AN EXAMINATION OF FAMILIAL CORRELATES OF CHILD PSYCHIATRIC DISORDERS

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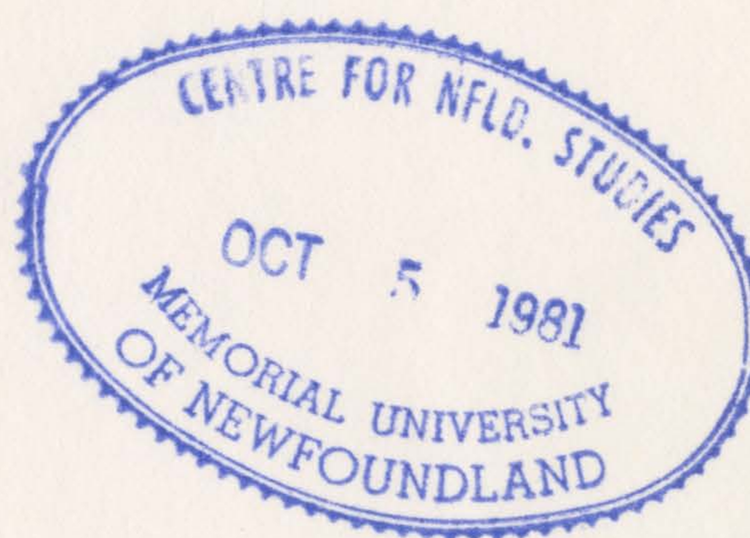

AN EXAMINATION OF FAMILIAL CORRELATES

OF CHILD PSYCHIATRIC DISORDERS

by

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ABSTRACT

The purpose of this study was to examine the familial correlates of psychiatric disorders in children receiving psychiatric services in Newfoundland.

The data for the study were collected through personal interviews with the parents of forty-five children receiving psychiatric services during a specified period of time. A structured questionnaire was administered to this sample consisting of parents of all ages, and occupational background. The data thus obtained were compared with the data obtained in a major research project on family life in St. John's, Newfoundland, using the same form of questionnaire.

A review of literature revealed that the family environments of children with psychiatric condition were unsuitable in many ways. Four main areas were discerned: 1) Marital Relationship of Parents, 2) Family Size, 3) Parental adequancy determined by their readiness for parenthood, and 4) Parents' Motives for having Children.

Theories of personality development supported the basic contention that deficiency in the family environment may cause child psychiatric disorders through its influence on parent-child relationship. A total of sixteen hypotheses were derived in the four areas of family life. An analysis of findings confirmed all but two hypotheses.

The general conclusion arrived at was that the marital relationship of parents of children with psychiatric disorders was conflict ridden. These children also came from relatively large families. The parents of these children reported being not ready to assume the parental role, and they lacked knowledge about child rearing. Many were dissatisfied with the role of child rearing. It was also noted that the parents of children with psychiatric disorders differed in their motives for having children; from that of the general population.

These findings are relevant to social workers and other personnel who work with children and their families, in child guidance clinics, in family counselling centers, in child welfare organizations, and so on in that they provide some measure of understanding of the background of children who are troubled and need assistance with their social and personal adjustment. Statistics indicate an upward trend in the population of children requiring psychiatric services, drawing attention to the need for competent mental health services for children and their families. Further research is therefore required to identify those social programs which strengthen family life, with a view to providing preventive treatment.

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CHAPTER I

INTRODUCTION

This is an age of concern about mental illness and mental health: mental illness for those who dwell on the question of personal and social maladaptation, and mental health for those who seem to be looking for a criteria of optimal psychological growth, the way the ideal child or adult should be (Jahoda, 1958).

Numerous studies have attested to the fact that most children show isolated psychological problems at one time or another and that many have transient periods of emotional disturbance or behavioral difficulties (Rutter, M. et al, 1970, Sheppard M. et al, 1971). To a considerable extent these are part and parcel of growing up and are not in themselves a cause for concern. As pointed out by Anna Freud (1945/1966), the child's level of performance fluctuates considerably from one stage of development to the next; in many instances, the transient phases of inefficiency may be quite normal. On the other hand, some children show disturbances of behavior, emotions, or relationships which interfere with their normal development and cause handicap to the children themselves, and/or distress or disturbance in the family or community which result in their need for treatment.

Statistical data giving information about prevalence and incidence of psychiatric disorders in the general child population has been difficult to ascertain because of inconsistent criteria for diagnosis and inadequate record of its occurrence (Quay 1972). Several epidemiological studies conducted in Britain and in North America do reveal that deviant behavior traits in children are more frequent than might be suspected and that these traits are clearly indictative of the presence of psychopathy when subjected to clinical assessment. These studies conclude that at any given point in time, somewhere in the region of five to fifteen percent of children in the Western World suffer from disorders of sufficient severity to handicap them in every-day life (Werry & Quay 1971, Lapouse & Monk, 1964, Rutter and Graham, 1966). Only a minority of children with these conditions get to see a psychiatrist. The very size of the problem means that family doctors, pediatricians, and nonmedical professionals such as teachers, social workers, psychologists and rehabilitation counsellors, working either inside or outside the psychiatric clinics, must also be expected to deal with some kind of psychiatric disorders and provide therapeutic intervention to the child and his family.

Precise statistics for Newfoundland and for Canada regarding the occurrance of child psychiatric disorders are

not obtainable. However, it is a fact that families with young children constitute one of the major burdens on the nation's mental health services (Statistics Canada 1978).

One of the reasons given for the lack of precise statistics is that psychiatric problems in children have many facets not easily encompassed in a single term. There is an extensive list of types of maladaptations, psychological disorders, mental illnesses or socially unsatisfying unsanctioned type of behavior found in childhood. Consequently, no less than 24 different systems of classification had been proposed for children's behavior disorders (Group for the advancement of Psychiatry 1966). In the recent years, it is generally agreed that for the most part psychiatric problems in children constitute exaggerations of or deviation from the normal rather than mental illnesses or diseases. Most deviant children differ from their normal peers in the number, instead of in the kind, of deviant behavior; and most conditions differ quantitively from the normal in terms of severity and associated impairment (Lessing & Zagerin 1971, Quay & Quay 1965).

Classification of Childhood Psycho-pathology:-

Ideally, the diagnostic classification of childhood and adolescent psychiatric disorders should indicate the nature of the individual's pathology; the severity; the

etiological agent or agents, if known; and the prognosis if known (Chess & Hassibi 1978). General classification groups of childhood psychiatric disorders are found to consist of descriptively similar but etiologically divergent syndromes. A classification system based on the current and historical symptom description originally worked out by World Health Organization (Rutter 1969), and recently proposed by the Task Force on Nomenclature and statistics (Spitzer et al 1977) provides the following descriptive categories of child psychiatric disturbances.

1) Emotional Disorders:-

This is one of the two largest groups of disorders. Emotional disorders, as the name suggests, are those in which the main problem involves an abnormality of the emotions such as anxiety, fear, depression, obsession, hypochondriasis and the like. Children in this category have received a variety of labels, e.g. overinhibited child, (Hewitt and Jenkins 1949), personality problems (Peterson 1961), disturbed neurotic (Quay 1964), and withdrawn, unhappy child (Patterson 1964). It is within this typology that the child who is clinically labeled as an anxiety neurotic or as phobic will be found. Fears, both general and specific are central features of emotional disorders (Rutter 1975).

2) Conduct Disorders:-

Conduct disorders are the other largest group of

disorders. The chief characteristic here is the abnormal behavior which gives rise to social disapproval. The category includes both the legally defined delinquency and non-delinquent disorders of conduct as shown by lying, fighting, bullying and destructive and disruptive behavior. Other behavior traits are disobedience, temper tantrum, quarrelsome; and inadequate guilt feeling. Children with conduct disorders may have some emotional difficulties (particularly depression), but it is the socially disapproved conduct which predominates (Mack 1969, Wolff 1971).

3) Hyperkinetic Syndrome:-

This disorder is characterized by poor concentration, as shown by short attention span and distractibility, and abnormality of motor function (Cantwell, D. 1976). These children, during early childhood, are characteristically very overactive in an uninhibited, disorganized, and poorly regulated way. In adolescence this overactivity often fades away and is replaced by an inert underactivity. Impulsiveness, marked mood-swings and aggression are common, and disturbed relationships with other children are usual. Sometimes, there is a delay in the development of speech, reading difficulties are common, and often intelligence is somewhat below average. There is a lack of engagement with the social world and there is a general immaturity in all respects of social intercourse (Quay & Quay 1965).

4) Infantile Autism:-

This is a rare but severe disorder present from the infancy period in which there are three main abnormalities. First, there is a failure in the development of social relationships so that the infant appears unresponsive and fails to become attached to his parents until well after the usual age. Later he totally fails to develop friendships and shows an odd stilted way of interacting with people. Second, there is a severe delay both in the understanding of language and in the use of speech. Third, there are a variety of compulsive and ritualistic activities. More than two-thirds of these children are mentally retarded. Those children who are not retarded could be trained with persistency and intensive training. However, the prognosis still remains guarded, as these children continue to have difficulty in adjusting to outside world and need a sheltered and protective environment (Rutter 1975).

5) Schizophrenia:-

Unlike autism, schizophrenia does not begin until later childhood or more usually adolescence, and cases before 7 years of age are rare (Rutter 1972). The onset is often insidious. The adolescent becomes perplexed and disturbed in his thinking, his school work falls off, his relationships with other people become more difficult and

he develops hallucinations and delusions. He may feel his thoughts are being controlled by an outside agent. Sometimes, the onset is quite acute, often with sudden development of ideas that he is being persecuted, and with depression or excitement.

6) Other Disorders:-

There are a number of common conditions which do not fall into any single well-defined category. Sometimes these disorders are described as disorders of biological functions. These conditions include enuresis and encopresis which develop beyond the age of 4 years and after the toilet training has been first established, but lost months or years later. Tics are other disorders in this category in which the main feature consists of quick, involuntary, apparently purposeless and frequently repeated movements which are not due to any neurological condition (Corbett, J.A. et al 1969). Obesity, excessive weight gain due to excessive intake of food in which overeating is symtomatic of the emotional state of the child (Mayer 1966), and sleeping disorders such as insomnia - i.e. interruptions or restlessness during sleep or hypersomnia - i.e. excessive sleep, are other conditions which fall in this category. A much more serious condition in this group of disorders is anorexia nervosa in which the main features are a persistent active refusal to eat and marked loss of weight,

often with a degree of activity and alertness which is surprising in relation to the patient's emaciation.

The last two categories are Adjustment Reaction and Developmental disorders. (a) Adjustment Reaction: This occurs in response to acute stress experienced due to disruptive life events, usually of unpleasant nature, such as death, severe illness or acute trauma. It is usually situation specific. (b) Developmental disorders: A specific delay in development is the main feature. Some scientists do not consider these two disorders to be of sufficient severity to include them as full psychiatric disorders. However, children with these conditions are often referred to, and treated in psychiatric clinics.

It has been already stated that for the most part child psychiatric disorders do not consitute diseases or illnesses. These abnormalities have in common only the consequence that they are not rewarding to the child himself and/or are objected by someone with whom he interacts. They are ways of acting or feeling that a child or his family or a group of people such as school, neighborhood etc. would greatly prefer altered. It is therefore necessary to understand the causes of these conditions in order to develop criteria for assessment, treatment, and hopefully the prevention of such mental disorders which if left unaltered, may thwart

the child's further development and restrict his ability to cope with the social reality within which he will have to operate.

Etiological Factors In Child Psychiatric Disorders

There have been a number of investigations to determine the causes of behavioral disorders in children. The topic has been dealt with from the point of view of geneticists, general pediatricians, psychiatrists, sociologists, psychologists, social workers, school teachers, and more recently by the legal profession. For the most part however, the arguments have been heated as to whether genetic or environmental influences (nature versus nurture) are most important in shaping the children's behavior, either normal or abnormal.

Genetic and cytologic studies have attempted to isolate biochemical and chromosomal abnormalities in order to determine a genetic basis for such disorders as schizophrenia, chronic anxiety state or chronic depression (McKusick 1966). The classical studies of monozygotic and dizygotic twins reared apart and together give evidence of genetic influences on maturity, intelligence and temperamental characteristics such as anxiety and impulsiveness (Freedman 1965, Scarr 1968). Organic factors are also found to be associated with such disorders as stammering (Kay, D.W.K. 1964), enuresis (Hallgren, B. 1957) and specific learning

problems despite normal intelligence (Hallgren 1956).

The role of certain temperamental characteristics - defined as the primary reactive behavioral style of each child - has also been the subject of investigation. It has been reported that significant individual differences exist in the behavioral responses of infants depending on their temperamental disposition (Thomas et al 1975).

The inheritance of psychiatric disorders in children is a highly controversial topic. The relationship is not a simple mendelian one, and absolute prediction is not possible (Kallman, F.J. 1953). Neurotic anxiety, depression and mild schizoid tendencies may possibly have an inherited component but in many instances of anxiety, depression, and disorders such as enuresis, stuttering, and learning difficulties etc. no significant constitutional or hereditary basis has been yet established (Gottesman, I, 1963). After reviewing the literature on the subject, Shield (1975) commented that while genetic factors do contribute to the etiology of childhood psychiatric disorders, the extent and the nature of the genetic contribution is not clear. What is clear is that it is not the disorders as such that are inherited but a predisposition to some of them. If hereditary and temperamental predispositions do exist, the subsequent development of an emotional disorder is largely

dependent on child's life experiences, particularly those associated with early social interaction.

This view is supported by Thomas and Chess (1977) in their famous study of temperament and its influence on the development of behavior in different groups of children. After twenty years of observations, the authors summarized their findings as follows:

> "The results of both qualitative and quantitative analyses confirmed the finding that features of temperament played significant roles in development of childhood behavior disorders - -. Beyond this, it became clear that any temperamental trait or pattern in any individual child could significantly enter into the development of a behavior disorder, if the environmental demands and expectations were sufficiently dissonant with the child's behavioral style - - -. In no case did a given pattern of temperament as such, result in behavioral disturbance. Deviant development was always the result of the interaction between a child's individual make-up and significant features of the environment". (pp 37-38)

Thus, the social environment of the child, as it interacts with the child's physical inheritance has been recognized to play a significant role in determining his behavioral style. While it is true that the child's innate physical characteristics or response tendencies partly determine a child's social experience, these social experiences, in turn influence the child's feelings, thoughts, and actions, and to a large extent, determine if his behavior is socially acceptable or deviant. (Thorpe 1960).

To conclude the arguments whether environment or genetic influences are most significant in determining the characteristic style of behavior of children, the following observations are offered:

In studying a child's behavior, whether normal or abnormal, one examines the process of the making of his personality. Behavioral development obviously is dependent upon the growth and age appropriate functional maturation of the central nervous system. The human organism however, is remarkably plastic in its adaptability and is extremely dependent on social intervention for its specifically human qualities such as feeling, acting, thinking, etc. All personality is both genetically and environmentally influenced. The former influence is responsible for the limitations of the central nervous system typical of the individual even though these restrictions are quite broad and allow great latitude in response to environment (Lowrey, G.H. 1978).

Environment literally means surroundings. The child's surroundings are an aggregate of innumerable interacting factors constant and changing, immediate and remote, direct and indirect.

A most important environmental and experiental base for a child's personality development is the quality and

nature of his early human environment that network of interdependent group relationship that is called the Family. Theories of child development state that early childhood years are the time of learning, perceiving, grasping, and growing. The environment that the children are exposed to during the early years plays an important role in determining how they grow, and what they learn as well as their ability to adapt to their changing world as adolescents and as adults. This process of social learning and the activities of the child are largely shaped by the parents and by his siblings. Compared to the influences of teachers and friends, the family is the most potent force in shaping the behavior of the child and the first referent of social development possessing of semi-autonomous control over the child (Cohen 1976). Behavior tendencies internalized in early childhood, in the home may persist psychologically even when the home has been left far behind in time and space. And therefore, what happens during early years in the family may be one of the most important determinants of behavior throughout one's life (Sears et al 1965).

One of the primary functions of the family in almost all parts of the world, is to teach the child rules and patterns of living of the particular segment of society into which the child is born. It may also teach him something about the ways of the wider society in which he may

eventually participate (Lidz 1963, Reiss 1965). This process is known as acculturation or socialization: raising the child to learn and accept ways of his particular culture or society.

The form and content of socialization is influenced by familial context variables. In addition to his genetic make-up other determinants of a child's development are: how his parents stimulate him; what sort of behaviors they manifest for him to imitate, for what acts they reward or punish him; what attitudes they have, and what kind of physical and emotional environment the parents provide for him (Bandura and Walters 1963). In a healthy family, parents share compatible values, and set realistic goals for themselves and for their children. They provide each other with support and gratification and facilitate each other's and their child's growth. In such a family, the child gains a sense of self-confidence and self-esteem (Erickson 1958). He learns to tolerate the limits placed on his desires and impulses by the necessity of living and interacting with other children. He comes to consider his family as a source of support in dealing with uncertainties and stresses of life. He grows within the family and with the family (Zigler and Child 1973).

Unfortunately families are not always healthy, and

indeed they may be the breeding grounds for various defects in personality or for behavior deviations (Chess & Hassibi 1978). In recent years, many familial context variables have been identified as associated with childhood psychopathology, e.g. broken homes, emotional and material deprivation, ill health of parents, inconsistent or harsh discipline, and unloving or quarrelsome homes. Age of parents, their past experiences, values, motives for having children are other factors found to be related to the disturbances in children.

