REVIEW OF RELATED LITERATURE
CHAPTER-III

REVIEW OF RELATED LITERATURE

For the formulation of the hypotheses in any research, it is imperative to discuss the review of literature pertaining to the theory and empirical findings related to the problem. The theoretical orientation pertaining to the concepts of the different variables has been presented in Chapter-II. A brief review of literature regarding the relationship of anxiety disorders and asthma with familial factors, daily hassles, and coping strategies is presented here.

FAMILIAL FACTORS

Several studies have considered different aspects of the family with reference to mental illness: family structure, family interaction, burden felt by the family because of the psychiatric, psychosomatic illness of one of its members and family ward treatment of mental patients. The Indian setup includes both joint as well as nuclear families. These family structures may have positive as well as adverse effects on the members thereby enhancing mental health or aggravating problems of mental health. In view of these observations a few researchers have examined the family structure (nuclear & joint) in relation to psychiatric illness (Carstairs & Kapur, 1976; Sethi & Manchanda, 1978;
Epidemiological surveys done by Sethi, et al. (1967; 1972; 1974), show a higher percentage of psychiatric disorders in nuclear families as compared to joint ones. Verghese & Beig (1974) and Wig, et al. (1982), in a survey of neuroses in Vellore township found a significant high occurrence of neuroses in nuclear families as compared to joint ones. Menon (1975) and Aggarwal, et al., (1978) found that emotionally disturbed women belonged more often to nuclear setup. Lal (1971); Bagadia, et al. (1973); Sethi, et al. (1974; 1976) found that depression and other related mental disorders are found more in nuclear families than in joint families. They found that in nuclear families there is lack of closeness, whereas in joint families members are closely knit, well adjusted and this leads to less pathology and vice-versa. Bhatti, et al. (1974), reported that patients coming from nuclear families form 67.5% of the total cases and patients from joint families form 32.5%. With regard to structure of the family, psychosis is 43.7% in nuclear and 43.2% in joint families, neurosis 29.5% and 28.4% in nuclear and joint families respectively. They also reported that in the nuclear families there was 9% prevalence of neurotic depression and 12.5% of prevalence was there in joint families. These statistical inferences conclude that family structure and
diagnosis are two independent variables. Sethi & Manchanda (1977) and Sethi & Gupta (1978) studied psychiatric patients of five year admission to General Medical and Associated Hospitals and found that there was a definite trend of over representation of unitary families (54.5%) in the studied sample. Further, intergroup comparisons showed significant higher occurrence of psychotic patients in the joint families. On the other hand, there was a significant higher occurrence of neurotic patients in the nuclear families. Ramachandran, et al. (1982), conducted a study on subjects with the age over 50. They found that those from nuclear and single member families were more depressed than those from the joint families. Jain, et al. (1989), conducted a comparative study of psychosocial factors in hysteria and depression. The sample consisted of 50 hysteria patients and 50 depressives. The results showed that hysterical patients came from joint families, while depression was more common among nuclear families. They also found that most of hysterical patients belonged to middle birth order in the family but majority of depressives patients of both sexes were eldest in the family. Bharat (1991), found in 10 out of 20 studies she reviewed, that nuclear type families were more susceptible to psychiatric disorders than joint families. She found contradictory evidence only in three studies.
Sharma & Srivastava (1991), also arrived at a similar conclusion. They both attributed these psychiatric disorders to the lack of a supportive network in nuclear type family in comparison to a joint family.

The above cited literature gives us an impression that nuclear families play a key role in psychiatric disorders. Along with the nuclear families, joint families have also been reported to be responsible for mental illness, but not to the extent the way nuclear families are responsible. Joint families, inspite of their offering support, warmth and care in the period of distress, are not completely free from the prevalence of psychiatric disorders. Dube (1970) and Thacore, et al. (1971; 1975) surveyed, 6038 families of rural as well as urban areas in Agra and found that prevalence of mental illness was significantly higher in joint families as compared to the unitary families (13.6% and 9.37% families were affected respectively). Venkoba Rao (1973), reported more jointness of family in the recurrent depression. Vyas & Bhardwaj (1977) found preponderance of joint families in a sample of 304 hysterical patients.

Cochrane (1979) suggested that in the family, where grandparents live with parents and children, it may contribute to lower than expected levels of adult mental illness and children maladjustments.
Nehra (1993) studied family typology and perceived social support in neurotics and found that neurotics on the whole showed greater family pathology, and perceived less social support as compared to normals. In another study Verma, et al. (1995) found that psychotics showed greater family pathology than normals. The results further indicated that psychotics were higher on altruistic, egoistic and anomic family type than normals. But no significant differences were found on normal cohesive family type between psychotics and normals.

Along with the joint and nuclear family structure some researchers suggest that the family environment contributes a great deal to the onset of physical and psychiatric illness. The researchers working in the field of environment and health agree that there exists a health-illness continuum and human functions rise and fall accordingly.

Moos & Moos (1971; 1976) using family environment scale have reported significant differences between family environment of normal families and of distressed families who are less cohesive, less expressive, independent, achievement oriented, religious and with more conflicts. These families were also less concerned with intellectual, cultural, and recreational activities.

Many researchers found that distressed families have less cohesion, less expressiveness, and have more conflicts (Young,
et al., 1976; Lange, 1978; White, 1978). Such families also tend to be less well organized, less oriented towards independence, achievement, and religious activities, and less concerned with intellectual and recreational pursuits (James & Hesselbrack, 1976).

A few researchers are of the view that schizophrenia and neurotic depression have been reported to be related to environment of the individual’s family (Paskiewiz, 1977; Wetzel, 1978).

The most significant aspect of the family environment is the warmth relationship between parent and child. Hetherington, et al. (1971) found that the families of neurotic delinquent boys were characterized by verbal aggression between the parents, and maternal dominance. Studies done by Jacob, et al. (1971) and Rohner (1980) proved that warmth is most crucial and pervasive factor affecting child’s development. Parental rejection leads to the development of neuroticism in the formative years of life.

Keitner, et al. (1985) in their studies found that dysfunctioning in the families gave rise to anxiety disorders in the individual. They also found that the unsupportive parent’s attitude made the individual more vulnerable towards the psychopathology.

