of their mothers, is more necessary. Mothers with children with special needs are responsible for nursing the sick child and are homebound due to caring for the child, and have few social support resources. They have little education and are likely to be unable to receive psychological support from studies and available resources. Therefore, they are more stressed and vulnerable. Accordingly, supporting all family members and the performance of the family, especially the mothers of these families, is essential. According to the results of this study, it is suggested that targeted interventions in the field

of children's psyche and body should be accompanied by supporting the mental health of mothers in schools and health centers.

Research Limitations: Despite the results obtained from the present study, this study also faced some limitations. One of the limitations of the study is that the discussion was about children, about whom mothers always feel guilty, and therefore, the respondents were less cooperative in self-declaration and completing the questionnaires due to the contradiction of the answer with their basic beliefs and the taboo nature of the research topic. In this study, only people who felt comfortable with the topic participated, not all people whose cooperation the researcher wanted. This issue affects the generalization of the results and therefore limits the external validity of the study.

Research Application: To more accurately examine the effectiveness of this approach, it is suggested that mothers with different severities of their children's illness be used in future studies, and different subgroups be considered.

Conflict of Interest: There is no conflict of interest in this study, and the authors' contributions are listed in the order of their names in the article.

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Reference

1. Maude P, James R, Searby A. The use of Open Dialogue in Trauma Informed Care services for mental health consumers and their family networks: A scoping review. *J Psychiatr Ment Health Nurs*. 2024 Aug;31(4):681-698. [doi: 10.1111/jpm.13023](https://doi.org/10.1111/jpm.13023).
2. van Houtum LAEM, Baaré WFC, Beckmann CF, Castro-Fornieles J, Cecil CAM, Dittrich J, Ebdrup BH, Fegert JM, Havdahl A, Hillegers MHJ, Kalisch R, Kushner SA, Mansuy IM, Mežinska S, Moreno C, Muetzel RL, Neumann A, Nordentoft M, Pingault JB, Preisig M, Raballo A, Saunders J, Sprooten E, Sugranyes G, Tiemeier H, van Woerden GM, Vandeleur CL, van Haren NEM. Running in the FAMILY: understanding and predicting the intergenerational transmission of mental illness. *Eur Child Adolesc Psychiatry*. 2024 Nov;33(11):3885-3898. [doi: 10.1007/s00787-024-02423-9](https://doi.org/10.1007/s00787-024-02423-9). [Epub 2024 Apr 13](https://pubmed.ncbi.nlm.nih.gov/47111111/).
3. Gravante F, Trotta F, Latina S, Simeone S, Alvaro R, Vellone E, Pucciarelli G. Quality of life in ICU survivors and their relatives with post-intensive care syndrome: A systematic review. *Nurs Crit Care*. 2024 Jul;29(4):807-823. [doi: 10.1111/nicc.13077](https://doi.org/10.1111/nicc.13077).
4. Stolper H, van der Vegt M, van Doesum K, Steketee M. The Integrated Family Approach in Mental Health Care Services: A Study of Risk Factors. *Int J Environ Res Public Health*. 2024 May 17;21(5):640. [doi: 10.3390/ijerph21050640](https://doi.org/10.3390/ijerph21050640)
5. Tham SS, Solomon P. Family Involvement in Routine Services for Individuals With Severe Mental Illness: Scoping Review of Barriers and Strategies. *Psychiatr Serv*. 2024 Oct 1;75(10):1009-1030. [doi: 10.1176/appi.ps.20230452](https://doi.org/10.1176/appi.ps.20230452).
6. Conner KO, Abusuampek DK, Kosyluk K, Tran JT, Davis-Cotton D, Hill AM, Brown AP. Mitigating the Stigma of Mental Illness: The Impact of Story-Telling in the Black Community. *Int J Environ Res Public Health*. 2024 Nov 6;21(11):1473. [doi: 10.3390/ijerph21111473](https://doi.org/10.3390/ijerph21111473).