This study is undertaken in an attempt to identify any significant differences between the familial characteristics of children referred for psychiatric assessment and treatment and the characteristics of the general population in the community. As stated in the preceding discussion, family provides the immediate context within which socialization and training occurs. A failure to consider the child's family background variables ignores the tremendous impact that the environmental factors have on personality development.

It is hoped that the results of this study will provide understanding of various family dynamics as they influence the child's emerging personality. This knowledge may help identify and hopefully correct those circumstances that

hinder and distort the normal growth and the successful development of those children who are troubled.

The next section will deal with the literature review of familial factors which have been found to be associated with childhood psychopathology and are selected for the purpose of this study.

CHAPTER II

LITERATURE REVIEW

In 1926, John Watson, the behaviorist stated:

> "Give me a dozen healthy infants, well formed, and my own specified world to bring them up in, and I will guarantee to take them, one at random and train them to become any type of specialist I might select; doctor, lawyer, artist, merchant-chief, and yes, even beggerman and thief, regardless of his talents, penchants, abilities, vocations and race of his ancestors".

This statement may seem rather amusing in view of the fact that the infant is not a "tabula rasa" - i.e. a clean slate on which the family and society can inscribe any pattern or outcome at will. But neither is the infant a "homunculus" - as previous centuries had it - in which the child's final adult psychological structure was present within him at birth, and in which development consisted of the maturation and unfolding of these fixed inherent characteristics. Needless to point out that Watson never did realize his dream for his assertions were an over-simplification of the view that differences in nurturing and individual life experiences exert significant influence on the emerging personality of the infant. While there is wisdom in the expression, "The apple never falls very far from the tree", the familial influence on the child's development is extremely subtle and fundamental. The variables involved are so complex and diversified in nature,

that it is impossible in any single discussion to exhaust all their possible manifestations. The following review of literature is therefore concerned with selected variables which might be described as "parent centered". It is concerned with: 1) degree and quality of intactness within the family, i.e. parents' marital relationship, 2) the size of the child's immediate family, 3) how ready and knowledgeable the parents were for assuming the parental role, and 4) what were their motives for having children and how do they value their children.

The review of literature about each of these variables deals with studies conducted in the fields of Psychiatry, Psychology, Sociology, and Social Work.

Marital Relationship And Psychiatric Disorders in Children

In recent years, the marriage relationship has been given central importance by many clinical writers as a focal point from which other problems in social interactions derive (e.g. Satir 1964). The following discussion reviews the quality of marital relationship and degree of intactness in the families of children with child psychiatric disorders.

Parents of emotionally disturbed children report more dissatisfaction and conflict with their spouse than do parents of normal children (Cummings et al 1966). In a study of direct observation of interparent relationship in

a clinic population, it was found that behavioral measures of interparent conflict was higher in parents of neurotic troubled children than in parents of normal children (Gassner & Murray 1969). The decision making process in families with emotionally disturbed children was also investigated and it was found that in a two-way interaction families with a disturbed child exchanged less information, took longer to reach a decision, and spent a greater proportion of time in silence. While there was no open hostility between the husband and wife, the relationship was characterized by avoidance, aloofness, and by cold and unloving atmosphere (Ferreira and Winter 1968).

Family relationships have been also given etiological significance for asthma and other psychosomatic disorders. Marital interaction assessed by interviews of mothers of children with psychosomatic disorders, and a number of other disorders such as school phobia, childhood psychosis, indicated that these mothers experienced more friction with husband, excluded husband from the mother child relation, and were domineering and depreciating toward the husband (Rees 1964).

Another line of research which supports the view that interaction between husband and wife, and resulting marital dissatisfaction is a contributing factor in asthma is the

repeated finding that the removal of the child from the home often results in immediate and dramatic improvement for some children (Purcell 1963, Peshkin 1963). These studies reported that 15 of 20 children who showed rapid remission of symptom when hospitalized, considered such emotions as anger and worry about family relationships to be factors precipitating asthma attacks.

Sociological investigations of juvenile delinquency have reported that a large number of young offenders come from broken homes (Glueck and Glueck 1950, Nye 1958). There was also some suggestion that the effects of a broken home are more disruptive if the child is pre-adolescent when the separation occurs, and if the child is a girl. Studies of Toby (1957), and Monahan (1957, 1960), show broken homes to be more frequent among female than male delinquents.

These studies led to the assumption that a main damage stemmed from the stress of family separation. However, a variety of research findings have since then shown that this is not the case. Three separate investigations have demonstated that the risk of delinquency is much increased if the parents divorce or separate, but the risk is only slightly raised if a parent dies. This suggests that it may be family discord and disharmony prior to the break-up rather than the break-up of family as such, which

leads to anti-social behavior (Douglas et al 1968, Gibson 1969, Gregory 1965).

Other studies have also demonstrated that the ongoing discord between the parents is related to conduct disorder rather than broken homes as such. For example McCord and McCord (1959) predicted on the basis of their findings that boys from homes rated as quarrelsome and neglecting (but unbroken) were more likely to become delinquent than boys from cohesive unbroken homes or broken homes. This finding was comfirmed by a recent study (West and Farrington 1973), in which delinquency was found to be twice as common when marital disharmony or serious parental conflict was present as when family relationships were smoother. In a study of adult patients' families, Rutter (1971), showed a strong relationship between marital discord and antisocial behavior in their children. Also in a separate epidemiological investigation, Rutter et al (1975) found that children from families with severe marital discord show an increased rate of behavioral deviance in school, and an increased rate of psychiatric disorders in general.

Many clinical investigations of children with conduct disorders report that these parents are indifferent and isolated from each other. Antagonistic, hostile relations between the parents are more frequent among families of

children with an emotionally disturbed or an immature child (Bennett 1960).

To conclude the review of literature to this point, marital dissatisfaction is implicated as etiogenetically significant in childhood psychopathology.

Family Size and Psychiatric Disorders in Children:

The importance of family size, i.e. number of children- to personal and social development of the individual; and its impact on the family relationships has been only recently recognized. Studies of the effect of family size on intellectual and social adjustment of children have been largely undertaken by psychologists and psychiatrists, and is the focus of the following discussion.

The earlier consensus of opinion was that children need other children with whom they can associate and learn their first social lessons, and the small family with one or two children does not provide this opportunity (Morgan 1932). Based on observations of a group of children in a nursery school, Bennett and Issack reported that children who came from small families, were liable to special difficulties of behavior and typical faults of character, where as children from large families were self-confident, and were more able to adapt to the outside world (1944). In a study of young school age children Adler (1956) found that

the only child had a particularly difficult time adjusting outside the home, where he was no longer the centre of attention. Moreover, only children often came from homes where parents were timid and pessimistic. These children tended to be full of anxiety, and needed continuous reassurance and support from their teachers.

In an exploratory study of large family, Bossard and Boll (1956) found that there were desirable influences on the personal development of children in large families. The majority of their 90 subjects felt that there was something in the atmosphere of the large family that tends to promote emotional security even in the face of economic and other difficulties. Support for this view comes from a study by Ellis and Beckley (1956). This study looked at the records of one thousand child guidance clinic patients. Children from large families (seven or more) were significantly less emotionally disturbed than children from smaller families, although the basis for rating was not specified. Other earlier studies have also reported that probability of jeolous responses and selfish, demanding behavior decreased as family size increased.

Recent investigations have challenged the view that large family size is condusive to better social and emotional adjustment. One of the earliest noted and most consistently

reported finding relating to the effects of family size has been the decline in IQ as number of children increases (Anastasi 1956). Psychiatric literature of personality development supports the view that small families are associated with well adjusted personality. In a review of literature of clinical observations, Rutter and Madge (1976) found that children from large families tend to have a lower level of intelligence and of reading attainment although no genetic factors could be accounted for this handicap. Poor verbal skills, (Nisbet and Entwistle 1967), increased lethargy and dependency in the infants and young children (Waldrop & Bell 1964), and poor self-image, low self-esteem (Rutter & Mitler 1972), are also found to be associated with large families. All these factors are found to be etiologically significant in the development of emotional and conduct disorders.

As with regards to conduct disorders, studies of juvenile delinquency have revealed that children from large families (at least 4 or 5 children) are twice as likely to develop conduct disorders just as they are more liable to become delinquent (McCord and McCord 1959, Power et al 1965, Nye 1958).

Several clinical investigations suggest that children from large families are overrepresented in any clinic popu-

lation. This was the finding of a systematic study conducted in child guidance clinics in France (Chonibard de Lauwe 1959). A clinical study conducted in the United States confirmed that children from large families are overrepresented, but there are differences in the symptoms presented by children from large families and those presented by children from small families. Children from large families less often showed anxiety and neurotic symptoms, but more often had school related problems or antisocial behavior (Tuckman and Regan 1967). In this particular study however, the social status of the family was not controlled, and therefore, the symptom patterns may reflect differentials in socioeconomic status as well as family size effects. Another study (Hawkes et al 1958) has shown that problems of adjustment, feeling of inferiority, symptoms of anxiety and tendencies to day dream to be highest in families with five or more children.

In summary, the recent investigations seem to support the view that deleterious effects on the development of children increase as family size increases, and that the large families are associated with childhood psychopathology.

Readiness For Parenthood and Psychiatric Disorders in Children:

It is only quite recently that specific attention has been given to the efficiency of parental role; and its in-

fluence on the development of children. However, the few pilot studies which were conducted in early 70's, do suggest that the knowledge and character of parental responses can be very influential in shaping children's behavior for better or worse (Johnson et al 1971, Patterson 1973, Patterson and Cobb 1971). These studies showed that parents of problem children seem to differ from other parents in being less good at recognizing when and how to intervene. They gave less encouragement and praise for good behavior, and gave a lot of attention (both positive and negative) when the child was misbehaving. Clinical investigations have verified the above findings that the parents of children who exhibited speech delays, and problems in communication and interaction with children their own age lacked in knowledge of how to provide stimulation to their children. Though these parents appeared to be of average intelligence they lacked both intellectual and emotional appreciation that play and conversation were important for babies. This was attributed to the fact that these parents were unprepared for assuming the role of parenthood, they were young, and children arrived soon after marriage (Skynner 1969, Wolff & Acton 1968).

Studies of juvenile delinquency have shown that most adolescents found it difficult to turn to their parents for information re subjects such as sex, friendship, vocation

etc.; partly because they felt their parents did not have sufficient knowledge due to lack of education or due to parental immaturity and confusion about life in general, and about their parental role in particular (Nye 1958). Studies conducted in Child Guidance clinics have shown that the children who were impulsive and aggressive came from homes where parents were less demanding, less controlling, and less well organized due to the fact that their children arrived too soon after marriage, or the parents were too young, and lacked in knowledge of child rearing (Baumrind 1967). Indeed, many clinical investigations of children who were physically abused or neglected by their parents and later developed psychiatric problems give evidence that these parents were ill prepared for parental role, and that they lacked the knowledge of the developmental needs of their children (Elmer & Gregg 1968, Steele, Pollock 1970). These parents were young, and themselves had unhappy childhood experiences of mothering; which equipped them poorly for a parental role.

Other studies however have shown that the age or education of parents per se is not related to the children's developmental problems. The children who exhibited severe difficulty in attending school, severe emotional upset, and separation anxiety, but showed absence of significant anti-social behavior came from homes where parents were rather

older (over 35 years); and the children were rather "late arrivals" in their life (Morgan 1959, Berg et al 1969). Their studies showed that while these parents were older than the average parental age, and had good educational background, they shared in some common characteristics with other parents; i.e. thay lacked knowledge and appreciation of child's developmental needs. This was related to their older age and established life style, resulting in general lack of control, and consistancy in approaching the child.

Not much is known about the early childhood experiences of parents, and its association with psychiatric disorders in children. One study deserves attention. Frommer and O'Shea (1973 a, b) found that women who had been deprived of good parenting experiences, or were unhappy in their childhood had more difficulties in infant care, and were more likely to have infants with problems than the controlled group. However, in spite of important and statistically significant association, most individuals from unhappy homes do <u>not</u> show these characteristics (Rutter & Hersov 1977).

To summarize the above discussion general lack of readiness for parenthood whether due to age, lack of knowledge, or immaturity, is implicated as significantly related to behavioral disorders in children. These studies, however, have tended to be contradictory and therefore, the

findings have been inconclusive.

Motivations For Children And Child Psychiatric Disorders:

In recent years, a number of sociological and some psychological investigations have been carried out to determine the motivations for child bearing. These studies have as their objectives the fertility expectations, and behavior of significant portions of population; the psychological factors associated with fertility differences, and social explanatory factors associated with child bearing motivations (Westoff, et al 1963, Bumpass & Westoff 1969, Pohlman 1969). The list of motivations is overwhelming. It includes motives that operate at different levels of consciousness and with different degrees of primacy. It includes motives that appear to be contradictory, although they may characterize different groups, or the same person at different times, or even the same person at the same time. Motivations for children are therefore complex, changing and often ambivalent (Fawcett 1975).

Parents obviously differ in their motivation for having children or not wanting them. There are well-known national, cultural and social variations in this respect (Arnold et al 1975). However, empirical evidence with regards to pre-natal desire for child, and its effect on the child's later development is virtually non-existent. The following review of literature is therefore based on

the conclusions reached largely by clinical observations of children with psychiatric disorders.

Birth histories of children with emotional disturbances such as withdrawn, shy and anxious personality reveal preponderance of unplanned and unwanted pregnancies (Goldfarb '61, Wolkind 1974). Some of these children were treated during their infancy for "failure to thrive" without known organic reason, and others were reported to be lethargic, unhappy and cranky children. Forsemann and Thuwe (1966) followed up 120 children born after requested abortion had been refused. Compared to a control group, they had a significantly greater frequency of psychiatric illness, educational difficulties, delinquency and admission into care. Many of these children were conceived before marriage and/or born illegitmately. Psycho-analytical literature however, is replete with case histories of children who were highly valued and desired by their parents. For example Malmquist (1971) studied a group of children who suffered from severe separation anxiety from their parents, and as a result they refused to leave home and go to school for the fear that something might happen to them or to their parents. He concluded that many of these children were born to parents who were isolated from each other, whose marriage was shaky, and whose life had generally become unsatisfactory and aimless. In some instances,

the child was conceived as a means of achieving an adult social status in the community, or for companionship. The work of Vogel and Bell (1960) illustrates the scapegoat role often played by the disturbed child in the family; the child's psychological maladjustment as this study shows, is an essential part of the family integration.

Children with low self-esteem, poor school performance, and rebellious behavior are often associated with such family dynamics where the children were originally desired to fulfil some goals set out by the parents for themselves, but had been unable to fulfil due to personal or environmental restrictions (Lidz et al 1957). Study by Lazarus (1960) and by Kennedy (1965) showed that children who were lacking in curiosity, who were unable to form relationships with other children and who were dependent for adult approval and companionship were born to parents who expected their children to provide them with love, companionship, support and care which they had lacked in their childhood and continued to miss in their marriage. In most cases, it was the mother whose need for the child to provide her with companionship was greater, and who found the marriage to be lonely without children. In some instances where the father was implicated, the motivation for having the childwas to "achieve a social status" through the child. This was evident particularly in those instances where

children showed rebellious attitudes directed more toward their mother.

Research evidence however is lacking about which pre-natal motivations for the child are related to behavioral disorders in children, and whether the parents' pre-natal motivation for or value of child plays a crucial role in the personality development of children.

Conclusion:-

A review of the literature shows that a relatively consistent cluster of familial characteristics has been associated with child psychiatric disorders. Research evidence is almost unanimous about the finding that marital relationships of the parents of troubled children is characterized by conflict or dissatisfaction, and dominance by one parent. Present knowledge about other factors, e.g. family size, age, and education of parents i.e. readiness for parenthood is not so conclusive and the literature review has presented diverging views on the subject. And finally, motives for having children and their relationship to child psychopathology have not been empirically tested so far it can be ascertained (Hoffman and Hoffman 1973).

Moreover, the vast majority of these studies are clinical assertions. Hence, until more data are available these postulates cannot be confirmed as etiological factors.

In the following chapter, theories of personality development will be discussed, which will provide the basis and rationale for the interpretation of the data in the study; and hypotheses will be generated with regards to each of these variables.

CHAPTER 3

THEORY AND HYPOTHESES

Theories of Personality Development:-

The body of knowledge that comprises the present understanding of personality development is not yet so scientifically coherent that a unified presentation of tenets and principles can be made. Several major theories have evolved about the personality development of children, e.g. Psychoanalytic theory, the developmental theory of Jean Piaget, Learning theory, role theory, and socio-cultural theory. The following discussion is divided into a consideration of two schools of thought, namely Psychoanalytic theory and social learning theory. These theories are selected because they are currently the most influential frameworks within which new formulations and observations of the child development are continuously being made.

Psychoanalytic Theory:-

The most famous proponent of Psycho-analytic theory was Sigmund Freud (1905). Later Anna Freud (1945/1960) reformulated some of his basic concepts, and Eric Erickson (1958) incorporated a social dimension into the core of psychoanalytic formulations.

Personality, according to psychoanalytic theory is organized in terms of three structural entities, the id, ego and super ego. In the normal, mature adult these

independent systems operate in a unitary-integrative fashion, channeling individual needs through adaptive environmental transactions.