**Faulty Parent-Child Relationships**

Family is mainly constitution of mother, father, child and sibling relations. If these relations are not healthy then they can
create pathology in families. The influence of the parent on the child is more important in shaping the child's behaviour than vice versa. Gassner & Murray (1969) observed that interaction between parents of neurotic children were marked by hostile conflict and that neurotic children were predominantly opposite in sex to the dominant parent, that is, the patient dyads of neurotic boys were characterized by maternal dominance, whereas the parental dyads of neurotic girls were paternally dominated. Similarly Klein, Plutchik & Conte (1973) found that in families who were receiving therapy, and who could be presumed to be in conflict, daughters exhibited fewer problems when mother was dominant and sons exhibited fewer problems when the father was dominant.

On the other hand, Hetherington, et al., (1971) found that families of neurotic delinquent boys were characterized by verbal aggression between the parents and maternal dominance, though the complimentary pattern for neurotic delinquent girl was not obtained.

While, overprotective parents may watch over their children constantly, protect them from the slightest risk, overly clothe and medicate them, and make up their minds for them at every opportunity. In essence, they smother the child's growth. While fathers have been known to overprotect their children, the problem
is probably more common among mothers (Weintraub & Frankel, 1977). Such maternal reactions appear to represent a compensatory type of behaviour in which the mother attempts, through her contact with the child, to gain satisfaction that normally should be obtained in her marriage. It is not uncommon in such cases for the mother to call the male child her “lover” and actually to encourage the child in behaviour somewhat typical of courting. A corollary syndrome also occurs between fathers and daughter.

In a study of the family background of children referred to a child guidance clinic, Jenkins (1966) found that those youngsters characterized as over anxious were likely to have an infantilizing, overprotective mother. Similarly, in his study of children with excessive fears, Poznanski (1973) found a dependent relationship upon an overprotective mother to be one key reason for the fears. Closely related to overprotection is restrictiveness. Parental restrictiveness is one of the most commonly heard complaints. Parents rigidly enforce restrictive rules and standard, and give the child little autonomy or freedom for growing in his or her own way. Restrictiveness may foster well-controlled, socialized behaviour, but it can also nurture fear, dependency, submission, repressed hostility and some dulling of intellectual striving (Becker, 1964; Baumrind, 1971).
Torma, et al. (1975) & Arieti (1978) studied phobias and truancy in relation to parenting styles and found that the phobic mother child relation is typically overprotective and symbolic, while the truants is distant aloof.

Arieti, (1978), explains the psychodynamic mechanisms of depression, in terms of an overprotecting mother, who very early in life of the clients manifested intense gratification of needs. The mother compelled by a sense of duty to be as lavish as possible in her care and manifestations of affection, this attitude predisposed the child to be respective to others.

Agarwal, Saksena & Singh (1978) have reported that mothers of emotionally maladjusted children as compared to mothers of normal children had a rejecting attitude and were authoritarian towards their children. The authors believe that these unhealthy child-rearing attitudes of mothers of maladjusted children explain the child’s emotional maladjustment.

Geetha, Shetty & Venkataramiah (1980) have compared the patterns of family interaction in childhood hysteria and childhood anxiety cases with that of normal children. The results have indicated that the clinical groups differed from the normals by way of abnormal interactions, in anxiety cases more impaired interactions between parents were observed while in childhood
hysterical cases parent-child interactions were impaired. Sharma, Bhat, & Sengupta (1980), in a study of neurotic children and their parents, have reported that family factors were important as the mechanism of identification was found to operate. They concluded that children learn neurotic behaviour from their parents.

Parker (1981), in his study on parental representation of patients with anxiety neurosis reported significantly greater parental overprotection and less parental care than controls. Arindell, et al. (1983), found that social and height phobias scored, both parents as lacking emotional warmth and being rejective and over-protective. Agoraphobics reported both parents as lacking emotional warmth, but only mothers as being rejective.

Rahman & Mahboob (1983) found that neurotics have less parental care and maternal overprotection.

Amianat, et al. (1984) in their study found that oppressive practices linked with the dominant submissive behaviour and suppression of autonomy to be directly contributing to self esteem, rejection problems, helplessness and depression in naturally disengaging children, Rosenbaum, et al. (1985) studied perceived contingency of parental reinforcement among depressed, paranoids and normals.

A faulty mother child relationship underlying the asthma disorder has been found by number of researchers as is seen in the
following studies:

In 1941, French & Alexander were among the first to comment upon the disturbed mother-child relationship, with the emphasis on the ambivalent attitude of the mother towards asthmatic child. The asthmatic attack is a repressed cry for mother’s help in response to a threat of separation, that the attack expresses opposing tendencies. The protest against wanting to reestablish a dependent relationship with mother. This conflict is the deepest and most primitive substratum of asthmatic attack.

Harris, et al. (1950) compared 22 asthmatic children with 17 children having allergic rhinitis and found that asthmatic children had more fear of maternal separation, were more fearful generally, and less aggressive. Some asthmatics had difficulty in crying and confiding and the mothers of these children were rigidly angry over misbehaviour. These interpretations from interviews and teacher’s reports appeared to support the results of French & Alexander, but findings from the battery of psychological tests were not reported.

Maternal overprotection as a potential etiological factor in asthmatics has been highlighted by many investigators (Little & Cohen, 1951; Mitchelle, et al., 1953; Morris, 1959).

Jansen (1965) reported contradictory findings and concluded that studies indicating that mothers of asthmatic children are
rejecting, overprotective and over anxious may be invalid due to —

i) different opinions of the meaning of terms.

ii) investigations made outside of the family situation.

iii) inexplicit definition of the role influence and function of the mother.

Knapp, et al. (1966) found that asthmatic subjects demonstrated an excessive dependence-independence conflict with an excessive mother child bond and core anxiety around the threat of separation. Often this acts as a powerful emotional arousal and a breakdown of psychological defenses and thus precipitating asthma attack.

