CHAPTER – 2

REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION

Review of studies of literature is an important prerequisite for actual planning and then execution of any research work. The research workers need to acquire up-to-date information of what has thought and said in particular areas so that they can derive benefit from the work of their predecessors. According to Scot and Wertheimar (1992), “Review of related literature may serve to avoid unnecessary duplication and may help of make progress towards the solution of new problem emphasizing the importance of survey of related literature.” Good, Barr and Scates (1941) have pointed out, “Survey of related literature helps us to know whether evidence already available solves problem adequately without further investigation and thus may save duplication.” Best (1978) wrote, “Practically all human knowledge can be found in books and library. Unlike other animals that must start a new with each generation, man builds upon the accumulated and recorded knowledge of the past. This constant adding to the vast store of the knowledge makes possible progress in all areas of human endeavor.

A brief review of research literature in the area of my study is presented below.
2.2 REVIEW OF RELATED LITERATURE :

Researchers have noted that birth of retarded child shatters the hope and aspirations of parents leading to hopelessness and negative attitude towards the child) (Ramaswamy: 1995). Speedwell and associates (2003), in their study, observed that parents of sick or disabled children are likely to be more stressed than parents of non-disabled children and may benefit from being given information about their child’s condition and its implications, but the stage at which parents should receive such information and who should provide it, has not been fully investigated.

For the parents of mildly retarded children, comparatively, the family problems were at a lesser level and the parents help themselves with a keep going tendency. Somewhat similar results and reasons could be offered from the studies of seiquira & associates (1990) in relation to severely retarded children. Seth (1979) in his enquiry showed that mothers perceived large number of associated problems like behavior problems, seizures, poor comprehension, drooling of saliva etc. were more disruptive for attending the routine family activities. Therefore it was very difficult to those mothers who were all time housewives with least help from other agencies.

Tangri and Verma (1992) compared the social burden between the mothers of mentally handicapped children with those of the mothers of the physically handicapped and reported that former category of mothers had higher social burden. Some other investigations also reported that the mothers of the female mentally retarded children most often reported
greater burden because of onset and many needs for unexplainable services, which lead to restlessness and mental strain to majority of the mothers with moderate to severe MRC.

Seiquira & associates (1990) found that more than 50% of the mothers of mentally retarded children were having severe financial burden. Jain and Satyavathi (1969) reports that 61% of parents studied by them had financial constraints. Many earlier studies on mentally retarded children also have reported rising financial burden because of two reasons, one is additional expenditure involved in caring for the MRC and the other is reduced sources of income because the parents had to spend extra time in parenting severely retarded children. (Mc Andrew: 1976, Seth : 1979 and Veena: 1985).

The concern of siblings varies according to the nature and degree of severity of their handicapped siblings’ disability. Key concerns were many such as how to deal with parents, friends, relatives and acquaintances and what kind of future they could expect for their handicapped sibling as well as for themselves; seem to be similar across types of impairments (Murphy: 1976).

Reeta (1983) in his book entitled “Handbook of disabled in India” surveyed the problems abroad and in the context of national scene. He also covered the categories of the disabled, specific disabled groups, facilities and concessions available and allied maters in more elaborate way and lucid enough to understand.
Informal supports extend beyond government-sponsored programs and include the natural supports provided by the extended family e.g., grandparents, friends, and neighbors (McDonnell et al., 1995). Lehman, Ellard, and Wortman (1986) suggested that natural supports are the most helpful to families under stress. Natural supports may include in-home assistance, house cleaning, and transportation from extended family members or friends. McDonnell et al. (1995) suggested that "the nature and type of support will be unique to the individuals involved, and be dependent on a mutual level of comfort in both seeking and providing acceptance”

More than half the mothers who brought their children for psychiatric treatment were themselves suffering from a psychiatric disorder. Maternal psychiatric illness was, in turn, associated with greater occurrence of psychopathology among offspring, underscoring the importance of developing interventions that address the needs of both children with psychiatric disorders and their at-risk mothers.