The id appears first, which is a reservoir of instincts. As the infant grows older the second structure of mind, - ego - begins to form whose main task is to control the instinctual desires, and thus manage behavior. The third structure of personality is super-ego which acts as a censor concerning the acceptability of thoughts, feelings and behavior; and helps individual distinguish between right and wrong.

Every behavior is the final outcome of the interaction of three structures of the mind as the child passes through the five phases of development. Accordingly all individuals go through the oral-dependency, anal, Oedipal-electra or the phallic stage, and latency and adolescence stages of development. The influences, experiences and interactions that occur in the earliest years and throughout the developmental stages play a crucial role in determining his personality traits, behavioral style and particular manifestations of psychopathology.

Social Learning Theory:-

The basic concepts of learning theory were first proposed by Pavlov in 1927. Since then a number of scientists have contributed to the development of the theory

which is known as social learning theory. Some of the well-known writers are Skinner (1969), Bandura (1963, 1974), Bandura and Walters (1969), and Eysenck (1967).

The central proposition of learning theory is that all behavior, feeling, and thoughts are learned, and that the acquisition of psychological process is much less sequential or fixed as proposed by psychoanalysts. A further assumption is that learning occurs through contiguous association of events. Much of the child's development is due to learning which is a result of positive and negative reinforcements (rewards and punishments) and the imitation of social models, (other people). Because the types of models to imitate vary so much as do the nature, amount and timing of rewards and punishments from child to child, social learning theorists stress the variety of individual behavior which is possible in children of the same age. The child's social behaviors, therefore, are the result to a great extent, of learning, which is a function of the effects other people have on him.

To conclude, both theories of personality development include tacit or explicit assumptions regarding the commulative effects of repeated experiences, though the mechanisms involved in the learning process are different in both. Both theories emphasis that the basics of personality develop in the mutual relationship of mother, father and infant after

birth. Personality, a resultant of the forces of family relationships,is reaffirmed throughout life in all of the stages of the family life span, and in the wider community. "Whatever of us is human derives from interpersonal relationships along patterns set down in the family". (Sears et at 1965).

Family relationships are continually in flux, with each phase of relating arising out of preceding relationship experiences. Positive and negative evaluation of interpersonal experiences in any area of family interaction tend to be made in terms of the total relationship.

Theories of personality development vary not so much in emphasising the importance of this relationship but in the aspects and processes of the relationship that they regard as crucial. Psychoanalysts have stressed the care taking function of the parents as they interact with psychosexual development and the role of the parental behavior in the resolution of conflicts at different stages of development as basic in the development of psychopathology. Social learning theory has focused on the parents as models and as sources of reinforcement which shape normal and deviant behavior in the child.

The theories of personality development hence, provide the basic assumption that the basis for deviant behavior is

largely to be found in the relationship in the home, principally those of each of the parents with the child, and the parents with each other. Although there are rare behavior problems that do not originate in family relationships, the vast majority do - certainly enough to make the assumption reasonable (Kanner 1938/1972).

There are many dimensions to parent-child relationships; such as, the extent to which there is love, anger, hostility, jeolousy and so forth. The disturbances of children arise because a particular pattern of relationship that exists between the parent and the child is less or more than is desirable for his optimal psychological growth (Singer and Singer 1969).

A number of patterns of deviant relationship has been identified between the parents and the children who suffer from psychiatric disorders (Becker et al 1959). The relationship may be one of parental dissension, hostility or rejection, in which child feels unwanted, or unloved. It may be one of overprotection, in which the child is sheilded from the ordinary hazards of life that the vast majority of persons would not consider dangerous. The effect is frequently that of producing a fearful child with resultant inhibition of curiosity. It may be a symbiotic relationship characterized by an abnormally close tie between one parent and a child. Or, it may be one of either excessive

permissiveness; or rigidity or inconsistency (Kanner 1938/1972). To whatever extent, the parents withhold love and approval, or fail to give their child security, they fail in the goal of socializing the child. The child's reaction to parental denial is revolt - as in conduct disorder - or containment or internalization of conflict with resulting symptom formation as in emotional disorders. In different children one or another form of deviant behavior may become the dominant mode of adaptation depending on his genetic endowment and temperamental characteristics (Chess and Hassibi 1978).

How parents raise children and socialize them into the wider community; or rather the interaction between the parent and the child will depend to a large extent on factors influencing parental behavior; such as parents knowledge about child rearing, their value system, their motivation for having children, their early and present life experiences, their education, their age, and their socio-economic station in life. It will also be influenced by their expectation of the child and their aspiration for him; how they feel about their life in general, and their characteristic style of coping with stress (Stolz 1969). Intra-familial factors discussed in the review of literature are therefore, related to the development of disturbances of behaviors and emotions in so far as they influence parent-

child relationships.

In the following section the mechanisms by which these factors may influence the parent-child relationship and contribute to the development of disorders will be discussed; and hypotheses will be presented for each of these variables.

Marital Relationship — Parent-child Relationship — Child Psychiatric Disorder

Review of literature in the preceding chapter indicated that marital relation of parents is associated with child psychiatric disorders; and that the disturbed children generally came from conflict-ridden homes (Nye 1958, Purcell 1963).

It has been argued that family discord does not provide a true environmental effect, but rather the impaired relationships between the child and the parents reflect genetically determined personality attributes. However, there is considerable circumstantial evidence against this suggestion (Rutter et al 1977). First, genetic factors play only a small part in the pathogenesis of delinquency, and conduct disorders. Second, even within a group of parents with personality disorders there is still an association between marital discord, and antisocial disorders in children. Third, the association is strongest when the discord directly involves or impinges on the children.

Fourth, children who experience severe family discord in early childhood are less likely to show later psychiatric disorders if they subsequently experience harmonious family relationships (Johnson 1967, Rutter 1971). It may therefore be concluded that although genetic factors may doubtless play some part, marital discord also has an adverse environmental influence leading to many psychiatric disorders. It is however, not known exactly which mechanisms are involved in the process by which family discord leads to child psychiatric disorders; but there is circumstancial evidence suggesting the probable operation of three main mechanisms (Rutter, M. 1978).

First, theories of personality development emphasize that children need stable, warm, intimate family relationships upon which to build their own social behavior and relationships outside the home. Discord and quarrelling interfere with the development of such family relationships and in so far as they do, the child is likely to be harmed. The evidence in favor of this hypothesis is the finding that a good relationship provides protective effect in an otherwise hostile environment, and the variety of findings that children with insecure relationships are more vulnerable to stress (Moore 1975, Douglas 1973).

It is therefore hypothesized that:

Hypothesis 1: marital relationship of parents whose

children are suffering from psychiatric disturbances is likely to be dissatisfactory and unhappy.

Second, the marital relationship between the parents is the only model of a close relationship of which the child is likely to have intensive experience over a long period of time. Quarrelling parents provide a deviant model of interpersonal behavior and in so far as the child follows this model, his own behavior may become disturbed. There is no direct evidence that this occurs, but numerous studies have shown that children do tend to imitate aggressive models (Bandura 1969).

It is therefore hypothesized that:

Hypothesis 2: the parents of children with psychiatric disturbances would be more likely to report that they handle their conflict and disagreements either by open hostility or by avoidance or indifference towards each other.

And third, marital satisfaction or dissatisfaction may determine the degree of parents' acceptance or rejection of the child (Kanner 1938/72). Marriage may have been motivated by pregnancy. If dissensions and incompatibilities have led to disillusionment, and raised the spectre of eventual dissolution of the marriage, it is extremely difficult to

care for children with unmixed pleasure and equanimity (Richards 1974). There is statistical evidence that when marriage is precipitated by pregnancy rather than other factors (especially when other factors for marriage are absent or less important) these marriages tend to have more difficulty, ultimately resulting in divorce (Christenson 1969).

It is therefore hypothesized that:

Hypothesis 3: parents of children with psychiatric disturbances would be more likely to report that their marriage was precipitated by pregnancy.

Family Size —— Parent-child Relationship —— Child Psychiatric Disorders

Review of literature suggests that family size is a factor in child psychiatric disorders. While the earlier consensus was that small family size was associated with childhood psychopathology, more recent studies contest the stereotype that children from large families are more self-reliant and mature (Nisbet & Entwistle 1967).

Various hypotheses have been put forward to explain the consequences of large family size on parent-child relationship resulting in adverse development of children. The most frequently advanced explanation is that in large families adequate care and supervision and the parents' ability to spread love and affection to meet the need of each child

becomes more and more difficult with mounting household chores, financial worries, and other problems of day to day living. There is research evidence to support this assumption that children from large families receive less adequate infant care, and less encouragement in school than do other children (Douglas '64). Financial and material resources are considerably less in large families (Land 1969). Of particular interest is the finding that in large families the parental role playing is characterized by less positive affect and more authoritarian practices restricting the child's autonomy, and thereby thwarting his intellectual curiosity (Nye et al 1970).

To the extent that parental child-care practices and attitude toward child rearing are influenced by the number of children in the family, one might expect that the personalities of the children would be influenced more generally than merely in cognitive development. If parents are less available to their children, if they are more authoritarian in their interaction with their children and if they are more harried and less warmly accepting, one would expect the children to be less dependent upon their parents, and to turn more to their siblings, or to relationships outside the family for emotional support. Where and how a given child turns will depend upon his special talents and proclivities.

In support of this view, one is tempted to quote the

Spanish writer René Durel. In a perceptive autobiographical account of the problems of a child in a large family, Durel (1971) recalls his school years and his search for a kind of self-confirmation that was not forthcoming from his parents and his dozen siblings.

> "The scramble for attention in a large family often means that the only one who really listens to is oneself ...... (In large families) there are in effect no parents, since parental attentiveness and concern can be stretched only so far and no further ......".

It is therefore hypothesized that:

Hypothesis 4: children with psychiatric problems would be more likely to come from large families.

Hypothesis 5: parents of disturbed children would be more likely to use authoritarian means in the training of their children.

Scientific evidence in support of these hypotheses comes from a study which found that children in large families learn early in life to reduce tensions associated with pain by persistently shouting about his problems in order to be heard —— as is the case with hypochondriasis (Gonda 1962), and with children who exhibit antisocial behavior, or conduct disorders. The need to shout about his problems arises because parents in large families tend to be less responsive to individual child's need for attention. Of significance is a finding that young school age children, and adolescents

from small families have favorable parent-child relationships resulting in better school performance; in less attention seeking behavior, and resulting in better interpersonal relationship outside the home (Sears 1970).

Finally, the scientists theorize that in the complex and changing society of today, the emphasis is on planning, rationalism and prudence oriented toward individual growth and achievement (Clausan & Clausan 1975). This is particularly suited to small family theme. In large families, parental role playing will be characterized by severe strain, due to greater pressure on their emotional and psychological resources. The presence of many small children seem to make parents more vulnerable to stress, and less satisfied with their life in general, with its consequent ill effect on parental role playing and on the child's development (Brown et al 1975).

It is therefore hypothesized that:

Hypothesis 6: children with psychiatric disturbances would more likely to come from families where parents in retrospect would have preferred to have a smaller family than their achieved family size; and

Hypothesis 7: the parents of children with psychiatric disturbances would be more likely to report

dissatisfaction with their life in general.

Readiness For Parenthood —— Parent-child Relationship —— Child Psychiatric Disorders

The literature suggests that the parents of emotionally disturbed children are less knowledgeable about child care, are young, immature, and are ill equipped with general readiness to carry out the responsibility of their parental role. (Skynner 1969, Wolff and Acton 1968).

It is not known exactly how the general lack of preparation for parenthood would influence the parent-child relationship to an extent that it may cause behavioral disorders. It has been however, suggested that readiness for parenthood equips the parent with a knowledge and a sense of confidence about his or her role which is an important factor in developing a secure and happy relationship between parent and child. Parental skill lies in knowing how to vary the response to different behaviors; and to different children with appropriate recognition of the ways in which their needs vary according to temperament, developmental level and circumstances. Thus, the ability to "read" babies' behavior, and interpret their communication is an important parental characteristic which has significant influence on the emerging personality of the child (Ainsworth 1973).

The parents who have personal deficiencies, such as lack of knowledge, experience or being thrown into parental

role too quickly after marriage are essentially unprepared for the role. They are ineffectual, lack in self-confidence and are unable to set limits. Studies of child-rearing practices support the view that the parents who are young and less knowledgeable about their children's developmental needs tend to be irritable in the enactment of their parental role, and tend to be either too demanding and controlling, or over-permissive. They are also inadvertently neglectful of their children (Sears et al 1958, Newson and Newson 1965). In a follow-up study, which used the same questionnaire as Sears et al study, Becker (1962) found that children raised by parents who are irritable, inconsistent and overpermissive or rigid, showed many symptoms of psycho-neurotic disorders, and the parents who were hostile, and rejecting created a child who showed anti-social or conduct disorder traits. These parents failed to encourage the child when he was doing what he should be doing, and seemed to be unduly preoccupied with this misdeeds.

The following hypotheses are therefore generated:

Hypothesis 8: parents of children with psychiatric disturbances would likely to be young when they first become parent.

Hypothesis 9: the parents of children with psychiatric disturbances would be more likely to report that they found transition to parenthood

difficult.

Hypothesis 10: that they were less ready for parental role.

Hypothesis 11: that they did not have sufficient knowledge about how to bring up their children.

Evidence in support of these hypotheses is derived from a study focusing on parents' reaction to transition to parenthood (Dyer E.D. 1963). This study reported that parents who found the transition difficult, reported a great many problems connected with their children. It was however found that the problems were less severe if parents had some prior knowledge about child rearing, were married three or more years before the arrival of the first child, or if the child was "planned" that is if they had decided to have a child on purpose and therefore had made necessary preparation and adjustment in life in anticipation of the child's arrival.

Dyer's study further points out that the parents who made necessary adjustments after the initial crisis, and who subsequently enjoyed their child-rearing role reported fewer behavior or emotional problems with their children. Hoffman (1961) supports this finding in a theoretical model that speculates that the amount a parent enjoys his or her work influences the consequences of the work.

It is hypothesized that:

Hypothesis 12: the parents of children with psychiatric disturbances would be more likely to report that they find the child-rearing role less satisfactory than other kinds of work.

Finally, parents who have had happy childhhod experiences themselves, would recreate their own parenting style after their parents as their models. Unhappy or adverse childhood experience prepares one for inadequate parental role. Indeed, research evidence supports the view that parents who physically and emotionally abuse their children with a consequent adverse effect on their development, themselves had been deprived as children, and had unhappy growing-up experiences (Spinetta & Rigler 1970).

It is therefore hypothesized that:

Hypothesis 13: the parents of psychiatrically disturbed children would be more likely to report that they found their childhood to be unsatisfactory.

Motives For Having Children —— Parent-child Relationship — Child Psychiatric Disorders

Review of literature suggests that there is a preponderance of unplanned pregnancies in the birth histories of children with psychiatric disorders (Goldfarb 1961, Wolkind 1974). In cases where the pregnancy was planned, and the child was desired, the motivation for having him may have

been other than the enjoyment of having the child for his own sake (Malmquist 1965). Empirical evidence however, is lacking with regards to which of the motives for having a child may significantly influence the parent-child relation so as to create an adverse effect on his development. The following explanation is therefore provided to understand the dynamic influences of motives for having children on parent-child relationship.

Therese Benedek (1970) points out that the child's need for mothering is absolute, while the need for an adult woman to mother is relative. A woman may desire marriage and yet not desire children. The motivation for marriage may be quite complex and need not encompass a desire for child. Along the broad spectrum of a woman's responses to a child are every variety of feelings, every variety of desire and motivation (Ackerman 1968).

Some women (and men) have intense desire for a child, some crave many, some few, some do not want any. For example, a recent survey in the United States showed that eleven per cent of all women between the age of 18 years and 34 years do not want any children (1978 U.S. Census). Some want a child not for the child but because of strong cultural pressures to join the ranks of parenthood, to fulfill a conventional idealized image of family life; to make oneself in a parent figure, or to satisfy the family's clamor for an heir to the

name (Rossi 1968).

Some want children for ulterior motives - such as: to please or punish the husband or wife; to use child as a pawn in the parental conflict; or to keep a marriage "off the rocks". Some children are desired because of a need to live vicariously through the child.

The desire for the child does not always lead to subsequent enjoyment of the child, and motivation for a child therefore may play a crucial role in determining parent-child relationship.

The child may be resented because one or both parents may consider him to be an imposition on their lives if he was originally unwanted and arrived as a result of unplanned and "accidental" pregnancy (Richards 1975).

It is therefore hypothesized that:

Hypothesis 14: the children with psychiatric disorders are more likely to be born as a result of unplanned or "accidental" pregnancy.

Parent-child relationship may be equally abnormal in cases where pregnancies, though planned and premeditated, had been entered into with ulterior motives in which the genuine desire for a child figures less than the purpose which his existence is intended to serve. Sociological

research gives evidence to support this hypothesis that for many people children provide more affiliative value than husband or wife (Gurin 1960). "Avoidance of loneliness in marriage" is another factor reported in child-rearing motivation. This in itself is not a bad motive but has a potential to be pathogenic if as a result the parents begin to expect the child to provide them with attention and companionship that is beyond the child's ability to provide (Chess, Hassibi 1978). These children would react to stress with anxiety and withdrawal as is evidenced in school phobic children (Hersov 1960). Some children may react by rebelling against rigid parental standards as is evidenced in children with conduct disorders. Some children become encopretic; in whose case encopresis becomes the symptom of repressed hostility towards a controlling, demanding parent (Rütter et al 1975).