Jacob (1972), investigated 173 healthy male undergraduates and 106 reported hay fever, sore throat, asthma or neurotic symptoms to describe the quality of their family experiences while growing up. Questionnaire and interview techniques were employed. Three clusters of faulty parent child interactions were examined: mother seen as demanding, cold and harsh; mother seen as over protective and ineffective; father seen as inadequate, cold and harsh. As expected, healthy subjects evidenced least signs of these clusters, while those who sought help for “neurotic” complaints were highest on each variable. Two patterns associated with respiratory illness were observed. Subjects who had sought
care for allergic symptoms described their mothers as overprotective and ineffective whereas those subjects who presented acute infections and respiratory symptoms were more likely to perceive their mothers as demanding, cold, and harsh.

Pinkerton (1974), Byrne (1977), Rubenstein (1979), and Meijer (1981) also found mothers of asthmatics as overprotective, often in some form of expression of anxiety. As children, asthmatics felt that their mothers had overcontrolled them and they also experienced strong dependency needs.

Georgan (1975), considers the symbolic significance of breathing and asthmatic attack with a particular focus on the mother child relationship and its symbolic importance.

Williams (1975) and Meijer (1976) while investigating the mother child relationship reported that allergic asthmatics show a special need for clinging possessiveness towards the mother and fixation on the mother. Asthmatic subjects also demonstrated an excessive dependence-independence conflict with an excessive mother child bond and core anxiety around the threat of separation.

Parker (1979), examined parental overprotection as an antecedent or a consequence of asthma in a child. Subjects were 50 asthmatics, 50 non-asthmatic siblings and 50 controls (mean age 33.8 years). Results reported that parental overprotection was a consequence of asthma in a child, but this was more clearly
demonstrated for the fathers than for the mothers. Parental overprotection associated with asthma is likely to reflect an adaptational response by parents to a child with a chronic, unpredictable illness arousing high levels of anxiety in parents.

Meijer (1981), reported that emotional disorders in asthmatic children are associated with pathogenic maternal family relationship patterns. Meijer opined that family relationships particularly of the mother’s childhood family seem important in the evaluation of childhood asthma. Given a constitutional allergic pre-disposition and familial allergy history, significant differences among asthmatic and non-asthmatic children and their families have been found.

Sharma & Nandakumar (1980), studied asthma patients and normals using a number of self report and projective tests. They observed that asthmatic subjects manifested marked affectional and dependency need in relation to the mother, they were anxious, insecure, and aggressive, and experienced irrational fears and guilt feelings.

Baron (1992), reported clinical study of 34 asthmatic children between the age of 10-15 years, followed at a specialized out-patient clinic in Montreal. The study found strong association between certain personality traits and an excessive use of medication and also between personality and family structure.
Regardless of the severity of their asthma, children of cohesive families possessed high level of anxiety and dependence. Pathological family settings were found to cause more emotional and behavioural problems in children.

Hamlet, et al. (1992) studied family functioning, extra familial social support available to mothers, and child life stress events were examined in relation to the children’s psychological adjustment and illness events. The mothers of asthmatic children reported a greater number of internalizing behaviour problems in their children, perceived their own social support as less adequate and reported a great number of stressful events. Further, regression analysis demonstrated that family functioning and chronic illness were significantly related to the psychological adjustment of the child.

**FAMILY INTERACTION PATTERNS**

Each day family members participate in semi-regular patterns of interaction with each other and with people and system outside the family. In these interchanges, family members are affected by and affect others, sometimes in repeated ways. A hyperactive child, for example, may create repeated experiences of frustration for a parent that contribute to the parent’s development of headaches. Some families may show repeated “chain reactions” in which stress enters the family through one member and is passed in a
predictable sequence to others (Boss, 1987). Emotions are an important medium to examine because they influence and can limit individual’s perception, thought processes and behaviour (Frijda, 1986; Lazarus, 1991; Clore, Schwartz & Conway, 1994) as well as affect health via emotional physiology (Lovallo, 1997). Strong negative emotions, for example, dispose parents to view children’s behaviour with disapproval, block their recollection of constructive parenting strategies and increase their rate of punitive parenting responses (Bradbury & Fincham, 1990).

Adults’ experiences of repeated negative emotion are related to the development of heart disease (Sherwood & Turner, 1992) and to depression in their children (Downey & Coyne, 1990).

Thus, chain reactions by which distress moves through a family have multiple effects. Second hand emotions alter the thought, behaviour and physiology of individual family members. These, in turn, may have aggregate effects on the functioning of the family as a whole.

Observational studies of family interactions show that an emotion expressed by one family member often has a predictive relationship to the emotion subsequently expressed by another family member. A consistent finding is that husband’s negative emotions predict wives’ negative emotions more than wives’ emotions predict husband’s (Notarius & Johnson, 1982; Roberts &
Krokoff, 1990), especially in distressed marriages (Gottman, 1979; Guthrie & Noller, 1988; Katz, Kramer & Gottman, 1992). Similar observational research on parent-child interactions shows mechanisms whereby negative emotions in a parent create distress in children (Patterson, 1980; Cummings & Davies, 1994).

Many investigators have stressed on the complexity and mutuality of relevant family interaction pattern as evident from the following studies:-

Rees (1963), found that a significant higher number of asthmatic children had an unsatisfactory family life as compared to a control group of normal children. There was less stability, security, warmth, affection and encouragement in the families of asthmatic children.

Jacob, et al., (1965) in a study to determine the incidence of psychosomatic predisposing factors in asthma predicted that a somatic factor and a psychological factor (disturbed parent-child relationship) must be present in order for an asthma to develop, that neither is sufficient and that both are necessary conditions. The somatic factor was identified as a hypersensitivity to antigens as measured by wheel reactions. The psychological factor was identified as a faulty parent child relationship consisting of maternal domination and paternal ineffectiveness. In 75.6% of the cases involving illness, both a somatic and a psychological factor
was evidenced. Furthermore, in 75.0% of non-asthmatic group, both of these factors were not present.

Vidal & Ruiz (1969), examined the influence of intrafamilial dynamics on psychosomatic illness. 14 psychosomatically ill subjects, 7 organically ill controls and 4 neurotic controls were included in the sample. It was found that the psychosomatic subjects tended to negate conflicting familial situation, whereas neurotic and organically ill subjects treated them openly.

Maclean & Ching (1973), and Luban & Comazzi (1973) emphasize on intra-family relationships. Luban & Comazzi (1973) describe in their study the psychological dynamics within the family and discuss the need for the physician to acquire a valid picture of the family unit with its strength and short comings. Continued flight from pressure of vital issues can lead to family neurosis. It is argued that physicians are in a good position to recognize these signs.