Maternal psychiatric illness is well-documented risk factor for child psychiatric disorders. Most generational studies of psychiatric illness employ “top-down” sampling—that is, identifying ill parents and then assessing their children. Researchers have found that children of depressed or anxious parents are themselves at a substantially increased risk (two-to five-fold) of psychiatric disorders (Weissman, Leckman, Merikangas et al; 1984). A relatively small number of “bottom-up” studies (for example, sampling from ill children) demonstrate that first-degree relatives of

The relationship between maternal and child psychiatric illness is complex and multifactorial. Contributing risk factors include shared genetic vulnerabilities (Merikangas, Weissman, Prusoff et al: 1988) and shared environmental factors such as poverty and domestic violence. Risk may be moderated by factors such as the father-child relationship and child temperament. Untreated maternal psychiatric illness is likely to affect children with psychiatric illness both directly (for example, by impaired parenting and decreased empathy) and indirectly (for example, by affecting the quality of mental health treatment received by their children). Notably, depressed and anxious mothers tend to overreport psychiatric symptoms among their children (Briggs-Gowan, Carter, Schwab-Stone, 1996) leading to misinformation about child psychopathology with the attendant risks of over treating the child and under treating the mother. Untreated maternal illness, in turn, has been associated with poor outcomes among children receiving psychiatric treatment (Brent, Birmaher, et al: 1998, Cobham, Dadds, Spence, 1998). In addition, impairment in maternal functioning (psychological well-being, emotional control, and social support) is
associated with increased use of child health services (Janicke, Finney, Riley : 2001). Thus untreated maternal psychiatric illness not only may lead to worse outcomes for children treated in mental health settings but simultaneously may increase child health care utilization.

To our knowledge, there is only one previous study of psychiatric illness among mothers who bring their depressed offspring for psychiatric treatment (Ferro, Verdeli, Pierre : 2000). In that study, investigators from Columbia University found elevated rates of current psychiatric diagnoses among mothers who brought their children to an urban research mental health clinic and low rates of maternal psychiatric treatment. Their bottom-up sampling procedures did not permit the investigators of elucidate the relationship between maternal and child illness by examining such questions as: which comes first? Does parenting an ill child contribute to increased maternal psychopathology? Do children become ill because of genetic predispositions for these disorders? From a public health perspective, however, this approach approximated the screening process one might use in pediatric mental health settings to identify-and ultimately treat-ill mothers of children who are receiving psychiatric treatment. Thus bottom-up methods are receiving psychiatric treatment. Thus bottom-up methods are especially relevant to clinicians and health care policy makers interested in improving care for families in pediatric clinical settings.

To further elucidate the relationship between maternal and child psychiatric illness, we reported results from a study designed to assess rates of lifetime and current psychiatric diagnoses by using clinician-
administered diagnostic interviews among mothers who brought their school-age children to a rural community pediatric mental health clinic. As in the Columbia study (Beck, Steer: 1993), we elected to use bottom-up sampling techniques so that the results might inform health care interventions in this setting. We also assessed the relationship between maternal diagnosis and occurrence of child psychopathology and characterized the functional impairments of mothers with psychiatric diagnoses.

**Mothers with and without a current diagnosis**

Fathers are clearly important, and a good father-child relationship may mitigate the effect of maternal depression on child outcomes (Tannenbaum, Forehand, 1994). We were able to enroll less than half those eligible for this study, and we have few data available on individuals who did not participate. A 50 percent “no show” rate is typical in community clinics, and our research recruitment reflects this broad clinical problem. Nevertheless, low participation rates raise questions about the estimates of illness prevalence in this sample.

Maternal psychiatric illness itself is likely to affect the quality of the data. Child assessments such as the CBCL rely on maternal report of child symptoms, and previous reports show that depressed and anxious mothers overendorse symptoms in their children (Briggs-Gowan, Carter, Schwab, 1996). However, in our study reports on the CBCL converged with the relatively objective K-SADS-PL assessment, which suggests that the higher rate of child psychopathology in offspring of ill mothers was not simply an
artifact of maternal reporting. Eighteen percent of children had no diagnosis on the K-SADS-PL, regardless of whether or not their mother had a diagnosis of psychiatric illness. The same interviewer evaluated both the mother and her child, so assessments were not blind to the clinical status of the other member of the dyad. This fact represents another potential source of bias in our study. In addition, the number of tapes (four) used to establish inferrater reliability on the SCID and the KSADS may have been insufficient to guarantee agreement among interviewers.

Despite these limitations, we found an exceptionally high prevalence of psychiatric disorders in a nonclinical population of adult females. More than half the mother (61 percent) assessed met DSM-IV criteria for at least one current axis I disorder, and more than three-fourths (79 percent) met criteria for lifetime psychiatric illness. Interestingly, our group found almost twice the rate of maternal psychiatric illness as detected in the Columbia study by Ferro and colleagues (61 percent compared with 31 percent) (Ferro, Verdeli, Pierre et al: 2000). This discrepancy may be explained by prominent differences in inclusion criteria of the two studies (children with any nonpsychotic disorder in our study compared with children with depression in the Columbia study), recruitment setting (community clinic versus research clinic), diagnostic instrument (SCID versus the self-report PRIME-MD Patient Problem Questionnaire), and demographic composition (rural Caucasian compared with urban Latina). Despite differences in samples and methods, it is notable that both groups found high rates of
untreated depression and anxiety among the mothers of children who had psychiatric illnesses.