Children are sometimes conceived or desired as a part of a scheme to keep husband (or wife) and to appeal to the marital partner's sense of responsibility. Sociological studies show that some parents consider children to be necessary for a happy marriage (Christopherson and Walters 1958). If parents find that the child's arrival had not reduced frequent quarrelling between the parents, marital discord or indifference toward each other, the child has failed to accomplish the major purpose for which he had been

conceived, and therefore may be resented as a bad investment, with resultant adverse effect on his development (Ackerman 1975). Unfortunately it is not possible to delineate clearly every type of motivation which is likely to influence subsequent parent-child relationship. From what information there is available from the previous research, it can be stated that if advantages and disadvantages of parenthood are placed in balance, the sum total of all those things that make being a parent to this particular child satisfactory is considerably outweighed by those things that make it undesirable.

The following hypotheses are therefore generated:

Hypothesis 15: parents of children with psychiatric disorders would be more likely to give "parent focused" reasons for wanting children than "child focused" reasons.

Hypothesis 16: The sum total of reasons for not wanting children would more likely outweigh the reasons for having them, in families with psychiatrically disturbed children.

Summary:-

From the foregoing discussion, it appears that several familial context variables play a significant role in determining parent-child relationships, and the personality devel-

opment of children.

The following chapter will describe the methods used for collecting and processing the data, and for testing the hypotheses as outlined above.

CHAPTER 4

METHODOLOGY

The Setting

This investigation was done at the Dr. Charles A. Janeway Child Health Centre. The Psychiatric Unit of the Janeway hospital provides services to children with psychiatric disturbances on in-patient and out-patient bases. The referrals are received from parents, schools, from medical practitioners and from social service organizations. Each child referred for psychiatric service is given an appointment for specific time for the purpose of assessing his emotional, intellectual and social functioning; and his family circumstances. Both parents are requested to accompany the child for this assessment. Two social workers are attached to this service; who interview all parents for social and family assessment of the child's situation.

The Sample

This was a study of two groups of families, one in which a child was referred for psychiatric assessment and treatment; the other group consisted of families in the general population. These two groups are referred to as Study or Clinic Group; and Comparison or Control Group.

Study Group:- This group was drawn from among the intact families known to Psychiatric Unit, during a specified period. The target number was fixed at the figure of forty-five.

This meant that parents of forty-five children known to the Psychiatric Unit during this period would be interviewed for the purpose of this study.

The Study Group consisted of three categories of children.

(1) Children receiving active treatment as in-patients on the Psychiatric Unit.

(2) Children referred for out-patient assessment and accepted for active treatment as out-patients. And

(3) Children discharged from the hospital, but continuing to receive psychiatric treatment as out-patients.

The actual sampling commenced in the second week of April, 1980, and continued through June 15, 1980, when the desired number was obtained. This method of sampling was selected for the reason that the Psychiatric Unit at the Janeway Child Health Centre is the only in-patient Psychiatric facility in the Province. It also serves the largest population of children for out-patient assessment and treatment. Consequently, it can be assumed that the social characteristics of this group would be relatively representative of the population of children where a need for psychiatric assessment and treatment has been felt necessary at any given point in time. The support for this method of sampling is derived from F. Stephan and P. McCarthy in "Sampling

OpinionS (1963).

Control Group:- This group consisted of a randomly drawn sample of approximately 200 couples from the residents of Metropolitan St. John's. This group at this point in time was under study by the Family Research Unit of the School of Social Work, Memorial University of Newfoundland. The group was drawn from a series of random numbers (using a Texas Instruments random numbers generator) from the telephone listing of population residing in Metropolitan St. John's.

The Study Group was then matched with the sample drawn from the general population.

Research Instrument

The instrument consisted of a structured questionaire administered to both parents in the Study Group by the researcher through a personal interview.

In the Control Group, the instrument was administered in a structured interview by social work students specifically trained in interviewing techniques for the collection of the data.

The instrument consisted of four separate indices as indepentent measures in this study. Each index measured a specific area of family life. These four major variables are:

(1) Marital Relationship of Parents

(2) Family Size

(3) Readiness for Parenthood

(4) Motivations for having children

A review of literature suggested that these four areas are significantly related to the development of child psychiatric disorders.

The questions for the Research Instrument for this study were derived from the Family Life Research Questionaire, designed by Family Life Unit, School of Social Work; for the purpose of a major research project in St. John's. The Family Life Research Questionaire was devised after perusing several research studies and their instruments both in Canada and in the United States. This instrument was used for the purpose of the present study for the following reasons.

One, it was a tested instrument having formed a basis for a major study on Family Life in St. John's, Newfoundland, and therefore provided important data for the Comparison Group.

Two, it was a comprehensive instrument, including as it did a wide range of measures of parental satisfaction and marital relationship; and motives for having children.

Three, it was non-threatening as the questions examined

were common attributes of family life, and therefore were easily adapted to the social history outline currently being utilized on the Psychiatric Unit for the purpose of diagnostic formulation of the patient's social and family situation.

The questionaire was pre-tested both in the Comparison Group and in the Study Group before commencing data collection.

Data Collection Procedure

The questionaire was administered through personal interviews with both parents. Whenever possible, the questionaire was administered concurrently but separately to the father and the mother of the child in the study. It was felt that this procedure would hopefully reduce the possibility of inter-respondent distortion of the data through discussion or interruption, and help maintain the confidentiality of each respondent.

The fathers were interviewed separately, as it has been well established in scientific literature that paternal attitude and relationship with the child is an influential factor in the development of personality and psycho-pathology (Becker et al 1962, Baumrind 1971). Only a limited number of studies have separately investigated the father's attitude, and motives for children. Research has generally relied on the reports given by the mother about one's present family life. Therefore, and given the nature of the problem, it was decided to investigate the relationship of paternal

motives, attitude, and his perception of the marital situation.

The timing of the interview with parents followed the Psychiatrist's interview with the child and the parents together, to obtain information about the child's developmental history and presenting complaints. The researcher then interviewed the parents alone for the purpose of obtaining the necessary social history.

The parents were explained the purpose of the study. The willingness of the parents to co-operate was then ascertained and the questionaire administered. None of the parents interviewed refused to participate and it was easy in practically all cases to establish satisfactory rapport with the parents.

The participants were assured of total confidentiality of the information they provided. Their identity was protected by assigning only a numerical identification to the questionaire. Information which could result in the identification of the participants was excluded from any written or verbal discussion of the subject.

Limitations of the Study

It is recognized that the sample used for the Study Group, although comparable to the population of children referred for psychiatric assessment and treatment during a

given year, does not take into account the number of children seen by psychiatrists in private practice, and also the children treated by a variety of rehabilitative programs offered by various social service organizations. It was noted earlier that the representativeness of the group can be assumed since this is the only organization with a facility for in-patient psychiatric care. It is however, recognized that the sample is small, time limited, and limited to the setting; and therefore the generalizability can be questioned.

Second, the study group investigation has been carried out by the researcher herself and is thus dependent on personal assessments and interpretations. Owing to the nature of the investigation there was no other choice. However, the use of a structured questionaire has provided a certain ammount of objectivity. Besides, each case is generally reviewed by the psychiatrist-in-charge, and therefore it may have helped reduce the possiblity of "the experimenter's bias".

Delimitations of the Study

It is recognized that no single external or internal factor can be said to have a direct bearing on the kind of personality that a child will develop; and that the behavior problems in children are usually determined by the coexistence of several factors; familial context variables selected for the purpose of this study being only some of

those factors.

As with regards to the influences of parent-child interaction, throughout it is appreciated that influences may be bidirectional (i.e. Parent ⟶ child and child ⟶ Parent). "Parent centered" variables are selected in so far as they may influence parents' behavior toward the child.

Measurement of the Data

The study dealt with many variables such as age of parents, their marital relationship, family size, motives for having children, knowledge and readiness for parental role, their method of dealing with conflict and disagreements between each other, and with their children; satisfaction with child-rearing role, individual life satisfaction, and how they valued their children.

Definitions of Specific Terms

Marital Satisfaction refers to the degree and amount of satisfaction that husband and wife experience in their marriage in terms of general categories of marital events.

Three questions were asked to assess the quality of marital relation of parents.

(1) Taking all things into consideration, how satisfied would you say you are with your marriage? (Appendix 2, Questionaire #1)

(2) How would you compare your marriage with those of others you know? (Question #2)

(3) If you had your life to live over again, would you marry the same person? (Question #35)

Family Size refers to the number of children in the child's immediate family.

Large Family refers to a family consisting of four and more children.

Readiness for Parenthood refers to amount of experience, and knowledge about child rearing, and parental role that the parents had when the first child arrived in their lives.

Motivation for having Children refers to reasons for having or not having children. A list of reasons was prepared; as recommended by Hoffman and Hoffman (1973).

Motivation to have a child will depend to some extent on the value of child to the parents.

Value of Child refers to the function they serve or the needs they fulfill for parents. These are divided into two categories for the purpose of this study.

(1) "Parent Focused" value of child refers to a group of variables which expressed desire for child in terms of child's utilitarian value to fulfill parental needs.

The group is composed of the following five reasons why parents have children:

i) Because marriage is lonely without children.

ii) Because my husband/wife wanted children.

iii) Because I wanted someone to carry on my

family name.

iv) Because having children would make my marriage stronger.

v) Because having children would prove I am an adult.

(2) "Child Focused" value of child refers to that group of variables which expressed desire for child for his own sake. It consists of the following five categories of reasons why parents have children.

i) Because it would be fun to have children around the house.

ii) Because children are a comfort in one's old age.

iii) Because I would enjoy caring for and raising children.

iv) Because I thought I would make a good parent.

v) Because having children would help our family economically in years to come. (See Questionnaire)

A likert-type scale consisting of five categories was devised to assess key variables related to Marital Relationship, Readiness for Parenthood, and Motivations for having Children. The family size variable was measured in terms of

number of children per family in each group.

The completed questionaire was coded for computer analysis, key punched on the IBM cards, and these formed the data bank. The analysis of data was begun using "Statis - tical Package for the Social Science Program" (Nie et al 1975). This program was run on the Memorial University of Newfoundland computer services IBM 370 computer.

The data are reported using percentages, t-test and Chi square test for significance at the 0.05 and 0.01 level.

In the following chapter an analysis of the findings will be made.

CHAPTER 5

FINDINGS

Before proceeding to a more detailed analysis of the findings, it would be appropriate to present the demographic characteristics of the study and control group of parents.

DEMOGRAPHIC CHARACTERISTICS

Age of Parents:

The age of parents in the study and control group ranged from 25 years to 60 and over years. Approximately half the study group was constituted of parents whose age ranged from 25 to 39 years. 55.6 per cent of study group mothers and 48.9 per cent of fathers were below the age of 40 years. Approximately 42.2 per cent of mothers and 44.5 per cent of fathers were in the age range of 40-45 years, while those above the age of 55 years accounted for the rest of the group.

The age of the parents in the comparison group appears to be approximately the same as the age of parents in the study group.

TABLE I

Age Distribution in the Study and Control Groups

Age	Study				Control			
	Mother		Father		Mother		Father	
	N	%	N	%	N	%	N	%
25-29	11	24.4	4	8.9	28	13.4	9	4.9
30-34	7	15.6	11	24.4	65	31.2	52	28.3
35-39	7	15.6	7	15.6	45	21.6	44	23.8
40-44	12	26.6	8	17.8	34	16.3	30	16.3
45-49	3	6.7	7	15.6	22	10.6	29	15.8
50-54	4	8.9	5	11.1	6	2.9	11	6.0
55-59	1	2.2	2	4.4	7	3.5	4	2.2
60-over	0	0.0	1	2.2	1	0.5	5	2.7
TOTAL	45	100.0	45	100.0	208	100.0	184	100.0

Religion of Parents:

The religion in the present study was classified under six categories. It appears that the study group consisted of somewhat larger proportion of parents who subscribe to the Roman Catholic religion. The study group consists of 57.8 per cent of parents who belong to Roman Catholic faith compared to 41.3 percent of control group parents.

TABLE 2

Religious Distribution in the Study and Control Groups

Religion	Study		Control	
	N	%	N	%
United Church	9	20.0	34	16.3
Roman Catholic	26	57.8	86	41.3
Anglican	6	13.4	53	25.5
Salvation Army	2	4.4	11	5.4
Pentecostal	0	0.0	5	2.4
Other	2	4.4	19	9.1
TOTAL	45	100.0	208	100.0

Educational Background of Parents:

The level of education was classified under eight categories.

TABLE 3

Level of Education in the Study and Control Groups

Level of Education	Study				Control			
	Mother		Father		Mother		Father	
	N	%	N	%	N	%	N	%
8th grade or less	8	17.8	7	15.5	14	6.7	11	5.9
Some high scnool	17	37.8	12	26.7	44	21.1	19	10.3
High school completed	8	17.8	4	8.9	43	20.7	27	14.6
Some tech school	2	4.5	4	8.9	16	7.7	20	10.8
Tech school completed	2	4.5	11	24.4	40	19.2	40	21.6
Some University	3	6.6	4	8.9	20	9.6	18	9.7
University graduate	5	11.0	3	6.7	23	11.2	43	23.3
Other	0	0.0	0	0.0	8	3.8	7	3.8
TOTAL	45	100.0	45	100.0	208	100.0	185	100.0

As shown in Table 3, the study group parents were represented in each educational category: Approximately half the parents in the study group had some high school education or had finished high school. Approximately same number of parents in control group had the same level of education.

It is interesting to note that 11.0 per cent of the

study group mothers were university graduates; which compares with 11.2 per cent of control group mothers with the same educational background. There are more university graduates amongst the control group fathers however, compared to fathers in the study group.

Occupational Background of Parents :

There were seven categories of occupations represented by study and control group parents.

TABLE 4

Occupation in the Study and Control Groups

Occupation	Study				Control			
	Mother		Father		Mother		Father	
	N	%	N	%	N	%	N	%
Housework	23	51.1	0	0.0	109	52.5	0	0.0
Laborers	10	22.2	11	24.4	31	14.9	26	14.1
Clerical/Sales	7	15.6	6	13.3	30	14.4	22	11.9
Managers/Proprietors	1	2.2	7	15.6	4	1.9	25	13.5
Technical/Mechanic	0	0.9	15	33.3	6	2.9	65	35.1
Professional	4	8.9	3	6.7	25	12.0	27	14.6
Other (Private Enterprise)	0	0.0	3	6.7	3	1.4	20	10.8
TOTAL	45	100.0	45	100.0	208	100.0	185	100.0

As Table 4 indicates, the occupational background of parents appears to be similar except in the category of

laborers. 46.6 per cent of study group parents belonged to the category of labor class, or unskilled workers, compared to 29.0 per cent in the comparison group. However, the managerial and clerical positions are slightly more represented in study group; 46.7 per cent in the study group against 41.7 per cent in comparison group.

Present Employment Status of Parents:

The study group consisted of 44.5 per cent of mothers who were presently employed, and 4.4 per cent of the women who were engaged in furthering their educational level. Approximately 51 per cent of the study group mothers were unemployed. An equal number of women were unemployed in the comparison group and referred to themselves as engaged in housework.

Amongst the fathers 86.7 per cent of the fathers were fully employed compared to 94.0 per cent of the fathers in the comparison group.

TABLE 5

Present Employment Status in the Study and Control Groups

Employment Status	Study				Control			
	Mother		Father		Mother		Father	
	N	%	N	%	N	%	N	%
Employed	20	44.5	39	86.7	102	49.0	175	94.6
Unemployed	23	51.1	6	13.3	106	51.0	9	4.9
Other*	2	4.4	0	0.0	0	0.0	1	0.5
TOTAL	45	100.0	45	100.0	208	100.0	185	100.0

*Engaged in educational program.

From the demographic data presented in the above tables, it appears that the study and control group parents are quite close in terms of their socio-economic status as indicated by their education, occupation, and the employment status background.

FINDINGS RELATED TO FAMILIAL CORRELATES

The findings related to familial correlates are analysed for the family as a composite unit. The responses of fathers and mothers are therefore combined; and the findings are presented as study group and control group parents. It was however necessary to analyse some questions separately for fathers and for mothers in order to avoid the influence of possible male-female differences in attitude and responses. Reasons are given whenever the findings are analysed separately.

MARITAL RELATIONSHIP

Three questions were examined to determine the association of marital relationship to child psychiatric disorders.

1) Degree of satisfaction parents feel in their marriage.
2) Methods used by parents to deal with marital conflict.
3) Reasons for marriage.

Marital Satisfaction

Degree of marital satisfaction was measured as a scale score. The scale consisted of response to three questions:

i) Taking all things into consideration, how satisfied are

you with your marriage?

ii) How would you compare your marriage with those of other people you know?

iii) If you had your life to live all over again, would you marry the same person?

It is therefore hypothesized that marital relationship of parents with psychiatrically disturbed children would likely to be dissatisfactory.

Table 6 shows the degree of satisfaction the control and study group parents felt in their marital relationship.