Peshkin (1974), and Stierlin (1977) also stress on the relationship between patterns of illness and aspects of family interaction, which can lead from family patterns of interaction to the occurrence or intensification of physical illness in family members, or emotional climate in home which might have led to the intractability of the asthmatic syndrome.
Wolman (1965) has suggested a socio-psychosomatic theory which also stresses family interaction in the development of mental illness. He states that in these types of families, the parent-child relationship becomes instrumental instead of vectorial and the child is forced to assume an abnormal hypervectorial (giving) attitude towards the parents.

Ferreira & Winter (1968) found that in three way (Father-Mother-Child) interaction, families with a neurotic child exchanged less information, took longer to reach a decision and spent a greater proportion of time in silence.

Sethi & Nathawat (1971), suggested the close linkage between forms of mental illness and the pathology of interpersonal relations in the family. According to him different types of family structure influence the development of tensions, schizophrenic and even suicidal behaviours.

Adam (1973), studied 49 obsessive children and their families. His observations suggest that certain family interaction styles play important causative roles in these disorders. These families did not prize warm interpersonal relationships. Adam concludes that the parents manifested hostile, rejecting, behaviour toward the child; they evoked intense anger that the child could not express directly but had to handle by the various obsessive and compulsive defenses.
Gurman & Kinskern (1978), suggest that pathogenic family interactions are the constant source of keeping the neurotic individual in a continuous sick situation. Aggarwal & Sexsena (1978) studied emotionally disturbed and maladjusted children of Indian schools. They found that in the family of emotionally disturbed child, the mother was lower in equalitarianism, comradeship and sharing. These findings tend to suggest that emotional disturbance is a result of interaction pattern among family members and the general environment of the home.

Geetha, et al. (1980) conducted a comparative study of family interaction in childhood hysteria, childhood anxiety and normal children. They found that in the anxiety group, husband and wife interaction is more impaired and marital counselling has to be considered. In the hysterical group, abnormal parent-child interaction needs more attention and correction.

Clinicians have observed that a predisposition to agoraphobic anxiety is associated with patterns of family interaction such as enmeshment, conflict avoidance and low level of parent management (Bowlby, 1973; Goldstein, 1982).

A study done by Burgess (1981) on parent child communication (for example, accepting the negative command) as characterizing families with problems between parent and child. Listening and observation skills were found to be particularly poor.
in parents who were dysfunctional communicators and these two skills are seen as critical element of communication with children.

Rao, et al. (1982) have examined the family situation of adolescent anxiety patients and normal adolescents. They have reported that the family situations of adolescent anxiety patients were more disturbed and stressful than those of normals because of the absence of free interaction among family members, highly authoritarian parents, children being under strict control, disturbed interaction between parents themselves, unresponsiveness in times of stress and high unrealistic expectations from their children.

Channabasavanna & Bhatti (1982), reported that neurotic families in all the different types have definitely pathological interactional patterns at the level of communication and leadership as compared to normals.

Carson (1984) & Liem (1980), found that family communication deviance has special relevance for the depression and schizophrenic type of disorder.

Kellner (1985), found that certain interactions within families and other early relationships set the stage for children to develop a neurotic life style in later life. He is also of the view that overprotective parents prevent their children from developing adequate effective coping techniques required in their adult life.
Bullock (1989), found that children who were seldom sought out as playmates were more likely to have parents who reported high degree of conflict within the family and lower levels of acceptance of their children. These parents also perceived their families as being less cohesive and expressive. Therefore, this study indicated that non-supportive family interaction and family environment may be indirectly related to peer rejection among children.

From the above cited literature, it is evident that both joint and nuclear families are prone to psychological and physical problems, but nuclear families are more prone to these disorders. Faulty parental attitudes also give rise to faulty development in the individual. Parental rejection leads to the development of neuroticism in formative years of life. Dysfunction in the families gives rise to anxiety disorders. Hence, the family is conceived as a unit of interacting personalities (Schvaneveldt, 1966). As the family is a system of interdependent and reciprocal relationships, the behaviour of any family member affects all the other family members and consequently affects family equilibrium. Interpersonal relationships between family members are important factors for family dynamics. Therefore, it is evident that family is a primary social unit. A family both emotionally and structurally well knit, can offer a built-in immunity against psychiatric
breakdowns and help in promoting positive mental health.

**DAILY HASSLES**

The course of life is not smooth, it is cluster of ups and downs. These ups and downs may be small events or major life events. The smaller occurrences, when negative in the course of life have been named as hassles (Kanner, et al., 1981). These hassles are the irritating, frustrating and distressing demands that to some extent characterize everyday transactions with the environment. According to Kanner, et al. (1981), “daily hassles proved more direct and broader estimate of stress in life than major life events”. Lazarus & Delongis (1983) are of the view that hassles, “plague us day in and day out”. When these hassles disturb daily activities, it leads to frustration, thus, more psychological distress.

According to Vingerhoet (1984) there are certain hassles which distress us more. The hassles which are independent of our psychological functioning distress us less. On the other hand, the hassles which are dependent upon our psychological functioning distress us more. These hassles are found to be specially important in determining the individual’s social functioning, health status, and morale (Lazarus & Cohen, 1977).

A few researchers in the field of daily hassles have reported that perception of daily hassles is related to personality and
various psychosocial factors. Some of the studies which are referred to as “diary studies” (which give day to day reports), have shown that mood states are more negative on days with many or severe stressful events (Stone & Neale, 1984; Eckenrode, 1984; Delongis, et al., 1988; Clark & Watson, 1988; Affleck, et al., 1994).

Diary studies have differentiated between positive and negative affective states and the results have indicated that stressful or undesirable daily events lead to clear increase in negative affect (N.A.), but have negligible or only modest effects on positive affect (P.A.), (Kanner, et al., 1981; Stone & Neale, 1984; Clark & Watson, 1988; Repetti, 1993; Smith & Chirstensen, 1996; David et al., 1997).

Diary studies have also found that the impact of events depends on the context in which they occur. Certain types of stressful or undesirable events which appear to be more likely than others to provoke negative mood states include interpersonal conflicts, events occurring in the domains of work or family and friends, overloads and health problems (Bolger, et al., 1989; Bolger & Schilling, 1991; Repetti, 1993; David et al., 1997).