7. Yin M, Li Z, Li X. Family influence on stigma internalization in people with severe mental illness: A grounded theory study. *Int J Ment Health Nurs*. 2024 Oct;33(5):1575-1590. [doi: 10.1111/inm.13346](https://doi.org/10.1111/inm.13346).
8. de Souza JMB, Miozzo AP, da Rosa Minho dos Santos R, Mocellin D, Rech GS, Trott G, Estivaleta GPM, Sganzerla D, de Souza D, Rosa RG, Teixeira C. Long-term effects of flexible visitation in the intensive care unit on family members' mental health: 12-month results from a randomized clinical trial. *Intensive Care Med*. 2024 Oct;50(10):1614-1621. [doi: 10.1007/s00134-024-07577-3](https://doi.org/10.1007/s00134-024-07577-3).
9. Treadwell KRH. Family Factors in the Development and Management of Anxiety Disorders. *Psychiatr Clin North Am*. 2024 Dec;47(4):787-800. [doi: 10.1016/j.psc.2024.04.018](https://doi.org/10.1016/j.psc.2024.04.018).
10. Mabunda NF. Nurses' perceptions of involving family members in the care of mental health care users. *Curationis*. 2024 Jul 5;47(1):e1-e9. [Doi: 10.4102/curationis.v47i1.2538](https://doi.org/10.4102/curationis.v47i1.2538).
11. Cudjoe E, Awortwe V. A phenomenological investigation of kinship involvement in the lives of children whose parents have mental illness. *Int J Qual Stud Health Well-being*. 2024 Dec;19(1):2414481. [doi: 10.1080/17482631.2024.2414481](https://doi.org/10.1080/17482631.2024.2414481).
12. Maybery D, Grant A, Piché G, Yates S, Ruud T, Dunkley-Smith A, Davidson G. Summarising Quantitative Outcomes in Parental Mental Illness Research. *Int J Ment Health Nurs*. 2024 Dec;33(6):1761-1795. [doi: 10.1111/inm.13385](https://doi.org/10.1111/inm.13385).
13. Chen YF, Yeh TP, Hsu HC, Lane HY, Lu SH, Ma WF. Clinical symptoms of the prodromal stage preceding serious mental illness in Taiwanese young adults: a qualitative study. *BMC Psychiatry*. 2025 Mar 3;25(1):187. [doi: 10.1186/s12888-025-06643-4](https://doi.org/10.1186/s12888-025-06643-4).
14. Tranberg K, Colnadar B, Nielsen MH, Hjorthøj C, Møller A. Interventions targeting patients with co-occurring severe mental illness and substance use (dual diagnosis) in general practice settings - a scoping review of the literature. *BMC Prim Care*. 2024 Aug 3;25(1):281. [doi: 10.1186/s12875-024-02504-3](https://doi.org/10.1186/s12875-024-02504-3).
15. Adu J, Oudshoorn A, Anderson K, Marshall CA, Stuart H. Negotiating familial mental illness stigma: The role of family members of persons living with mental illnesses. *PLoS One*. 2024 Sep 30;19(9):e0311170. [doi: 10.1371/journal.pone.0311170](https://doi.org/10.1371/journal.pone.0311170).
16. Burger TJ, van Eck RM, Lachmeijer M, de Wilde-Schutten KRG, Lanssen M, van Alphen C, van Haasteren N, Groen K, Schirmbeck F, Vellinga A, Kikkert MJ, Dekker J, de Haan L, de Koning MB. Perspective matters in recovery: the views of persons with severe mental illness, family, and mental health professionals on collaboration during recovery, a qualitative study. *BMC Psychiatry*. 2024 Nov 14;24(1):802. [doi: 10.1186/s12888-024-06198-w](https://doi.org/10.1186/s12888-024-06198-w).
17. Sud D, Bradley E, Tritter J, Maidment I. The impact of providing care for physical health in severe mental illness on informal carers: a qualitative study. *BMC Psychiatry*. 2024 Jun 6;24(1):426. [doi: 10.1186/s12888-024-05864-3](https://doi.org/10.1186/s12888-024-05864-3).
18. Neulinger B, Ebert C, Lochbühler K, Bergmann A, Gensichen J, Lukaschek K. Screening tools assessing mental illness in primary care: A systematic review. *Eur J Gen Pract*. 2024 Dec;30(1):2418299. [doi: 10.1080/13814788.2024.2418299](https://doi.org/10.1080/13814788.2024.2418299).
19. Guan Z, Zwi AB, Sun M, Poon AWC. Validation and reliability of the Chinese version of the Friendship Scale (FS-C) in family caregivers of people with severe mental illness. *Arch Psychiatr Nurs*. 2024 Dec;53:95-101. [doi: 10.1016/j.apnu.2024.10.006](https://doi.org/10.1016/j.apnu.2024.10.006).