TABLE 6

Degree of Marital Satisfaction in the Study and Control Group

Degree of Marital Dissatisfaction	Study		Control	
	N	%	N	%
Very satisfied	9	10.0	142	36.1
Satisfied	19	21.1	199	50.6
Somewhat satisfied	31	34.4	39	9.9
Dissatisfied	29	24.5	10	2.6
Very dissatisfied	9	10.0	3	0.8
TOTAL	90	100.0	393	100.0

$t = 12.3$, $P < 0.01$

It would appear that only 10 per cent of study group parents were very happy with their marriage compared to 36.1

per cent of parents in the control group. Twenty-one per cent of clinic parents felt content in their relationship with their spouse compared to half of the parents in the control group (50.6 per cent) who were happy the way their marriage was going. Thirty-four per cent of clinic parents were only somewhat happy in their marriage and showed some signs of disenchantment with their marriage. However, only 9.9 per cent of the control group parents were only a bit satisfied with their marriage. Thirty-four per cent however, were definitely disenchanted with their marriage, and perhaps would not have married the same person if they had to do it over again, compared to only 3.4 per cent of the control group parents who were equally unhappy with their spouse.

The difference between the two Groups was significant at 0.01 level of confidence on the t test; which confirmed the hypothesis that children with psychiatric disturbances had parents who were unhappy with their marriage, they perhaps would not have married the same person if they could do it again, and that they felt that their own marriage was not as good as some of the people they knew.

In spite of such unhappiness, these parents were staying together perhaps due to financial reasons or for the sake of children.

This finding is verified by recent research evidence

that certain psychiatric disorders, for example conduct disorders and emotional disorders may be more common in unhappy unbroken homes than in harmonious but broken homes (Rutter 1975). It suggests that ongoing disturbance in the family relationships may be more damaging to the child than the broken home as such.

Many reasons can be suggested as to why this occurs. Perhaps one of the reasons is that the quarrelling parents often provide inconsistent discipline and child rearing, as a result the child is likely to find it more difficult to learn how he is expected to behave. Or, it may be that the child becomes a family focus of discontent, or, he may have conflicting loyalties towards his parents; which give rise to strain and anxiety.

Whatever may have been the individual circumstance, the strong association of marital dissatisfaction of parents and child psychiatric disorder points out the effect of marital relationship on the growing child's emerging personality and his emotional health and well being.

Methods Used to Deal with Marital Conflict

It was hypothesized that parents of psychiatrically disturbed children are likely to deal with their marital conflict by either avoidence of issues, or by frequently resorting to violent means.

Avoidance of Issues:

Parents were asked how often they avoid the issue or refuse to deal with the issue during a conflict.

Their answers were on a scale which ranged from 1) never, 2) almost never, 3) sometimes, 4) almost always, and 5) always.

Table 7 shows the responses of parents about the frequency with which they would use avoidance of issues as a method of dealing with marital conflict.

TABLE 7

Frequency of Avoidance of Issues During Marital Conflict in the Study and Control Groups

Response	Study		Control	
	N	%	N	%
Never	16	17.8	180	45.8
Almost never	20	22.2	82	20.9
Sometimes	26	28.9	118	30.0
Almost always	18	20.0	8	2.0
Always	10	11.0	5	1.3
TOTAL	90	100.0	393	100.0

$t = 7.96, \quad P < 0.01$

From the responses given, it appears that only 16 parents (17.8 per cent) in the clinic group always dealt with issues as they came up, and discussed the problems

with their spouse, and perhaps arrived at some understanding, compared to 45.8 per cent of the control group parents. Approximately one fifth of the clinic parents almost never avoided the issue and often perhaps did resolve their conflict by dealing with it, compared to 20.9 per cent of the comparison group parents. Parents who sometimes avoided discussing the problems involved, numbered 28.9 per cent in the study group compared to 30 per cent in the control group. Perhaps these parents felt less confident about their own ability to discuss matters calmly, or were not sure how their spouse would react if they started dealing with disagreements more honestly.

However, one third of the clinic parents it would seem always or almost always bottled up their feelings, and brooded over them, and perhaps felt quite miserable about their situation because they could not or would not deal with them; while only 3.3 per cent of the comparison group parents acted in the same manner.

A high degree of statistical significance was reached when two groups were compared on t distribution; suggesting that the frequency with which the parents used avoidance of issues as a method of dealing with a marital conflict is associated with child psychiatric disorders.

Marital Violence as a Method of Dealing with Conflict

Parents in both groups were asked how often did they:

1) argue and yell a lot, 2) threaten to use force and 3) actually use force in order to resolve a conflict or disagreement between the two.

Sum total of responses to all three questions provided a marital violence score.

Table 8 shows the responses of parents about frequency with which they used force, or violence in order to resolve a marital conflict.

TABLE 8

Frequency of Marital Violence During a Conflict

Response	Study		Control	
	N	%	N	%
Never	6	6.7	86	21.9
Almost never	39	43.4	274	69.7
Sometimes	22	24.4	31	7.9
Almost always	20	22.2	2	0.5
Always	3	3.3	0	0.0
TOTAL	90	100.0	393	100.0

$t = 11.16$, $P < .001$

The data suggests that only 6 study group parents (6.7 per cent) never scream and yell at their spouse, or use physical or verbal force in order to get their spouse to agree with them; compared to 86 parents (21.9 per cent) in the control group. 43.3 per cent of study parents almost

never resort to severe means for solving their disagreements, compared to 274 parents (69.7 per cent) who almost never engage in severe arguments in order to resolve their conflict. Twenty-two study group parents, (24.4 per cent) while only 31 control group parents (7.9 per cent) reported that they sometimes use harsh methods in order to reach an agreement or to deal with a conflict. Parents who almost always dealt with a conflict by shouting and yelling at each other or by using a force numbered 22 (22.2 per cent) in the study group, but only 0.5 per cent in the control group. Three per cent of the study group parents always dealt with a conflict in a violent manner, while none of the control group parents had to always depend on such harsh measures.

The difference between the two groups was statistically significant at 0.001 level of confidence when the groups were compared on t distribution. This finding suggests that marital violence was present more often in the families with psychiatrically disturbed children than in the general population. The finding verifies the previous evidence that the parents of psychiatrically disturbed children were conflict ridden, and more prone to use harsh, forceful and overt methods of resolving their differences (Rutter 1971).

The finding does not reveal which of the two methods was more frequently utilized by the parents to resolve their marital disagreements. It is however, observed that almost

half the study parents (49.9 per cent) reported that they used hostile measures to resolve marital conflict at least sometimes if not always. It can therefore be suggested that there is a strong possibility of more frequent presence of marital violence when the couples are at odds with each other in the case of the parents with emotionally disturbed children.

As previously stated in this study, quarrelling parents provide a deviant model of interpersonal relationship, and in so far as the child follows this model his behavior may become disturbed. Rutter (1975) points out that the children are harmed by open hostility of parents towards each other, or by lack of warmth and positive affection, indifference towards each other. On the whole however, as Rutter (1975) feels, it is the overt quarrelling and discord which interferes with the child's normal development.

Reasons for Marriage:

Reason for getting married was investigated in order to determine its relationship with child psychiatric disorders. The parents in both groups were asked an open ended question for their reasons for getting married. It was hypothesized that the parents of psychiatrically disturbed children would more likely to give pregnancy as a reason for getting married. From the responses received, ten reasons for getting married were tabled as shown in Table 9.

TABLE 9

Reasons for Marriage in the Study and Control Groups

Reasons	Study		Control	
	N	%	N	%
Love	22	24.5	212	54.5
Security	5	5.6	10	2.5
Companionship	8	8.9	7	1.8
To start a family	4	4.4	22	5.7
Social pressure	5	5.6	26	6.7
To get away from home	3	3.3	4	1.0
Pregnancy	37	41.1	52	13.4
Wanted to live together	4	4.4	50	12.8
Financial benefit	0	0.0	3	0.8
Sexual fulfilment	2	2.2	3	0.8
TOTAL	90	100.0	389	100.0

$\chi^2 = 67.79$, $P < 0.01$, significant

It is rather interesting to note that only 24.5 per cent of study parents, compared to more than half of the control group stated that they get married because they were in love with their partner. This perhaps in itself may be the reason for such a lack of warmth and affection towards each other for many of the parents in the study group. However, for a large number of parents (41.1 per cent) in the study group, pregnancy was the main reason for getting married while only 52 parents (13.4 per cent) stated pregnancy to be the main reason why they got married.

As shown, a high degree of statistical significance was obtained when the two groups were compared on chi square distributions; which confirmed the hypothesis that marriage was precipitated by pregnancy for a large number of parents of children with psychiatric disorders.

The finding is in accordance with other research evidence which suggests that when the parents marry hastily on account of an unplanned; and perhaps an unwanted pregnancy they tend to find a close relationship with spouse to be confining, and unsatisfactory (Christopherson 1969). The evidence gathered so far in the present study indicates that the parents of psychiatrically disturbed children did indeed find their marriage to be unsatisfactory and unhappy.

It should be noted that the finding does not give evidence that the particular child in the study was conceived out of wed-lock, although the possibility does exist. From other research evidence, it can be only suggested that since the precipitating reason for marriage is a contributing factor for marital happiness, which ultimately makes difference in the parents' attitude toward their children, pre-marital pregnancy as a reason for getting married may well be related to child psychiatric disorders.

FAMILY SIZE:

This section will examine the relationship of family size to child psychiatric disorders. Four separate

questions were examined to assess this relationship.

Number of Children in the Family:

It was hypothesized that children with psychiatric disturbances would likely come from large families. The following Table provides the distribution of the total number of families in both groups according to number of children in the family.

TABLE 10

Family Size in the Study and Control Groups

No. of children in Family	Study		Control	
	N	%	N	%
1	3	6.7	15	7.5
2	10	22.2	83	41.3
3	15	33.3	53	26.3
4+	17	37.8	50	24.9
TOTAL	45	100.0	201	100.0

$t = 2.19, \quad P < 0.05$

As shown in the Table, 6.7 per cent of the families consisted of only one child each in the study group, where as this category comprised 7.5 per cent of the families in the control group. Ten families in the study group (22.2 per cent) compared to 41.3 per cent (almost double the size of the study group) had two children per family. Fifteen families (33.3 per cent) in the study group had three children each, while 26.3 per cent of control group parents

claimed to have three children each. Thirty-seven per cent of the families in the study group however, consisted of four or more children each compared to only 24.9 per cent of the control group. The two groups were significantly different when compared on t distribution.

This finding is similar to previous research related to the effects of family size on the emotional and social adjustment of children (Rutter et al 1970, Tuckman and Regan 1967). These two studies however, compared family size to specific categories of psychiatric disorders. Both these studies reported a significant relationship between large family size and conduct disorders but the significance level was not reached in case of emotional disorders.

Due to practical limitations of the present study, family size was not compared to separate categories of disorders. It should however be noted that the children with conduct disorders in the present study comprised only 22.2 per cent of the total group, as compared emotional disorders, which consisted of approximately 28.9 per cent. (see Appendix 1, Table 2). Supportive evidence for this finding is provided by several studies which found significant relationship between large families and emotional disorders (Waldrop and Bell 1964, Hawkel et al 1958).

This finding is interesting from yet another point of

view. It is generally held that Newfoundland family is traditionally large and is known to be child oriented. That a clinic population would still consist of significantly greater number of large families lends further support to the hypothesis that large family size is related to child psychiatric disorders.

Parents' Preferrance for Number of Children:

The parents in both groups were asked whether they would have liked to have more children, same number of children or fewer number of children if they could do it all over again.

It was hypothesized that the parents of psychiatrically disturbed children would have preferred fewer number of children if they could do it all over again.

TABLE 11

Number of Children Preferred in Retrospect by Parents in the Study and Control Groups

Number of Children	Study N	Study %	Control N	Control %
More	7	7.8	89	22.8
Same	42	46.7	273	69.6
Fewer	41	45.5	30	7.6
TOTAL	90	100.0	392	100.0

$\chi^2 = 85.1, \; P < 0.01$

In the study group, it appears that only a small number of parents, 7.8 per cent would have more children if they could do it all over again, while a little less than a quarter of the comparision group parents (22.8 per cent) would have opted for more children if they could do it all over again. Forty-two study group parents (46.7 per cent) would not have altered their family size even if they could do it, and were content with the number of children they had as compared to 69.6 per cent of the parents in the comparision group who would have done the same. 45.5 per cent of the clinic group parents would however change their family size, and would prefer smaller families, if they could do it, while only 7.6 per cent in the control group would have had fewer children if they could do it.

The two groups were statistically different, when compared on Chi square distribution, at the 0.01 level of confidence.

It is worth noting that within the study group, 55 per cent of the sample stated that they would have either liked to have more children, or would have kept to the same number of children; which is considerably larger than the group which stated preference for smaller family size if they could do it over again.

This finding is rather interesting in view of the

evidence shown in Table 10 that although the statistical significance was obtained, the two groups are quite close when one considers the average number of children per family. It is therefore rather surprising that so many families would have opted for smaller family size if they could live their life all over again.

There is no direct evidence in the literature to support this particular finding. Theoretically, however, it can be postulated that for many parents, parenthood is not a voluntary act, and the presence of children is perhaps a reminder of the lack of control they have over their own destiny when making such an important decision in their life (Rossi 1968). In the aftermath of stress caused either by psychological factors, or by economic and practical factors, or perhaps reasons related to children themselves, this group of parents realizes now, as perhaps never before that they would have been able to cope better had they had fewer children; and perhaps that might have made a difference in their child's development.

Perhaps it is worth noting here comments made by parents in the study sample. Two of the parents who had rather small families, commented that while they love each one of their children just the same, and nothing in the world would make them part with their children; if they could do it all over again, they would have never married,

nor would they have entered parenthood.

Whatever may be the individual circumstances, the results support the assumption that troubled children come from families where their parents would likely have a small size family if they could do it all over again.

Use of Authoritarian Discipline in Child Care Functions:

An attempt was made to assess the amount and frequency of arbitrary measures used by parents in the training of their children; and its relationship to child psychiatric disorders.

The parents in both groups were asked how often do they: 1) argue and yell a lot, 2) threaten to use force and 3) actually use force in order to resolve a disagreement between themselves and their children. Sum total of response to these questions provided a measure of authoritarian discipline.

Answers were on a scale which ranged from: 1) never, 2) almost never, 3) sometimes, 4) almost always and 5) always. It was hypothesized that parents of psychiatrically disturbed children would be likely to resort to frequent use of authoritarian means in the training of their children.

Table 12 provides the frequency with which authoritarian discipline applied in both groups.

TABLE 12

Frequency of Authoritarian Discipline in the Study and Control Groups.

Response	Study		Control	
	N	%	N	%
Never	0	0.0	56	14.2
Almost never	12	13.3	176	44.8
Sometimes	29	32.2	154	39.2
Almost always	41	45.6	7	1.8
Always	8	8.9	0	0.0
TOTAL	90	100.0	393	100.0

$t = 13.94$, $P < 0.01$

Above data suggests that none of the parents in the study group, while 56 parents in the control group never use physical force or arbitrary means to get their children to listen to them. 12 study group parents (13.3 per cent) while 176 control parents (44.8 per cent) almost never resort to harsh disciplinary measures in order to train their children. The parents who sometimes scream and yell at their children, and perhaps used some force numbered 32.2 per cent in study group and 39.2 per cent in control group. Forty-one clinic parents (45.6 per cent) almost always either smacked their children or argued and yelled a lot compared to only 1.8 per cent of control group parents who did the same. Eight parents (8.9 per cent) consistently resorted to

harsh discipline, while none of the parents in the control group resorted to severe disciplinary measures regularly.

The difference between the two groups as indicated was significant at 0.01 level of confidence when the groups were compared on t distribution; which confirmed the hypothesis that the parents of psychiatrically disturbed children tend to be frequently authoritarian in the training of their children.

This finding verifies an immense body of research on the method of discipline and its effect on the child's development (Yarrow et al 1968). Rutter (1975) argues that very severe or very lax discipline appears unsatisfactory in its effects. And, while severity of punishment in and of itself is not a major influence, frequency of punishment is more important; as very frequent harsh discipline is often associated with rejection and hostility. Different children will react differently to harsh discipline depending on their individual temperament and constitutional characteristics.

Individuals Satisfaction with Life in General:

The degree of satisfaction one has in life was assessed in terms of its relationship with child psychiatric disorders.

A measure of individual life satisfaction was derived on the basis of response to two separate questions: 1) How satisfied do you feel with your life in general, and

2) When you make plans ahead, how often do you usually get to carry them out the way you planned.

The response was measured on a scale which ranged from 1) Very satisfied, 2) Satisfied 3) Somewhat satisfied 4) Dissatisfied and 5) Very Dissatisfied; as shown in Table 13.

TABLE 13

Degree of Individual Satisfaction in the Study and Control Groups

Degree of Individual Satisfaction	Study		Control	
	N	%	N	%
Very satisfied	7	7.8	103	26.2
Satisfied	34	37.8	215	54.7
Somewhat satisfied	35	38.8	70	17.8
Dissatisfied	14	15.6	5	1.3
Very dissatisfied	0	0.0	0	0.0
TOTAL	90	100.0	393	100.0

$t = 8.03, \quad P < 0.01$

It would appear from the response, that somewhat less than half the study parents (45.6 per cent) were very happy with their life in general and seem to have certain amount of control over their life situation; while a large majority of the control group parents (80.9 per cent) appear to be in complete command of their lives, and were very happy

about it. Approximately, thirty-nine per cent of the study parents were somewhat satisfied with their life; where as only 17.8 per cent comprised that category in the comparison group. Fifteen per cent of clinic parents however exerted only a litte or no control over their life situation, could only occassionlly carry out the plans they made, and felt a little helpless about their life in general, compared to only 1.3 per cent of control group parents who felt that way. As expected, none of the parents in either group felt totally disenchanted with their life in general, and perhaps found some satisfactions and rewards in life.