Mothers with diagnoses showed marked impairments in functioning across domains, typically in clinically significant ranges (MacHorney, Ware, Raczek : 1993). They also experienced significantly higher levels of partner abuse (both physical and verbal) and lower levels of social support than the mothers without a diagnosis. Studies indicate that marital conflict is highly stressful for women, even when they are in good relationships (Ennis, Kelly, Lambert : 2001), and social support is important to women (Taylor, Klein, Lewis, : 2000). It is likely that mothers with depression of anxiety will have difficulty navigating interpersonal problems (for example, extricating themselves from abusive relationships) and that the interpersonal problems they experience (especially marital conflict and absent social support) will exacerbate their psychiatric symptoms. Thus these mothers experience a range of difficulties that might have an impact on their capacity to optimally manage children suffering from their own psychiatric illnesses.

In support of the hypothesis that maternal psychiatric illness is associated with greater levels of child illness in this population, we found that children of mothers with current axis I disorders were more likely to experience higher levels of psychopathology themselves: they met criteria for significantly more diagnoses on the K-SADS-PL, experienced higher levels of anxiety and depressive symptoms, were more withdrawn, and complained of more somatic symptoms than children of mothers without a current axis
I disorder. This finding is especially remarkable given the fact that all children in this sample were being brought to the clinic for psychiatric evaluations. Thus, even among a group of children seen in a mental health clinic, having a mother with psychiatric illness predicts greater symptom burden on the child. Interestingly, offspring of mothers with a psychiatric illness (typically depression or anxiety in this sample) were at greater risk of internalizing—but not externalizing—disorders. This may reflect the well-documented genetic link between internalizing disorders across generations.

Despite clinically significant levels of symptoms and impairment, two-thirds of mothers with a diagnosis were receiving no psychiatric treatment. In addition to contributing to needless suffering, the economic costs of untreated psychiatric illness are high (Simon, Barber, Birnbaum; 2001). Untreated maternal illness leads to lost productivity of mothers (Judd, Akisskal, Zeller et al: 2000) and higher utilization of public resources by their children (Janicke, Finney, Riley: 2001). In addition, having a mother with psychiatric symptoms predicts poor response to child psychiatric treatment (Brent, Kolko, Birmaher et al: 1998, Cobham, Dadds, Spence: 1998).

Because this was not an epidemiologic study, we cannot conclude that rates of maternal psychiatric illness detected in this sample are representative. In fact, on the basis of evidence that suggests that mothers with depression and anxiety are more likely to seek treatment for their children than non-depressed mothers with anxiety (Janicke, Finney, Riley:...
we suspect that the rates of psychiatric illness in our sample may be higher than in mothers of ill children who are not brought in for treatment. From a clinical and services perspective, pediatric mental health clinics may represent an underutilized sitting in which to identify and possibly treat mothers with undetected psychiatric illness.

Seeta Sinclair (1981) described mental retardation as sub average intellectual function combined with subnormal adaptation to a person’s surrounding.

The parents of children with disabilities, including those with mental retardation, may need a great deal of additional support from society, friends, and other family members to find the happiness that compensates for the frustrations and inconveniences of having a child (Knoll, 1992; Turnbull & Turnbull, 1985).

The birth of a child with a mental disability may cause parents to view themselves as failures in what they consider one of their fundamental purposes in life. For some parents, these feelings of failure and loss of self-worth are temporary. For others, these emotions may last a lifetime. ‘What can be said with certainty is that the process of adjustment for parents is continuous and distinctly individual (Hardman, Drew, Egan, Sz Wolf, 1996).

Other authors (Cleveland, 1980; Lamb, 1983) indicated that fathers and mothers may react very differently to the child. The mother may take on the role of physical protector and guardian of the child's needs, while the
father is more reserved in his role. He may cope by withdrawing and internalizing his feelings.

Professionals should always be aware of the extreme emotional stress placed on the family and realize that, for the time being, this reaction may be the only one possible for the parents. With time, patience, and continued support, professionals eventually may help parents face the reality of their situation and begin making accommodations for the child in their family (Gallimore, Weisnen Bemheimer, Guthrie, & Nihira, 1993). Eventually, parents may realize that the birth of a child with retardation need not stigmatize their lives or cast any doubts on their integrity as adequate parents or human beings.