20. Herzberg MP, Nielsen AN, Luby J, Sylvester CM. Measuring neuroplasticity in human development: the potential to inform the type and timing of mental health interventions. *Neuropsychopharmacology*. 2024 Nov;50(1):124-136. [doi: 10.1038/s41386-024-01947-7](https://doi.org/10.1038/s41386-024-01947-7).
21. Ngubane NP, De Gama BZ. The Influence of Culture on the Cause, Diagnosis and Treatment of Serious Mental Illness (Ufufunyana): Perspectives of Traditional Health Practitioners in the Harry Gwala District, KwaZulu-Natal. *Cult Med Psychiatry*. 2024 Sep;48(3):634-654. [doi: 10.1007/s11013-024-09863-7](https://doi.org/10.1007/s11013-024-09863-7).
22. Roy L, Leclair M, Crocker AG, Abdel-Baki A, de Benedictis L, Bérubé FA, Thibeault E, Latimer E, Roy MA. Risk factors for homelessness and housing instability in the first episode of mental illness: Initial findings from the AMONT study. *Early Interv Psychiatry*. 2024 Jul;18(7):561-570. [doi: 10.1111/eip.13495](https://doi.org/10.1111/eip.13495).
23. Berrett-Abebe J, Reed SC. Exploring the Relationship between Food Insecurity, Chronic Health Conditions, and Serious Mental Illness in the United States: Implications for Social Work. *Health Soc Work*. 2024 Aug 1;49(3):147-156. [doi: 10.1093/hsw/hlae012](https://doi.org/10.1093/hsw/hlae012).
24. Derogatis LR. Symptom Checklist-90-Revised. In *Handbook of psychiatric measures*. American Psychiatric Association 2000: 81-84
25. Fathi Ashtiani A, Dadsetan M. Psychological tests, personality and mental health, Besat pub; 2009.
26. Dohrenwend BP, Dohrenwend BS. Perspectives on the past and future of psychiatric epidemiology. The 1981 Rema Lapouse Lecture. *Am J Public Health*. 1982 Nov;72(11):1271-9. [doi: 10.2105/ajph.72.11.1271](https://doi.org/10.2105/ajph.72.11.1271).
27. Ostberg M. Parental stress, psychosocial problems, and responsiveness in help-seeking parents with small (2-45 months old) children. *Acta Paediatr*. 1998 Jan;87(1):69-76. [doi: 10.1080/08035259850157903](https://doi.org/10.1080/08035259850157903).
28. Crnic KA, Greenberg MT. Minor parenting stresses with young children. *Child Dev*. 1990 Oct;61(5):1628-37. [doi: 10.1111/j.1467-8624.1990.tb02889.x](https://doi.org/10.1111/j.1467-8624.1990.tb02889.x).
29. Sajedi F, Vameghi R, Ali-Zad V, Malek-Khosravi G, Karimlou M, Ravarian A et al . Is Anxiety More Common in Mothers of Children with Cerebral Palsy?. *jrehab* 2011; 11 :15-20. [URL: http://rehabilitationj.uswr.ac.ir/article-1-679-en.html](http://rehabilitationj.uswr.ac.ir/article-1-679-en.html)
30. Rodrigue JR, Morgan SM. Family stress and adjustment as perceived by parents of children with ADHD. *Pam. Behav. Ther* 2009; 19: 371-379.
31. Morris MM. Parental stress and marital satisfaction in families of children with ADHD. *Desertion abstract International* 2001; 61(7-A).
32. Rutter M, Silberg J, O'Connor T, Simonoff E. Genetics and child psychiatry: I Advances in quantitative and molecular genetics. *J Child Psychol Psychiatry*. 1999 Jan;40(1):3-18. [PMID: 10102724](https://pubmed.ncbi.nlm.nih.gov/10102724/).
33. Faraone SV, Biederman J, Lehman BK, Spencer T, Norman D, Seidman LJ, Kraus I, Perrin J, Chen WJ, Tsuang MT. Intellectual performance and school failure in children with attention deficit hyperactivity disorder and in their siblings. *J Abnorm Psychol*. 1993 Nov;102(4):616-623. [doi: 10.1037/0021-843X.102.4.616](https://doi.org/10.1037/0021-843X.102.4.616).

34. Grant A, Leonard R, Linden M. A qualitative study of health visitors' family-focused practice with mothers with mental illness in Northern Ireland: Perspectives of health visitors, mothers and partners. PLoS One. 2024 Aug 15;19(8):e0306890. [doi: 10.1371/journal.pone.0306890](https://doi.org/10.1371/journal.pone.0306890).
35. Pawluski JL. The parental brain, perinatal mental illness, and treatment: A review of key structural and functional changes. Semin Perinatol. 2024 Oct;48(6):151951. [doi: 10.1016/j.semperi.2024.151951](https://doi.org/10.1016/j.semperi.2024.151951).