As can be seen, the two groups were significantly different at the 0.01 level of confidence when compared on t distribution.

This finding lends support to other research evidence that the disturbed children usually come from disorganized, and unhappy household, where parents found it difficult to set goals for themselves and for their children. When the parents did set goals, they found it extremely difficult to carry them out, adding more stress to their already strained existence (Malmquist 1971).

The reasons for this dissatisfaction with life were not investigated. Evidence so far available in the present study suggests that it may be related either to marital

conflict, or to family size. It may also be related to the joblessness of the father, or to the emotional or physical ill health of the parents or children. Whatever, may be the individual circumstance, the feeling of dissatisfaction and powerlessness one had about one's life may have seriously affected one's parenting function, as these parents are frequently irritable and often this irritability impinges greatly on their children (Rutter 1975).

In general therefore, it appears that individual life satisfaction is associated with child psychiatric disorders.

READINESS FOR PARENTHOOD

This section will examine how adequate the parents were for their parental role, when they first entered parenthood. Six questions were examined in order to assess its association with child psychiatric disorders.

General Readiness for Parenthood:

The parents were asked to evaluate their general readiness for assuming the parental role when they first became parents, on a scale which ranged from: 1) Very ready, 2) Ready, 3) Somewhat ready, 4) Not very ready, and 5) Not at all ready. It was hypothesized that parents of emotionally disturbed children would likely to report that they were less ready for parenthood when thay first became parents. Table 14 provides the responses of parents.

TABLE 14

Degree of Readiness for Parenthood in the Study and Control Groups

Degree of Readiness for Parenthood	Study		Control	
	N	%	N	%
Very ready	2	2.2	74	18.9
Ready	8	8.9	178	45.4
Somewhat ready	23	25.6	106	27.0
Not very ready	37	41.1	24	6.1
Not at all ready	20	22.2	10	2.6
TOTAL	90	100.0	392	100.0

$t = 13.16$, $P < 0.01$

Strikingly, a very high per centage of study parents (63.3 per cent) felt that they were not ready for assuming parental role when they first became parents; while less than one-tenth (8.7 per cent) of the control group population felt such a lack of confidence in their general preparation for assuming parental role.

As shown, the difference between the two groups was significant at the 0.01 level of confidence when the groups were compared on t distribution.

This finding is in accordance with other studies which conclude that general readiness and emotional preparation for the arrival of the first child is an important ingred-

ient in the parents subsequent response to the child care role (Dyer '63). Perhaps the parents of emotionally disturbed children were caught unprepared for the parental role because the child arrived soon after marriage on account of pre-marital pregnancy as the evidence suggests. They may have felt that parenthood was "thrust upon" them.

In reviewing the caretaking arrangement of a group of children, Bowlby (1969) concluded that the parents who are "thrown" into parental role fail to be adequately "maternal" and consequently fail to provide positive bonding experience to the child. The findings of the present study therefore suggest that readiness for parental role is associated with child psychiatric disorder.

Knowledge About Parental Role:

Degree of knowledge one has about child rearing function was examined in terms of its relationship with child psychiatric disorders.

The parents in the study and control groups were asked to evaluate the degree of knowledge they had about child rearing and other related function when they first became parents. The response was rated on a scale which ranged from: 1) Very knowledgeable 2) Knowledgeable 3) Somewhat knowledgeable 4) Not very knowledgeable and 5) Not at all knowledgeable; as shown in Table 15.

It was hypothesized that the parents of psychiatrically disturbed children would likely to be less knowledgeable about child care when they first became parents.

TABLE 15

Degree of knowledge About Parental Role in the Study and Control Groups

Degree of Knowledge	Study N	Study %	Control N	Control %
Very knowledgeable	2	2.2	36	9.2
Knowledgeable	5	5.6	120	30.6
Somewhat knowledgeable	26	28.9	156	39.8
Not very knowledgeable	38	42.2	59	15.0
Not at all knowledgeable	19	21.1	21	5.4
TOTAL	90	100.0	392	100.0

$t = 8.5$, $P < 0.01$

As Table 15 shows, only two parents (2.2 per cent) felt most confident in the amount of knowledge they had about their child care role prior to becoming a parent, compared to thirty-six parents (9.2 per cent) in the control group. Five parents in the study group (5.5 per cent) while 30.7 per cent of the control group parents rated themselves being knowledgeable about their role. The study group consisted of only 29.0 per cent compared to 39.8 per cent of control parents who felt somewhat confident in their knowledge about what it takes to be a successful parent. Thirty-eight

parents in the clinic group (42.2 per cent) did not have knowledge about child care functions when they first became parents, compared to only 15.0 per cent of parents in the control group who felt that way. Approximately one-fifth of the study parents however lacked completely in their knowledge about child rearing, while only 5.2 per cent of control parents were lacking totally in such confidence.

The difference between the two Groups was significant at the 0.01 level of confidence on t test.

This finding is supported by evidence gathered by Chilman (1978) in a study examining correlates of parental satisfaction. Chilman reported that parents who had some prior knowledge of how children grow and develop their individual personality relied more on their own common sense in rearing their children. They felt confident about their role; and perhaps they actually were more effective in child rearing for their children were reported to have fewer problems. Lower scoring parents in the Chilman study felt the need of help in child-rearing knowledge available to them and, these were the same parents who reported having children with behavior and emotional problems.

It is worth noting here that parental skills lie in knowing how to respond to various behaviors and how to stimulate their children. Linked with other evidence, it suggests

that the more extensive the parents' knowledge about child rearing, the greater the intellectual performance and social adjustment of the child, as these parents would know how to vary the quality and quantity of stimulus according to the child's individual need and capability (Kagan 1976). That a statistically significant number of parents in the clinic group felt that they did not have suffient knowledge about child care when they first became parents, suggests that parental lack of knowledge about their child care role is related to psychiatric disorders in children.

Transition to Parenthood:

The ease with which transition to parenthood is made was examined in terms of its association with child psychiatric disorders. The parents were asked to rate how they found the change from having no children to becoming a parent on a scale which ranged from: 1) Very easy 2) Easy 3) Somewhat easy 4) Difficult and 5) Very difficult; as shown in Table 16

It was hypothesized that the parents of psychiatrically disturbed children are more likely to report that the transition to parenthood was difficult for them.

TABLE 16

Transition to Parenthood in the Study and Control Groups

Response	Study		Control	
	N	%	N	%
Very easy	0	0.0	87	22.2
Easy	5	5.6	161	41.1
Somewhat easy	17	18.9	91	23.2
Difficult	46	51.1	44	11.2
Very Difficult	22	24.4	9	2.3
TOTAL	90	100.0	392	100.0

$t = 14.37, \quad P < 0.01$

It is rather surprising to note that not a single parent in the study group found it very easy to make the transition, while 22.2 per cent of control group felt that the transition was very easy. A rather small number of clinic group parents (5.6 per cent) reported that the change was easy as compared to 41.1 per cent of control group parents. The parents for whom the change was somewhat easy totalled 18.9 per cent in the Clinic Group, which is somewhat close but far from being equal to 23.3 per cent of parents in the Control Group. For the large majority of the clinic parents however the change was difficult or very difficult (76.5 per cent), while only 13.5 per cent in the comparison group felt that the change was difficult from having no children to becoming a parent.

The two Groups were different at the 0.01 level of significance on t distribution.

Dyer (1963) provides supportive evidence to this finding. He found that the parents who found the transition too difficult, felt parenthood to be too confining, and a trap. These parents also complained a lot about their children and their problems. Those parents who overcame 'the crisis' of parenthood, and made the necessary adjustment were more satisfied with their parental role, which perhaps did influence their child rearing practices.

A more recent but rather indirect evidence is found in Chilman's study. Chilman (1978) reported that the psychological ease with which the mother approached her parental tasks was related to the number of complaints she made about her children's problems.

The finding therefore suggests that there is an association between the parental difficulty in adjusting to being parents and psychiatric disturbances in children.

Age of Parents When First Child Born

The age of parents when they first assumed a parental role was examined in terms of its relationship to child psychiatric disorder.

It was hypothesized that the parents of psychiatric-

ally disturbed children were likely to be young when they first became parents.

TABLE 17

Age Distribution of Parents when First Child Born in the Study and Control Groups

Age	Study		Control	
	N	%	N	%
15 - 19	18	20.0	42	10.7
20 - 24	40	44.4	173	44.0
25 - 29	15	16.7	131	33.3
30 - 34	11	12.2	30	7.6
35 - 39	3	3.3	10	2.6
40 - 44	3	3.3	7	1.8
TOTAL	90	100.0	393	100.0

$t = 0.68, \quad P > 0.05$

It was learned that about one-fifth of the study parents (20.0 per cent) below the age of 20 years when they first became parents, where as only 10.7 per cent control group parents were in the same age category. 44.4 per cent of study group parents were between the age of 20 - 24 years which is almost equal to control group parents (44.0 per cent). A somewhat higher percentage of control group parents is represented in the age category of 25 to 29 years (33.3 per cent) compared to 16.7 per cent in the study group. The remaining of the parents were distributed between the

three categories of 30 to 44 years, but as can be seen, the study group is consistently more represented in the age range between 30 to 44 years.

On the average however, the parents in both groups were approximately 24 years old when they first became parents. Statistical significance was not reached when the groups were compared on t distribution. This would suggest that the age of parents when they first entered child-rearing role was not a determining factor in their subsequent ability to adjust to their parental role; and hence influence their child's development.

This finding is similar to those of Morgan (1959) and Hersov (1960). These studies found that the age of parents was not related to psychiatric disturbances in children. On the contrary, they found that their group consisted of "unusually elderly parents" with an only child, or that the first child was a "late arrival".

Research related to child abuse also provide similar evidence that parents who abuse their children are not necessarily young parents (Smith et al 1975).

From the evidence of other studies and on the basis of the findings of the present study it can be suggested that a young age of parents in and of itself may not be related to child psychiatric disorders.

Parents' Childhood Experience

An attempt was made to examine the childhood experiences of parents and its relationship to children's psychiatric disorders. The parents in both groups were asked how satisfied they were with their life as a child. Their response was rated on a scale which ranged from: 1) Very satisfied 2) Satisfied 3) Somewhat satisfied 4) Dissatisfied and 5) Very dissatisfied.

It was hypothesized that the parents of psychiatrically disturbed children would likely to have had an unsatisfactory childhood.

TABLE 18

Recall of Childhood Experienc of Parents in the Study and Control Groups

Degree of Satisfaction	Study N	Study %	Control N	Control %
Very satisfied	2	2.2	161	41.0
Satisfied	26	28.9	156	39.7
Somewhat satisfied	31	34.4	54	13.7
Dissatisfied	23	25.6	14	3.6
Very dissatisfied	8	8.9	8	2.0
TOTAL	90	100.0	393	100.0

$t = 11.32, \quad P < 0.01$

Data presented in Table 18, indicate that a very

small number (2.2 per cent) of parents in the study group had very happy memories of their childhood compared to a large group of parents in the control group (41.0 per cent). Twenty-six study group parents (28.9 per cent) compared to 39.7 per cent of control group parents were just happy the way they lived as children, and did not have complaints about their past experiences. The largest number of the study parents were however only somewhat happy about their childhood experience (34.4 per cent) compared to 13.7 per cent in the control group. Approximately one quarter of the clinic parents (25.4 per cent) were however dissatisfied with their life as children, compared to only 3.6 per cent of the control group parents. The parents with very many unhappy childhhod memories comprised 8.9 per cent in the Study Group, while only 2 per cent in the Control Group had such miserable life experience when they were growing up.

Statistical significance was reached at 0.01 level when two Groups were compared on t distribution.

These results confirm the conclusions drawn by largely clinical studies that parents who abuse their children and deprive them of positive life experience were themselves brought up in an atmosphere lacking in warmth and positive affection.

Anthony and Benedek (1970) have noted that youngsters

who lack positive parenting experience have a greater tendency than others to become ineffective, dissatisfied parents. In effect one learns to be a parent through being parented. Stolz (1967) argues this contention. She believes that mothers and fathers may change considerably in their later years through their many experiences, including their marriage and life situation.

This finding linked with other evidence in the present study suggests that the parents of psychiatrically disturbed children were inadequately prepared for their parental role, and their life experiences did not change sufficiently to alter the pattern laid down early in life so as to significantly influence their children's development. In this respect, it is suggested that early childhood experience of parents is related to child psychiatric disorders.

Satisfaction With Child-Rearing Role:

The degree of satisfaction parents experience with the child-rearing role was examined in terms of its association with child psychiatric disorders.

Parents in both Groups were asked how satisfied they were with their child-rearing role compared with other kinds of work they could imagine themselves doing. The response was rated on a scale which ranged from: 1) Much more satisfying 2) Somewhat more satisfying 3) Equally satisfying 4) Somewhat less satisfying and 5) Much less

satisfying.

It was hypothesized that the parents of troubled children would more likely to find their child-rearing role less satisfying than any other kind of work they could imagine themselves doing.

The findings were analysed separately for fathers and for mothers in both Groups. An assumption was made that since in the Newfoundland community, the child-rearing role is primarily alloted to mothers, the paternal response to the question may vary according to one's belief system of what constitutes a paternal role; and that the separate investigation may help reduce the possibility of inter-parental distortion.

TABLE 19A

Satisfaction with Child-Rearing Role for Mothers in Study and Control Groups

Degree of satisfaction	Study N	Study %	Control N	Control %
Much more satisfying	2	4.4	81	39.0
Somewhat more satisfying	12	26.7	55	26.4
Equally satisfying	21	46.7	63	30.3
Somewhat less satisfying	9	20.0	8	3.8
Much less satisfying	1	2.2	1	0.5
TOTAL	45	100.0	208	100.0

$t = 5.78$, $P < 0.01$, significant

Satisfaction with Child=Rearing Role for Fathers in Study and Control Groups

TABLE 19B

Degree of Satisfation	Study N	Study %	Control N	Control %
Much nore satisfying	0	0.0	40	23.0
Somewhat more satisfying	0	0.0	43	24.7
Equally satisfying	15	33.3	77	44.2
Somewhat less satisfying	28	62.2	13	7.5
Much less satisfying	2	4.5	1	0.6
TOTAL	45	100.0	174	100.0

$t = 9.10$, $P < 0.01$, significant

In case of mothers, as per Table 19A it was surprising to find that only two mothers (4.4 per cent) in the study group found their child-rearing role to be more satisfying than any other job they could be doing, compared to eighty-one mothers (39.0 per cent) in the control group. The mothers who felt their child-rearing role was somewhat more satisfactory than other roles that they had or could have were approximately equal in number in both groups. (26.7 per cent study group mothers V 26.4 per cent in control group). The largest group of clinic mothers found child rearing as satisfying as any other job (46.7 per cent), while 30.0 per cent of control mothers comprised that category. Ten study mothers however found child-rearing role to be less satisfying (22.2 per cent), while only 4.3 per cent of the control group mothers felt they could be doing something else.

While approximately 78 per cent of the Study Group mothers were happy being the home makers for their children, the difference between the study and comparison group was significant when compared on t distribution at 0.01 level. This would suggest that a significant number of women in the study group embraced their child-rearing role rather half heartedly.

This finding about maternal dissatisfaction or disenchantment with child-rearing role is similar to the findings that Childman (1978) reported in her study of correlates of

parental satisfaction. Chilman concluded that mothers who were dissatisfied with their child-rearing role may have been unhappy and seemingly "poorly adjusted" largely because they were less well suited to a full time mother role.

From the evidence gathered so far in the present study it can be suggested that the disenchantment with the child-rearing role may be caused by the presence of too many children; or because they were dissatisfied with their life in general. For some women who were unemployed, the underlying discontent with their role may have led these women to wish for other roles or role changes, which in turn might provide them with greater satisfaction with their children. On the other hand, it can also be argued that for employed women the outside job or professional status provided greater satisfaction than being "just the housewife" and being tied down with children.

Whatever may have been the individual's reasons, the results support the hypothesis that the degree of satisfaction the mother feels in her child-rearing role is related to children's adjustment.

In respect to the father groups, (Table 19B), it is rather interesting to note that not a single father in the study group reported being more satisfied with child-rearing role while forty fathers (23.0 per cent) in the control group

found it to be much more satisfying and 24.7 per cent found it to be somewhat more satisfying, thus forming almost half the group. Fifteen fathers (33.3 per cent) in study group found the child care role as satisfactory as any other work they did, compared to 44.2 per cent in the comparison group who responded to this category. Total of 66.7 per cent of the study group fathers however found the tasks related to raising children to be less satisfying than other kind of tasks they could be doing, compared to only 8.1 per cent of control group parents who comprised the same category. The difference between the two groups was significant at 0.01 level of confidence as shown.

This finding is similar to findings of other studies (Moss 1967, Pritchard and Ward 1973). Pritchard and Ward reported that the fathers of emotionally disturbed children had a tendency to "opt out" of their responsibility and that they gave little support and help to their wives in household tasks or in caring for their children.

Unfortunately, due to practical limitations of the present study, the difference between mothers and fathers, i.e. inter-parental differences, was not examined. Available evidence however suggests that it may well be that the fathers are a main source of contingent stimulation in the critical period of infancy, and that their attitude and responsivity to the child may be significantly related to

later emotional responses of the child.

MOTIVATIONS FOR HAVING CHILDREN

This section will examine the findings related to motivations for having children, and its relationship to child psychiatric disorders. Three separate questions were examined in order to assess this relationship.