Daily events also vary in terms of chronicity. There are some events which represent totally novel and unexpected experiences and other events which occur repetitively, over weeks, months or
year. Bolger, et al. (1989) found that habituation of mood responses occurred when nonconflicting events were reported on a series of 2 or more days, whereas repeated interpersonal conflicts led to progressive worsening of mood. The effects of recurrent stressors may depend on the individual's ability to cope with them in the past, with successful coping resulting in habituation and unsuccessful coping in sensitization. Diary studies also found that the effects of daily hassles or events persist longer in vulnerable individuals, for example, those experiencing chronic stress or low social support (Caspi, et al., 1987; Affleck, et al., 1994).

Bolger & Schilling (1991), investigated the mechanisms through which neuroticism leads to distress in daily life. Neuroticism may lead to distress through exposing people to greater number of stressful events, through increasing their reactivity to those events or through a mechanism unrelated to environmental events. There were 399 subjects which provided daily reports of minor stressful events and mood for 6 weeks. Exposure and reactivity to these minor stressors explained over 40% of the distress difference between high and low neuroticism subjects. Reactivity to stressors accounted for twice as much of the distress difference as exposure to stressors. These results suggest that reactions within stressful situations are more important than situation selection in explaining how neuroticism leads to distress.
in daily life.

There are large and relatively stable individual differences in average mood levels as well as in intensity ranges. Women, for example, report higher negative affect and more intense positive affectivity than do men (Fujita, 1991). Various investigators found that individuals higher in negative affectivity report more frequent daily stressors and they also rate events as more severe (Watson & Pennebaker, 1989; Bolger & Schilling, 1991; Marco & Suls, 1993). Even in the absence of events, negative affectivity is associated with more negative mood states (Watson & Clark, 1984).

Marco & Suls, (1993); Bolger & Zuckerman, (1995) reported that negative affectivity is an important moderator of stress reactivity, which increases the intensity of negative mood responses to minor stressors and also the duration of such responses.

Some investigators (Marco & Suls, 1993) have adopted experience sampling methodology (ESM) to assess effects of daily events on mood. Both events and mood are measured at frequent intervals throughout the day, further allowing detection of more fine grained temporal relationships and reducing biases in recall. ESM results indicate that minor events do contribute to mood fluctuations observed within as well as between days.

From the above cited literature it can be concluded that daily
hassles are effective predictors of mood, their effect on one's mental and physical health. Psycho-social stressors in everyday life are capable of activating cardiovascular, neuroendocrine and immunologic response systems (Stone et al., 1996; VanEck et al., 1996). Experimental results reported by Pike, et al. (1997) lend support that chronic stress exacerbates responses to acute psychosocial stressors, increasing the level of immediate distress as well as its duration.

Marleen, et al. (1998) used experience sampling methodology to examine the relationship between stressful daily events and mood. 85 male white-collar workers completed self reports 10 times a day for 5 days. Controlling for individual differences in mood levels, multilevel regression analysis showed that events were followed by increase in negative affect (NA) and agitation (Ag) and by decrease in positive affect (PA). More unpleasant events were associated with greater changes in all three mood dimensions: controllability mitigated the effects of events on negative affectivity and positive affectivity. Prior events had persistent effects on current mood. High perceived stress (PS) was associated with greater reactivity of NA and PA to current events, whereas trait anxiety moderated reactivity of Ag. Results indicated that PS is related not only to a higher frequency of reported events but also to more intense and prolonged mood response to daily
Apart from these, another factor that may influence is how individuals experience daily stress in their level of previous exposure to major life events or chronic difficulties. Relatively very few studies have focussed on this issue, but scattered findings show that previous stress exposure may be of considerable importance in explaining individual differences. Recent life events have been shown to influence levels of positive affectivity and negative affectivity and also increases the probability of stressful daily event occurrences (Eckenrode, 1984; Suh, Diener & Fujita, 1996). In the support of this idea, Caspi, et al. (1987) found that chronic stress of living in a low quality neighborhood exacerbated the immediate effects of daily events on mood. They further found that low quality neighborhood also increased the likelihood that daily stressors would have an enduring effect on next day’s mood.

Delongis, et al. (1988) found that individuals with a higher number of daily hassles, were more likely to experience next day mood disturbance following a day with many hassles. Experimental results reported by Pike et al. (1997) lend support that chronic stress exacerbates responses to acute psychosocial stressors. They also increased the level of immediate distress as well as its duration.
In summary, personality (in particular trait-negative affectivity) and recent stress influenced mood either directly or indirectly by moderating the effects of stressful daily events on mood.

Several empirical reports indicate that the occurrence of minor daily problems is associated with lower psychological well being and mild physical symptoms (Clark & Watson, 1988). Minor stressors produce physical or emotional threat because they create discrepancies, may be for short time, between the demands of the situation and the resources of the person and thereby increase acute distress (Lewinsohn, et al., 1972; Rehm, 1978; Stone, 1981; Monroe, 1983; Eckenrode, 1984; Lazarus & Folkman, 1984).

Sheryl, et al. (1987) examined three personality variables — locus of control, assertiveness, and meaning in life, as possible moderators of the relation between stressors and subjective well being. Results from a sample of 160 students showed that any moderating effects were not extensive and were mainly limited to the locus of control variable with female subjects. Further, the replication of the study on a sample of 120 community members found no significant moderating effects. Chronic daily hassles were found to have effect on well being reports. Among the personality variables, meaning in life consistently predicted positive well being and internal locus of control and assertiveness had direct but
somewhat less consistent effects.

Daily hassles are also related with the psychological functioning of the individual. Those individuals who are vulnerable to distress, experience more hassles than healthy individuals. Kanner, et al. (1981) found that daily hassles were a better predictor of psychological symptoms than life events. Monroe (1983) too reported similar results.

Lewinsohn, et al. (1973) found that depressed persons were particularly sensitive to aversive events. It was reported that mood would be related to aversive events in the daily life of normal persons. MacPhillamy & Lewinsohn (1974) also found that depressed persons reported fewer pleasant events than non-depressed psychiatric and normal groups.