Planning of Pregnancy:-

Whether the child was born as a result of planned or unplanned pregnancy was examined in terms of its relationship to child psychiatric disorders.

The study group parents were asked a question whether the child under treatment was "planned" or "unplanned". Since it was not possible to ask such a direct question about any particular child in the comparison group owing to the nature of the study, the parents in both groups were asked to list all their children by age, sex, and how many children were born as a result of planned pregnancy. Differences in both groups were observed in terms of total number of pregnancies planned by parents in each group; based on the assumption that each child had a potential to be born as a result of a planned pregnancy.

Only the mother's response to the number of planned versus unplanned pregnancies was considered valid since the fathers tended to depend on their wife's assessment of the situation.

It was hypothesized that the parents of children with psychiatric disturbances would be likely to report more "unplanned" pregnancies.

TABLE 20

Parents' Recall of Number of Planned Pregnancies in Study and Control Groups

Planned Pregnancy	Study N	Study %	Control N	Control %
0	14	31.1	70	34.0
1	13	28.9	57	27.7
2	12	26.7	60	29.1
3	5	11.1	17	8.2
4	1	2.2	2	1.0
TOTAL	45	100.0	206	100.0

$t = 0.57$, $P > 0.05$, not significant

As indicated by the response received, 28.9 per cent of the clinic mothers stated that they planned only 1 of their children, which appoximately compares with control group mothers who formed 27.7 per cent of control group. Twelve couples in the study group (26.7 per cent) had two of their children born as a result of planned pregnancy, versus sixty couples (29.1 per cent) in the control group who reported that they planned two of their pregnancies. Three of their children were planned by five mothers each (11.1 per cent) in the study group compared to seventeen (8.2 per

cent) of the control group parents who planned three of their children. One mother (4.4 per cent) in the study group reported having planned four of her children, while only two mothers in the control group (1.0 per cent) reported having planned four of their children each. Forteen mothers in study group (31.1 per cent) reported having planned none of their pregnancies, and that it "just happened" while seventy mothers (34.0 per cent) in the control group reported that they did not plan any of their children.

Significance level was not reached when the two distributions were compared on t test; thereby suggesting that there were more or less equal number of unplanned and planned pregnancies in the study and control groups.

This finding contradicts some of the earlier cited evidence (Goldfarb 1961, Wolkind 1974). Both these studies reported "pre-ponderence" of "unplanned" pregnancies in the birth histories of children who were being treated for psychiatric disorders. Both studies were however, clinical investigations and did not use control group to compare the data.

It can be argued that the large number of unplanned pregnancies in the general community is suggestive of the prevailing attitude towards family planning in Newfoundland; which may be due to education, religion, lack of family

planning knowledge or the means to obtain such knowledge.

Whatever may be the individual circumstance, the finding is interesting from the point of view that not all children who are born as a result of unplanned or "accidental" pregnancy do show up in psychiatric clinics. It is perhaps worth noting that "unplanned" pregnancy may not necessarily mean an "unwanted child". It can also be stated that since the family is in a constant state of dynamic interaction, an unwanted child may become wanted for reasons unrelated or related to the child; or a child who is welcomed at first may become a source of conflict later on (Chess and Hassibi 1978).

Motives for Having Children:

Motive for having children, i.e. "For what purpose the children are valued by parents", was examined in terms of its association with child psychiatric disorders.

A list describing ten reasons why people have children was prepared and presented to the parents. The parents were asked to rate how important each of the reasons was for them for having children. The scale ranged from: 1) Very important 2) Important 3) Somewhat important 4) Not important 5) Not at all important.

The list was then divided equally in two categories which formed "Child Focus" reasons, and "Parent Focus" reasons.

The "Child Focused" category consisted of those reasons in which the child was desired for the enjoyment of having him for his own sake; or for the fun of parenthood.

"Parent Focused" reasons consisted of those reasons in which the child was desired for the functions he may fulfil for his parents (see the Methodology Chapter for a list of reasons).

It was hypothesized that the parents of psychiatrically disturbed children would more likely to give "parent focused" reasons for having children than "child focused" reasons.

Table 20 shows the response received from parents in both groups.

TABLE 21A

Motives for Having Children in the Study and Control Groups

Child Focus Reasons	Study N	Study %	Control N	Control %
Very important	1	1.1	37	9.4
Important	12	13.3	80	20.4
Somewhat important	46	51.1	170	43.2
Not important	26	28.9	89	22.6
Not at all important	5	5.6	17	4.4
TOTAL	90	100.0	393	100.0

$t = 2.90, \quad P < 0.05$

As shown by Table 21A, only 14.4 per cent of clinic

parents, compared to approximately double the number of parents in the control group (29.8 per cent) placed high value on the child himself for having him. For these parents children were a joy, and fun to have them for their own sake.

Approximately half the study group (51.1 per cent) compared to 43.2 per cent in the control group felt that the child was desired for some reasons related to the value of child himself. They felt that the child was desired because he gave some pleasure to them.

However, approximately one-third of the study group parents (34.5 per cent) felt that the child was desired for reasons other than the joy and pleasure of having him compared to approximately one-quarter of the control group parents who gave similar response. They did not think that the reasons for their having children was because they would enjoy having children around the house, or because they thought being parents would be fun. These parents placed lower value on having children for their own sake, indicating that the children were desired for some other reasons; as it would seem from their response to parent focused reasons, as shown in Table 21B.

TABLE 21B

Motives for Having Children in the Study and Control Groups

Parent Focused Reasons	Study N	Study %	Control N	Control %
Very important	8	8.9	10	2.5
Important	31	34.4	44	11.2
Somewhat important	30	33.3	84	21.4
Not important	15	16.7	128	32.6
Not at all important	6	6.7	127	32.3
TOTAL	90	100.0	393	100.0

$t = 8.20$, $P < 0.01$, significant

Clinic parents out numbered the control parents considerably (43.3 per cent against 13.7 per cent) in the amount of importance they gave to "parent focused" reasons for having children. These parents desired children because of certain goals related to themselves, rather than having the child for his own sake.

For 30 parents (33.3 per cent) in the study group, "parent focused" reasons were only somewhat important to have a child, compared to 84 parents (21.4 per cent) in the control group. This would suggest that for this group of parents, children were conceived for some reasons related to parents, while other reasons related to children themselves.

However, only 21 parents (23.4 per cent) in the study

group gave less importance to "parent focus" reasons for having children, thereby indicating that the child was desired for his own sake; while a large majority of parents (64.9 per cent) in the comparison group gave less importance to "parent focus" reasons for having him. For these parents the desire for a child was related to the child himself, and enjoyment of having him far outweighed any reasons related to themselves.

Significance level was reached for both categories of reasons for having children at .05 level of confidence in "child focused" reasons, while 0.01 level of confidence was achieved in "parent focused" value of child. This confirmed the hypothesis that the parents of psychiatrically disturbed children are more likely to value their children in terms of functions or needs they fulfill for their parents; rather than the enjoyment of having the child for his own sake.

As stated earlier in this study; there is no scientific evidence to verify this finding as far as it can be ascertained (Hoffman and Hoffman 1973). Many clinical studies however have suggested a link between the parents' motives for having a child; and his psychological maladjustment (Vogel and Bell 1960, Malmquist 1971). These studies found that the children who were under psychiatric treatment were conceived for a purpose of "keeping the marriage together", "to avoid lonliness" or because the parents wanted to live

vicariously through their child. These parents expected the child to fulfil a role, or fulfil some functions for parents; which was beyond his capacity.

Sociological studies provide theoretical support to this finding. It has been suggested that for many parents, children come to represent an avenue of compensation for their husbands' or wives' lack of affection (Rainwater 1960, Chilman 1978). As previously observed, since there is significantly greater sense of distance in the marital relation of parents with psychiatrically disturbed children, it seems relevant to find that the clinic group parents would give greater importance to motives related to themselves for having children, and these parents would value the child in terms of functions they fulfil for parents. In this sense, motives for having children is associated with psychiatric disorders.

Value of Child to his Parents

An attempt was made to assess how important the child is in parents' life; i.e. how much the children are valued by parents; and its association with child psychiatric disorder.

Parents in both groups were presented with a list of reasons for having children and a list of reasons for not wanting them, if they had to decide at this point in time whether or not to have more children. The sum total of

reasons for a desire for child minus sum total of reasons for not wanting more children provided a "value of child". (see Appendix B. Questionaire, Question #27, 28).

The "value of child" was rated on a scale which ranged from: 1) Very important, 2) Important, 3) Somewhat important, 4) Not very important, 5) Not at all important.

It was hypothesized that the sum total of reasons for not wanting children would likely to outweigh the reasons for desire for children, in the families of children with child psychiatric disorders.

The findings were analysed separately for fathers and for mothers in each group, based on an assumption that male-female difference in traditionally held attitudes toward children may influence their response; and that the separate analysis of the data may help avoid the possibility of inter-parental response.

TABLE 22A

Importance of Children in Mothers' Lives in the Study and Control Groups

Degree of Importance	Study N	Study %	Control N	Control %
Very important	3	6.7	33	15.9
Important	5	11.1	95	45.7
Somehwat important	26	57.8	75	36.1
Not important	11	24.4	5	2.3
Not at all important	0	0.0	0	0.0
TOTAL	45	100.0	208	100.0

$t = 6.07$, $P < 0.01$

Only 17.8 per cent of clinic mothers, compared to 61.6 per cent of control group mothers valued their children highly. These parents felt that children were very important part of their lives, and that no reasons in the world would have been good enough for not having them. These parents found children a joy to have, and they did not think that children caused them any problems as such. It perhaps strengthened their marriage or gave them recognition in the society.

Children were only somewhat important in the lives of 57.8 per cent of the clinic mothers, compared to 36.1 per cent in the control group. For these mothers, as it would suggest, the reasons for having children weighed as much,

if not more, as the reasons for not wanting them. They perhaps saw some disadvantages in having children, and were not sure how children fitted in, in their lives.

However, for 24.4 per cent of clinic mothers, children seem to play a less important role; compared to only 2.4 per cent of the mothers in the comparison group, who felt that the children did not play as important a role in their life as did other matters. They found their children to be perhaps interfering with their lives.

As expected, none of the mothers in either group felt having a child was not at all important to them, thereby suggesting that children were important to all parents but to a varying degree.

In respect to the fathers groups (Table 22B), 22.2 per cent of study group fathers attached high value to the child, compared to more than half the control group fahters (60.5 per cent). Approximately sixty-eight per cent of clinic fahters against only 37.3 per cent of comparison group felt that having a child was only somewhat important to them, and they weighed both the pros and cons of having a child in their lives; though they still saw some of the nice things about having them.

Children seem to play a less important role in the lives of 11.1 per cent of clinic fathers compared to 2.2

per cent of the control group fathers. Again, as in case of mothers, not a single father felt that children had no place in their lives, and therefore, did see some value in having them somewhere along the way.

TABLE 22B

Importance of Children in Fathers' Lives in the Study and Control Groups

Degree of Importance	Study N	Study %	Control N	Control %
Very important	2	4.4	22	11.9
Important	8	17.8	90	48.6
Somewhat important	30	66.7	69	37.3
Not important	5	11.1	4	2.2
Not at all important	0	0.0	0	0.0
TOTAL	45	100.0	185	100.0

$t = 4.75$, $P < 0.01$

As shown, the difference between the study group and comparison group was significant at .01 level of confidence on t distributions, in respect to both groups of parents which confirmed the hypothesis that for parents of psychiatrically disturbed children, the reasons for not wanting children seem to outweigh the reasons for having them.

As far as it can be ascertained, research evidence to lend support to this finding is lacking (Hoffman and Hoffman

1973). There is indirect evidence provided by clinical studies (Malmquist 1971, Rutter 1975). Clinicians frequently observe that dissatisfaction in marriage relationships are often projected on to both the parent-child relationship and the children themselves. The previous evidence in the study therefore may lend support to this finding. It has been observed that the marital satisfaction of the parents in the study group was at low ebb, and in fact conflict ridden. If the child was desired for strengthening the marriage in the first place, then for many parents the child failed to fulfil the expectations placed on him, and this may have influenced the value of child in their lives. It is perhaps worth pointing out here that the clinic mothers consistently scored lower in the way they felt about having children when compared with clinic fathers. Almost a quarter clinic mothers (24.4 per cent) compared to only 11.1 per cent of clinic fathers felt that children did not play as important a role in their lives as did other matters. This finding may seem rather surprising, as one would expect that mothers, in a traditional community such as Newfoundland, would perhaps attach higher value to maternal role; having children would perhaps give them more satisfaction than not having them.

Research evidence however, suggests that this is not the case. In a study investigating how having a child affected the life of parents, Hoffman (1963) found that

women gave more negative response than did the men. The most common response from women was that "children tie you down". The finding of the present study is therefore in accordance with Hoffman study, particularly when one considers that the clinic mothers perhaps had to bear the major responsibility for child rearing with little or no support from their spouse in view of their poor marital relationship.

This finding suggests that the parents of psychiatrically disturbed children do not hold as high value of their children as do parents in general population. It should be pointed out that the findings do not provide evidence that lower value of child is related to child psychiatric disorder in either cause or in effect.

Summary

In general, the results obtained supported the proposition that the family environment of children with psychiatric disturbances is likely to be different from that of the general population.

In assessing the marital relations of the parents with psychiatric disorders, a significant correlation was obtained between marital satisfaction and child psychiatric disorders. Approximately one-third of the group of clinic parents reported being unhappy in their marriage.

There was significant difference reached in the frequency

of violence, or force being used by parents to resolve their marital conflict or disagreement. One quarter of the clinic parents reported sometime or another using force or harsh measures during a marital conflict.

The reasons for marriage were also found to be related to child psychiatric disorders. The clinic group consisted of more parents who got married on account of a pregnancy; rather than any other reason.

In relation to family size, significantly large family size was found in the background of children with psychiatric disorders. A significant number of parents reported that they would have had smaller family size if they could do it all over again.

In assessing the method of discipline the results showed that approximately half the number of study group parents frequently used authoritarian means of discipline.

Moreover, the clinic parents were significantly less satisfied with their life in general.

In assessing the readiness for parenthood, it was found that parents of children with a psychiatric condition were significantly less ready for parental roles; they reported being less knowledgeable about their role when they first became parents, and they found it more difficult to adjust

to their parental role.

In respect to the age of parents when they first assumed parental role, the significant level was not reached when the groups were compared on t distribution. However, 20.0 per cent of study group parents were below the age of nineteen years, compared to a 10.0 per cent in the control group. There were however, more parents in the study group, who comprised the last three categories of age, i.e. parents who were thirty years old and over, and the average age of parents in both groups was approximately twenty-four years. This finding is in accordance with other research evidence as previously stated.

The degree of satisfaction parents felt about their child-rearing role was found to be related to child psychiatric disorder. A significant number of clinic parents reported being less happy about child-rearing role compared to other kinds of work they could be doing. Statistical significance was reached when parents' childhood experience was compared on t distribution. Parents of children with psychiatric disturbances were significantly less satisfied with their life when they were growing up.

In case of motivation for having children, it was rather interesting to find that there is a large number of "unplanned" pregnancies in the general population, as the

significant level was not reached between the two groups. This could be partly attributed to the difficulty in measuring the number of "unplanned pregnancy". However, owing to the nature of the study, there was no other choice. It can also be suggested however, that "unplanned pregnancy" may not necessarily be an indication of "unwelcome" or "unwanted" pregnancy.

In assessing the reasons parents gave for having children, a statistically significant number of parents reported that children were desired for the parent-related functions they fulfil for parents, rather than the enjoyment of having the child for his own sake.

How much did parents value their children was assessed. A large number of parents of children with psychiatric disturbances reported lower value of child, and gave lower importance to the place of child in their life. It was not ascertained whether the lower value of child was the cause or effect of having children with psychiatric disturbances.

Research evidence in the field of psychiatry, sociology and psychology generally support or verify the findings obtained in this study, as noted before.

In the following chapter some general conclusions will be outlined, as well as discussion of the findings and their implications for mental health services for children, and

their families as well as future research.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

General Summary

This study was based on the assumption that children are referred for many kinds of emotional and behavioral problems for which no significant organic or constitutional cause has been established, and that the environment of the child, mainly his/her immediate family environment may be responsible for his condition.

A review of the literature showed that the immediate environment of children with psychiatric condition was found to be deficient in many ways, of which four main areas were: 1) child's parents' marital relationship, 2) number of children in his family, 3) his parents adequacy as parents, determined by their readiness for parenthood, and 4) parents' motives for having children.

Theories of personality development supported the contention that familial factors may influence the development of behavior disorders; through their influence on parent-child relationship. A basic assumption was made that personality develops in the mutual relationship of mother, father, and infant after birth. The disturbances of children arise because the particular pattern of relationship that exists between the parent and the child is less or more

than is desirable for his optimal psychological growth. Deficiency in any area of family life will therefore influence the parent-child relationship and will influence his personal adjustment.

Hypotheses were derived on the basis of this assumption in each of four areas of family life. Questions were examined through personal interviews with parents of children who were receiving psychiatric care and treatment. The information was collected by administering a structured questionnaire. The data thus obtained were compared with the data obtained in a major research project on family life in St. John's, Newfoundland, using the same form of questionnaire. The data were computerized for analysis.