Mclean (1976), has argued on the basis of clinical data that micro-stressors acting cumulatively, along with the absence of compensatory experiences can be potent source of psychological stress.

Costa & McCrae (1980) found that extraversion was associated with state positive affect and neuroticism was associated with state negative affect. In addition, neuroticism showed a modest inverse association with positive affect.

Finlay, et al. (1981), examined the loss and threat events. They found that loss events have been associated with depression
and threat with anxiety. Individuals who perceived events as being desirable were less likely to experience depressive symptoms.

Hammer, et al. (1985), found that the depressive symptoms were best predicted by interaction between self-schemas (dependent vs self-critical) and types of events (interpersonal vs achievement) which occurred in a day.

Bolger & Schilling (1991) in their study, on 399 subjects, found that the individuals with higher level of neuroticism experience more daily stress, especially of an interpersonal nature. They also found that individuals high on neuroticism were more distressed by aversive events than those who were low on neuroticism.

In four separate samples, Watson & Clark (1992) reported correlation ranging from 0.52 to 0.65 between extraversion and trait positive affect. Marco & Suls (1993) reported that neuroticism accounted for significant amounts of within and across day variation in negative mood.

Lu (1994) studied 102 first year students. Measurements of stressors (major life events, minor daily hassles and perceived university stress), personality (locus of control, extraversion and neuroticism), and mental health (depression, anxiety and somatic symptoms) were taken. Using multivariate analyses, he found that life events predicted anxiety while daily hassles predicted
depression. (ii) locus of control and extraversion correlated negatively, while neuroticism correlated positively with university stress. (iii) neuroticism had a main effect on symptoms reporting across the board, while extraversion had a vulnerability effect on somatic symptoms.

Bolger & Zuckerman (1995) found that individuals who are high on neuroticism reacted to interpersonal stress with more anger and depression than did low on neuroticism individuals. Suls, et al. (1998) also found that neuroticism is related to emotional reactivity in response to both interpersonal and non-interpersonal problems and undesirable family and friend stressors, undesirable leisure stressors and undesirable financial stressors (David et al., 1997).

The individuals who are high on neuroticism face and feel more distress. One plausible reason being that these individuals are unable to adequately cope with the stress, which in turn leads to more emotional reactivity, i.e., more anxiety, depression, hostility and self consciousness (McCrae, 1990; Bolger & Zuckerman, 1995).

There is dearth of studies of daily hassles as related with asthma. Mostly studies done in this field pertain to stressful life events. The few available studies on daily hassles in relation to psychosomatic illness are reported below:-
A few researchers have found that people with preexisting emotional or physical dysfunction disorders, or adverse socioeconomic factors feel more hassled. They feel more psychological distressed due to their physical disorders which make them incompetent in coping with daily stressors (Dohrenwend, et al., 1984; Swearinger & Cohen, 1985).

Watson & Clark (1984), have demonstrated a relationship between neuroticism and physical health complaints, when they face stressful events. They generally react with strong negative emotions to unpleasant events.

It has been repeatedly noted by clinicians that psychological stressors appear to be associated with the expression of asthma in individuals who have a genetic vulnerability for developing the disease (Teiramaa, 1981; Levitan, 1985).

Research on daily events and upper respiratory infection has tended to find the absence of desirable events to be more consistently predictive of reported symptomatology than the presence of undesirable ones (Stone, 1987). On the other hand Dancey et al. (1995) observed that neither desirable nor undesirable events reliably predicted symptoms of irritable bowel syndrome. Hence, it would seem that the appearance and nature of relationship between daily events and health very much depends on the health outcome measure studied.
Lepore, et al. (1991) found that daily hassles which include low intensity, relatively discrete stressors (e.g., disagreement with spouse, missing a bus), chronic strains include ongoing social and environmental conditions that represent high intensity stressors, that threaten survival. They found that chronic strains were associated with greater levels of psychosomatic symptomatology as well as low perceived social support.

David, et al. (1996) examined the lagged relationship between daily events and somatic symptoms. Fourty eight students completed the students assessment of daily experience questionnaire and the somatic symptoms subscale of the General Health Questionnaire for five days. They found that undesirable events were correlated with somatic symptoms three to four days later.

In the end, it can be concluded that persons with low psychosocial resources are vulnerable to illness and mood disturbance when their stress levels increase, even if they generally have little stress in their lives.

From the above studies it is clear that daily hassles play a very important role in disturbing and maintaining our mental and physical health. Daily hassles influence our mood, our personality and experiencing of stress levels. Daily hassles which are irritating
cause physical ailments such as asthma, ulcer, hypertension, etc.,
along with physical ailments. Daily hassles also cause neurotic
behaviour styles in the vulnerable individuals. Therefore, one
should use effective styles in dealing with these stressors. By using
efficacious coping styles one can enhance one’s mental and
physical health.

COPING STRATEGIES

Over the years, it has come to light that it is as important to
know how to cope with stress effectively as to know the source of
stress. Coping refers to the things that people do to avoid being
harmed by life strains. It has acquired a variety of conceptual
meanings being commonly used interchangeably with such kindred
concepts as mastery, defense and adaptation (White, 1974). The
review of literature pertaining to coping strategies in relation to
mental/physical health is presented below.

Everyone has a unique quota of distress and ill health. Some
people are habitually anxious or sad, whereas others are calm and
happy. Some people suffer from many physical ailments, whereas
others are rarely ill. In several studies problem-focussed strategies
have been reported to have positive association with measures of
psychological well being (Folkman & Lazarus, Gruen &
Delongis, 1986). On the other hand, a reliance on emotion-
focussed tends to be associated with poor psychological well being
Vitaliano, et al. (1990) examined coping profile of individuals experiencing psychiatric, physical health, work or family problems. Comparisons were made in subjects with and without anxiety and depression to control for the effects of distress. Coping was similar for subjects in similar problem categories, but different for subjects in different categories. Psychiatric subjects made more use of avoidance and less use of social support. Subjects with physical health problem were among the most frequent users of social support. Subjects with family problems were among the most frequent users of problem-focussed coping and the least frequent users of self blame. Subjects with work stress were the most frequent user of self blame. Results also showed that persons with psychopathology coped in maladaptive ways involving dysfunctional strategies that constitute the behavioural disorders.

Amongst the psychiatric disorders that have been associated with faulty coping strategies, depression is one of them. Overall, researchers found that depressives use more avoidant coping behaviour and wishful thinking while dealing with stress. There is evidence that suggests that depressed and non-depressed individuals may be different in their coping responses.

Coyne, et al. (1981) found that depressed persons tended to appraise situations as requiring more information before they could
act and surprisingly, to view fewer events as necessitating acceptance and accommodation. They were more likely to use such responses as seeking advice and emotional support and engaging in wishful thinking.

Billing, et al. (1983) and Mitchell & Hadson (1983) found that depressed patients made greater use of information seeking and emotional discharge and high level of avoidance coping combined with low level of active cognitive and behavioural coping strategies and also they made less use of problem solving responses than did the non-depressed.

A number of studies suggest that depressives engage in more emotion-focussed coping and they less frequently relied on the strategy of problem solving. They considered general activity as less useful in their struggle against depressive feelings (Cappeliez et al., 1986). Other researchers also found that depressives use hostile confrontation, emotional discharge, and seeking emotional support than do non-depressed (Coyne, et al., 1981; Billing & Moos, 1984; Folkman & Lazarus, 1986; Rao, et al., 1990; Moos, 1997).

Bryant et al. (1986) conducted a study to compare the appraisal processes, coping strategies and environmental hassles of 20 depressed psychiatric patients, 20 non-depressed psychiatric patients and 20 normal subjects in threat and challenge situations.
The results indicated that depressed psychiatric patients compared with non-depressed controls used significantly fewer situation analysis and solution generation coping skills in threat situations and used these coping skills less frequently than controls in challenge situations. They used significantly more self punitive coping skills, greater number of denial oriented coping skills than normal subjects and non-depressed psychiatric patients.

Along with depression, neuroticism is another variable which shows the patterns of faulty strategies. The individuals who are high on neuroticism use less problem-focussed strategies and rely more on emotional and wishful thinking. The findings of several studies suggest that those who are high on neuroticism are less likely to engage in problem-focussed coping (Parkes, 1986; Endler & Parker, 1990; Hooker et al., 1994). They tend to rely on emotion-focussed forms of coping, particularly ones that involve escape, avoidance, and self blame. They are also more prone to endorse coping responses that indicate hostile reactions, passivity, and indecisiveness (Bolger, 1990; Terry, 1994).

Asle Hoffart, et al. (1993) conducted a longitudinal research, to study coping strategies in major depressed agoraphobic and comorbid in-patients. The first aim of this study was to explore the diagnostic specificity of coping styles by comparing ways of coping in non-anxious, major depressed, non-depressed
agoraphobic and both major depressed and agoraphobic (comorbid) in-patients. The second aim was to investigate whether a vulnerability model, a state model, or a combined vulnerability state model of coping accounted best for the data. On admission and when discharged 95 patients completed the ways of coping checklist and were evaluated on several symptom scales. Self-report symptom scales were completed at one year follow-up as well. The ‘purely’ agoraphobic and the comobid patients showed less seeking of social support and more wishful thinking than the major depressed patients. For the wishful thinking scale, these differences were related to differences in level of global psychopathology. Overall, the results for the seeking social support scale were consistent with a combined vulnerability-state model. The problem-focussed coping and wishful thinking scores behaved mostly as state phenomena. The avoidance scores provided ambiguous evidence. In a sub-sample of 30 agoraphobic patients who received a combination of exposure and psychodynamic treatment, higher pre-treatment levels of seeking social support and lower pre-treatment levels of avoidance as coping both predicted a more favorable course of symptoms pertaining to fear of fear in the one year follow-up period.

Marco, at al. (1999) examined the relationship between coping efforts and stress-related mood changes. Men and women
with high levels of work or marital stress reported stress and coping efforts approximately once an hour for 2 days using an electronic diary, stress episodes were identified as a stress free time followed by a stressor at the next time point. Results showed that greater mood changes were associated with appraisals of high stress and high disruptiveness. Appraisals of high control and high desirability were associated with more planning, direct action, and fewer acceptance coping efforts. Coping failed to predict any pre-to-post stressor mood changes.

There are also a few other studies in the literature which differentiate between neurotic and normal individuals' coping strategies. A large number of normals reported the use of help seeking behaviours while neurotics reported keeping feelings to themselves. Normals, therefore, make greater use of their social networks for coping assistance. Normal individuals use positive approach to stress, while neurotics reported making negative comparisons (Thoits, 1986; Rao, et al., 1989).

According to Carver et al. (1989) and Bolger (1990) in stressful situations individuals who are high on neuroticism tend to focus on the associated level of emotional distress rather than on going in for goal directed behaviour. Such people rely more on emotion-focussed strategies than individuals who have low level of neuroticism.
Schill et al. (1984) compared coping behaviour of stressed, low anxious under graduates (efficient copers) and stressed, high anxious subjects (inefficient copers). Efficient copers dealt with life stress primarily by trying to analyze their problems and taking direct action. Inefficient copers stopped functioning well, sought the support of others, and if male, resorted to drugs, alcohol, or sex as a source of stress.

Vitaliano et al. (1985) found problem-focussed coping to be negatively related with both depression and anxiety. Coping through using wishful thinking and seeking social support correlated positively with anxiety. Vitaliano et al. (1990) found that, in non-psychiatric samples, problem-focussed coping predicted less depression and emotion-focussed coping predicted more depression only when stressors were appraised as controllable.

Olah, Attila et al. (1989) investigated the relationship among constructive, passive, and escape coping strategies, frequency of stressful experience, and individual’s anxiety reactions. Results showed that both trait anxiety and frequency of stressful experiences were related positively with escape coping strategies and negatively with constructive coping strategies. General situational effect also correlated positively with escape coping
strategies and negatively with constructive coping strategies. However, the rate of recurrence showed the reverse trend.

Salkovskis (1991), in a study with phobic patients found that phobic and panic disorder patients reported increased use of avoidance strategies with stressors.