An analysis of the findings supported the central proposition that the family background of children with psychiatric disturbances was deficient in more than one way. The marital relationship of their parents was conflict ridden. Their attitude toward one another was indifferent or avoidance of each other; or they tended to resort to harsh measures to resolve their conflict. For many parents pregnancy was the main reason for getting married, perhaps for the legality of providing the baby with a father.

Family size of the children with maladjusted personality was somewhat larger and their parents often wished

that they had had fewer children. Perhaps they felt they could have coped better with a smaller family, which might have made differences in their children's development. The child was often disciplined by arbitrary means; his parents were often discontent with life having to cope with it all.

The parents of troubled children were found to be less ready for assuming parental role, they lacked in knowledge about child rearing, and the parental role; and they found it difficult to make adjustment to being parents. Their early childhood experience was unhappy, and they themselves did not enjoy the child-rearing role as much as they would have liked. Many parents perhaps did wish for other roles either simultaneously, or wished that they could be doing something else rather than being tied down with children.

The motives for having children for many parents of emotionally disturbed children were related to their own personal needs, such as to strengthen their marriage; to please husband or wife, or to achieve social status through having a child; rather than the enjoyment of having a child for his own sake, or the fun of parenthood. Many parents also gave lower importance to the place of child in their lives, and saw only a few advantages connected with having children, rather than not having them at all.

In general, the findings suggest that the children who

are referred for psychiatric assessment and treatment come from a vastly deficient environment, and that so much deficiency cannot fail to influence parental role playing resulting in strained relationship between the parent and the child; either through neglect, over protection or rigidity.

It may be argued that why is it that not all children in the same family show up in psychiatric clinics; or present a psychiatric condition. Many reasons can be given as to why this occurs. One of them is that, different children react differently to the environmental stress depending on their individual constitutional or hereditary make-up. Some biological or temperamental factors limit the child's ability to cope with the most benign demands of environment, while other children find ingenious ways to survive and develop in an intolerable situation. Moreover, it is a rather well known fact that all neglected children do not become socially deviant adults, nor does every pre-mature infant become educationally handicapped or emotionally insecure. An effective environment for the optimal growth of one child is different from that needed for another child. This is where the parental differences in knowledge about child rearing and their role might make difference in the children's ultimate social adjustment.

Another reason often given is that no two children

born in the same family do experience the same set of environmental factors. The family is in a constant state of dynamic change and the environment of the first child is very different from the environment of the second, third or the subsequent child.

It is therefore suggested that the cummulative effects of a long term undesirable environment as shown by the results of this study, cannot fail to influence the child's emerging personality.

Implications For Mental Health Services

Two issues can be raised with regards to the provision of mental health services for children and families, on the basis of this study. One is who is the patient, or rather, is child alone the patient, and if not, what is the treatment?

If an assumption is made that the child is primarily at fault with himself, and the root of his psychiatric condition lies internally within himself, the prescription for his treatment will be one thing. On the other hand, if one considers the child to be a developing organism in his social environment; it is then acknowledged that the social factors can and do hinder or facilitate his development. In this instance, the provision of service requires a different kind of approach.

Historically in Newfoundland, as almost everywhere else, mental health service for children is an institution oriented service; hospital based; and follows the same medical model as the model being followed for adult service. A question can be raised, is the child who is truanting from school, or is defiant of parental authority a "sick" child, in the sense of his requiring hospitalization? Or, is the child who is anxious, timid, nervous, and perhaps a bit withdrawn, best "treated" by his abrupt removal from his natural surroundings? Moreover, what about children who receive psychiatric services as "out patients"? Are they not traumatized as a result of being labelled as psychiatric patients?

The results of this study suggest that the fact that a child is referred to a psychiatric clinic does not necessarily mean there is any serious problem in the child himself. In fact, the data point to the pathology inherent in the family background of the children who are often labelled as those "mental" kids as a result of their hospitalization. Even if one believes that the inherent pathology may not be the primary cause of children's problems, the fact remains that it exists side by side, and that it cannot be ignored. Failure to correct such an unhealthy environment would only be counter productive of any attempt to treat a child with these disorders. A treatment program which does not in-

clude the treatment of his circumstances, may not be effective and in the long run, not in the best interest of the child or his family. Because of this, the mental health needs of a vast majority of children require a move away from institutionally based service. It requires a creation of service which is comphrehensive, community based, multidisciplinary and family centered.

A comprehensive service is one which provides a full range of mental health services for families as well as for children. Operationally, it means a provision of direct clinical services as well as a program of community consultation and education.

A community based service is one which works with and for children and their families in their own communities, by uniting homes, schools, and community institutions and services.

Mental health services require an interdisciplinary approach, a team approach consisting of professionals with a variety of special training and experience working closely together in an interdependent fashion. No one professional discipline has sufficient preparation to function alone. All disciplines such as psychiatry, psychology, social work, nursing, education, which can offer a unique and useful perspective to the overall diagnostic, treatment or

service delivery can be involved in an interdependent fashion.

It is fruitless to treat children alone if the service does not simultaneously intervene, and thwart all pervasive influence of those social factors which distort normal growth and successful development of those children who are troubled. The attention therefore needs to be focused on family centered service which is committed to ensuring that the family provides the focus of any attempt to plan and deliver services for children and youth. It is preferable to save a family rather than to attempt to allocate the resources necessary to provide an alternative. Thus, in a child-oriented program to prevent and/or assist troubled youth, the emphasis needs to be on the whole family. This would mean a wide range of services to cover all aspects of family life.

The findings on child rearing derived from this study lend support to a number of other studies that point to the importance of a satisfying, co-operative, conflict free marriage to the satisfaction of parents in their child-rearing role (Chilman 1978, Rutter 1975). Attention needs to be directed towards pre-marital counselling, which may include not only the guidance directed as to how to "live happily ever after", but also the recognition that in spite of it all, marital dissatisfaction is common, and "normal"

and if the problems do arise later in marriage, early help with problems can prevent later, more serious difficulties. Marriage counselling needs to include as its perspective education of parents as to how their interpersonal conflict impinges upon children, and how to avoid open arguments and fights which may be detrimental to the child's overall social adjustment.

Since many marriages, it seems, do occur on account of pregnancy, a viable solution can be adoption services as an alternative to marriage, and thus prevent problems later on not only for the couple themselves but also for the child who has to witness his parents' marital strife. Better yet would be contraceptive knowledge freely available to young couples who are still at the stage of courting each other, and marriage may or may not be as yet, one of their future plans.

So much has been stated in the scientific literature about the effect of large family size on the mental health of parents and children, that it would be repetitious to suggest the need for services in this area. The data that many parents would have preferred smaller family size if they could do it all over again, only reaffirms the importance of family planning counselling and strengthening of these services in St. John's and the vicinity.

The data indicates a crying need for programs for preparation for parental role, and the need for knowledge about child rearing. They strongly suggest that the parents who are not ready for parental role; who had an unhappy growing up experience, and who are less satisfied playing a nurturant role may not be particularly satisfied and happy being parents and this may influence their functioning. They may not be able to give loving warmth, plus firm, democratic, kindly discipline, discipline that is neither too harsh nor too permissive. The need for parent education programs which not only suggests but demonstrates how to stimulate children, when to praise them, how to discourage dependency, how to play with him, and how to talk to him; cannot be underestimated.

Parent counselling all too often involves just the mother; more emphasis seems indicated on counselling with parents together regarding parent-child relationship and parental concerns. This is a bit different from the family therapy concept, which of course, is indicated in some situations. Perhaps, enriched family focussed counselling services through the schools may help prevent later serious problems in children. The education system in this sense has a special role not only with regards to parent-education program, but also it can provide early detection of symptoms both in the child and his family, so as to

provide early intervention to stimulate healthy growth and development.

A note about the value of child to his parents and the motives for having children is in order. The results indicate that the concept of child bearing motivations needs to be further explored. If children are desired for their utilitarian value, such as strengthening marriage, achieving social status, or for avoidance of loneliness in marriage as this study suggests, then alternatives to child bearing can be considered, and then examined for their effect on parent-child relationship.

In conclusion, this study has demonstrated that the family life of children with psychiatric disorders needs further attention, and that the services for children and families need to be redefined. Present services are oriented toward crisis, rescue and remedy rather than toward prevention and planning. It is reactive rather than proactive. Given the complexity of family life, and the dynamic nature of parent-child relationship, the services need to take into consideration planning of long-term policies; policies which not only correct the pathology in the family system, but also promote mental health of all individuals in the family. Only well planned and well coordinated programs can fulfil this goal; and therefore the future research should be directed to identifying those

social programs which strengthen family life with a view to providing preventive treatment.

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APPENDIX A

Characteristics of Children
in
The Study Group

TABLE 1

Characteristics of Children by Age and Sex in Study Group

Age (years)	Male		Female	
	N	%	N	%
0 - 4	2	8.0	1	5.0
5 - 9	11	44.0	6	30.0
10 - 14	12	48.0	10	50.0
15 - over	0	0.0	3	15.0
TOTAL	25	100.0	20	100.0

TABLE 2

Psychiatric Diagnosis of Children in Study Group

Diagnostic Category	Male N	Female N
Emotional disorders	3	10
Conduct disorders	8	2
Hyperkinetic syndrome	5	-
Infantile autism	1	1
Childhood schizophrenia	-	1
Adjustment reaction	3	3
Developmental disorder	3	1
Other - Encopreses	2	1
Anorexia Nervosa	-	1
TOTAL	25	20

APPENDIX B

Questionnaire

FAMILY LIFE STUDY QUESTIONNAIRE

First I'd like to ask you some general questions about how you feel about your present life situation.

A.

1. Taking all things into consideration, how satisfied would you say you are with your maggiage?

very satisfied	satisfied	somewhat satisfied	dissatisfied	very dissatisfied

2. How would you compare your marriage with those of other people you know?

better than any I know	better than most	about average	not as good as most	worse than any I know

3. How satisfied are you with being a parent?

very satisfied	satisfied	somewhat satisfied	dissatisfied	very dissatisfied

4. How would you compare your satisfaction as a parent with that of other parents you know?

much grater	grater	same	less	much less

5. How satisfied do you feel with your life generally?

very satisfied	satisfied	somewhat satisfied	dissatisfied	very dissatisfied

6. How improtant do you feel it is to plan your life a good way ahead.

very important	important	somewhat important	not very important	not at all important

7. When you do make plans ahead how often do you usually get to carry things out the way you planned? (i.e., without having to make a change in them.)

very often	often	sometimes	seldom	never

8. How satisfied were you with your life as a child?

very satisfied | satisfied | somewhat satisfied | dissatisfied | very dissatisfied

B. <u>Early Marriage</u>

Now, I have some questions dating back to the time just before and when you first got married.

9. How long did you and your husband/wife go out together before you got married?

less than 6 months | 6 months -1 year | more than 1 year but less than 2 yrs. | 2-3 years | more than 3 years

10. How old were you when you got married? ________

11. How much schooling had you completed by then?

8th grade or less
some high school
grad. high school
some tech. school
grad. tech. school
some university
grad. university
other (specify)

12. What were your reasons for getting married?

____

____

____

13.
13. People have different opinions and have made statements about what it takes to make a successful marriage. At the time of your marriage, how knowledgeable would you say you were on this subject?

very knowledgeable | knowledgeable | somewhat knowledgeable | not very knowledgeable | not at all knowledgeable

14. How ready for marriage do you feel you were?

very ready	ready	somewhat ready	not very ready	not at all ready

15. How easy was it for you to change from being single to being married?

very easy	easy	somewhat easy	difficult	very difficult

16. How old were you when you first became a parent? ________

17. When you first became a parent, how knowledgeable would you say you were about what it takes to be a successful parent?

very knowledgeable	somewhat knowledgable	knowledgeable	not very knowledgeable	not at all knowledgeable

18. How ready for parenthood did you feel you were?

very ready	ready	somewhat ready	not very ready	not at all ready

19. How easy was it for you to make the change from having no children to becoming a parent?

very easy	easy	somewhat easy	difficult	very difficult

20. When you were first married, how many children did you think you would like to have?

____

21. How many children do you have now?

sex	birth date
___	__________
___	__________
___	__________

22. Did you plan your first? ________

second? ________

third? ________

23. Do you expect to have more children than you already have?

No   Yes   If yes ... How many more? ______

24. Now, I'd like you to imagine that you could live your life all over again. If you could just do that:

i. Would you have a different sized family?

few children   same number of children   more children

C. Children (I)

In this section, I will be asking questions about children in general and looking at why some people decide to have children and others decide not to. In making this decision, couples often look at both the advantages and disadvantages of having children.

25. I am now going to read you a number of reasons people sometimes give for wanting children. For each one, I'd like you to think back to the time when you were first married and tell me how important this reason was for you.

	very important	important	somewhat important	not very important	not at all important
1. Because marriage is lonely without children.					
2. Because my husband/wife wanted children.					
3. Because having children would make my marriage stronger.					
4. Because I wanted someone to carry on my family name.					
5. Because having children would help our family economically in years to come.					
6. Because it would be fun to have children around the house.					
7. Because children are a comfort in one's old age.					
8. Because I would enjoy caring for and raising children.					
9. Because having children would prove I'm an adult.					
10. Because I thought I would make a good parent.					

26. Often people feel two ways at the same time. While they decide they want children, they still realize that there are reasons for not having children. I will now read you a list of reasons people sometimes give for not wanting children. Again, I'd like you to think back to the time when you were first married and tell me how important you felt these reasons were.

	very important	important	somewhat important	not very important	not at all important
1. Because children would interfere with the time I could spend with my husband/wife.					
2. Because my husband/wife did't want children.					
3. Because having children would cause problems between me and my husband/wife.					
4. Because having and raising children is too expensive.					
5. Because children are noisy and disruptive to household.					
6. Because children are a couse of worry throughout one's life.					
7. Because children would be a lot of work and bother for me.					
8. Because having children would restrict my activities as an adult.					
9. Because I felt I would not make a good parent.					

Children (II)

27.

Now that you have children, how important do you see these reasons for having children at this point in time?	very important	important	somewhat important	not very important	not at all important
1. Because marriage is lonely without children.					
2. Because having children makes my marriage stronger.					
3. Because I want children to carry on my family name and/or traditions.					
4. Because having children helps or will help our family economically.					
5. Because it is fun to have children around the house.					
6. Because children are a comfort in one's old age.					
7. Because I enjoy caring for and having children.					
8. Because I think I make a good parent.					

28.

If you had to make a decision whether or not to have more children, how important would the following reasons be for not wanting children?	Very important	important	somewhat important	not very important	not at all important
1. Because children interfere with the time I could spend with my husband/wife.					
2. Because my husband/wife doesn't want children.					
3. Because children cause problems between me and my husband/wife.					
4. Because having and raising children is too expensive.					
5. Because children are noisy and disruptive.					
6. Because children are a cause of worry throughout one's life.					
7. Because children are a lot of work and bother for me.					
8. Because children restrict my activities as an adult.					
9. Because I feel I do not make a good parent.					

29. Every kind of work has certain day to day satisfactions, but some people find some kinds or work more satisfying than others. Compared with other kinds of work you could imagine yourself doing, how would you rate the satisfaction of childrearing?

much more satisfying	somewhat more satisfying	equally satisfying	somewhat less satisfying	much less satisfying

30. Here is a list of things which you and your children might do when you are trying to solve a problem. Taking all disagreements into account, not just the most serious ones, indicate how frequently you do the following during a conflict.

	Never	Almost never	sometimes	Almost always	always
1. Avoid the issue.					
2. Try to discuss the issue calmly.					
3. Argue and yell a lot.					
4. Threaten to use force.					
5. Actually use force.					
5. Other(specify).					

31. Here is a list of things which you and your husband/wife might do when you are trying to solve a problem. Taking all disagreements into account, not just the most serious ones, indicate how frequently you and your husband/wife do the following during a conflict.

	Never	Almost Never	Sometimes	Almost Always	Always
1. Avoid the issue					
2. Try to discuss the issue calmly					
3. Argue and yell a lot					
4. Threaten to use force					
5. Actually use force					
6. Other (specify)					

32. In your present family, who takes responsibility for the following:

	Husband Much more Than wife	Husband More Than wife	Husband & Wife Equally	Wife more Than Husband	Wife much More than Husband
a. Earning family income					
b. Child rearing					
c. Housework					
d. Organizing family recreation					
e. Helping with personal problems					

33. How satisfied are you with this arrangement?

very satisfied	satisfied	somewhat satisfied	dissatisfied	very dissatisfied

Current Social Situation

To analyse results of this questionnaire, we need some specific information about your present situation.

34. What is your present marital status?

1st. marriage   re-marriage   not legally married

35. If you had your life to liver over again, would you marry the same person?

Yes definitely	Probably	Uncertain	Probably Not	No, definitely Not

36. What is your date of marriage? (or date when you started living together if not legally married.)

____

37. What is your date of birth? ____________________

38. Sex: Female   Male

39. What is your religion? ____________________

40. How much schooling have you completed?

8th grade or less
some high school
grad. high school
some tech. school
grad. tech. school
some university
grad.university
other (specify)

41. What is your usual occupation? ________________

42. What is your husband's/wife occupation? ____________________

43. Are you employed now?

No

If no:

i. Are you looking for work?

No Yes

ii. Are you engaged in any educational or occupational program aimed at employment in the future?

NO Yes

Yes

If yes:

i. What is your present occupation?

____

ii. Do you work?

Full time Part-time.

iii. Do you work because:
Your family needs the income?
You enjoy your work?
Other (specify)