According to Magnus, et al. (1993) anxiety patients adopt more of confrontive coping strategies in response to conflicts. These ineffective coping strategies, i.e., confrontive (less planful coping, less of active cognitive component) coping with conflicts spawn or continue the conflicts, as they continuously feel more distressed than normals. They make poor coping choices in dealing with stress. Due to their heightened negative affectivity, they react in a hostile way. Finally, it could be that they engage in less anticipatory and preventive coping than other people, which results in greater exposure to stressors, including conflicts.

Bolger & Zuckerman (1995) assessed responses to daily interpersonal stressors. They found that a high level of neuroticism is associated with the use of more planful problem solving, self controlling coping, social support seeking, and escape avoidance.

Behavioural avoidance is a prominent feature of the anxiety disorder, with avoidance generally being viewed as part of the disorder itself, rather than as coping strategy. However, for many anxiety sufferers, behavioural avoidance may initially be used as a
strategy for coping with anxiety. Davey, et al. (1995) reported that phobia sufferers are more likely to use avoidance as a general coping strategy than are non-clinical samples. Cognitive avoidance (e.g., an agoraphobia sufferer imagining that he/she is in a safe place while undertaking an anxiety provoking task) has, in fact, been shown to be a common feature of many phobics (Watts, Trezise & Sharrock, 1986), and it has been implicated in the maintenance of phobic symptoms.

O'Brien, et al. (1996) & Gunthert, et al. (1999) found that anxiety disorder patients make poor choices regarding how to handle stress. These individuals use more hostile reactions, self blame, distancing, withdrawal and less planful problem solving to cope with stress. Basically these patients adopt less adaptive coping strategies to combat the stress and hence feel more distressed.

David & Suls (1999) conducted a study with a community sample of adult men, found that neuroticism was associated with use of catharsis and relaxation to cope with daily stressors.

From the above mentioned studies it is clear that depressives and neurotics adopt more avoidant coping, wishful thinking, and emotion-focused strategies. They also rely more on seeking information about the situation before acting. It has been found that stress and coping are related to each other. Coping is
conceived either as a moderator or as a mediator (Frese, 1986).

In the past few decades several investigators have also shown a relationship between coping and psychosomatic symptoms. The relationship between stress and coping imply each of the following issues:

a) The association between coping and psychosocial load or stressor.

b) The connection between coping and psychosomatic symptoms.

c) The role of coping styles as moderating factors in the stress illness relationship.

Schwartz et al. (1981) found the association between coping strategies that emphasize suppression of anger/hostility with physical symptomatology.

Nakano (1989) examined the relationship among psychological/physical symptoms, hassles and intervening variables of stress in 128 adults (32-62 years). The intervening variables were 5 coping strategies — type A behaviour, hardiness, social support and social interest. Results showed that there was a strong association between hassles and symptoms. Symptoms were related to avoidance emotion-focussed coping and type A behaviour. Individuals with high symptoms tended not to use problem-focussed coping and showed more type A behaviour. Avoidance
and active cognitive coping used by subjects had significant negative correlation with symptoms.

Some studies in literature have reported certain coping styles of asthmatic patients. Dirks et al. (1980) have defined three types of styles in asthmatic patients. They are — (a) an appropriate adaptive response to asthma management, (b) the use of ‘hopeless dependency’ on physicians and hospital services, and (c) inappropriate excessive independence.

Strunk et al. (1985) in a well conducted case controlled study of 21 children with severe asthma who died of asthma following discharge from hospital, found that the psychological risk factors were prominent in severely asthmatic children who subsequently died of asthma. The psychological risk factors that were identified in this study included disregard of asthmatic symptoms, depressive symptoms, conflict between the patients’, parents, and hospital staff regarding the medical management of the patient and self care of asthma while in hospital.

Rae et al. (1986) in a case control study of deaths from asthma in New Zealand adults identified a variety of factors that delineated patients with asthma who were at high risk of death. These factors were non-compliance with medication in patients, who deny their illness excessively as well as the presence of overt psychosocial problems.
Yellowlees et al. (1988) compared the psychiatric status of 13 patients who had suffered a near miss asthma death along with 36 asthmatics, who had not experienced such an episode and found few differences between the groups. Both groups however, showed higher than expected levels of psychiatric morbidity, severe lifestyle and social restrictions.

In another study, Yellowlees & Ruffin (1989) studied 25 patients who had suffered a near miss asthma death (NMAD) and had undergone a comprehensive psychiatric evaluation on average 13 months following this event. All patients had very high levels of denial and following NMAD, patients appeared to either decompensate psychiatrically, usually exhibiting symptoms of anxiety disorders or further increased their levels of denial. The presence of high levels of denial of asthma and history of psychiatric illness in patients appear to be factor that may increase the likelihood of death from asthma.

Sokhey et al. (1994) found that the asthmatics differ from normals on the way they cope with stress, i.e., they use less of problem solving approach and have less ability to retain an optimistic outlook towards life when faced with stress which serves as a resistance. They also differ from normals on the way they avoid stress, i.e., they get away less from things for a while or take a vacation to avoid stress.
Farr (1999) found that patients with asthma, cope with their disease in ways that are deleterious to them. The coping styles used by these patients often were used by them before the onset of the asthma, but the asthma amplifies those styles and the coping styles can amplify the asthma. They reflect denial, anger, bargaining, and depression.

Sexton et al. (1999) examined the uncertainty experienced by persons with asthma and the coping strategies they used. The sample of 99 adults was interviewed by the investigators. Subjects responded to demographic and illness related questions and completed the Mishel Uncertainty in illness scale and the Jalowiec Coping Scale. Subjects who had asthma for a longer duration reported lower level of uncertainty. Those who were hospitalized because of asthma and those for whom pollen was a trigger experienced greater uncertainty. Females, individuals who went to an emergency department because of asthma, and those who attended pulmonary support groups used more coping strategies. Understanding the sources of perceived uncertainty may assist individuals to cope with and manage the chronic and acute phase of asthma.

Small et al. (1999) found that individuals with chronic obstructive pulmonary disease or asthma cope well with it. The informants identified two types of coping strategies they use to
manage their situation, which may be categorized as problem-focused, including energy conservation, utilization and restoration and emotion-focused, including being positive accepting, the physical limitations, distracting and normalizing.

From the above studies it may be concluded that it is very important to have effective coping repertoire. Effective coping may play an important role in health promotion, disease prevention, and more rapid recovery from illness.