International Journal of Multidisciplinary Research And Studies

Available online at https://ijmras.com/

INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY RESEARCH AND STUDIES
ISSN: 2640 7272
Volume:04; Issue:01 (2021)

IMPACTS OF PSYCHOLOGICAL DISORDER ON KIDS.

Anjali Kumari
M.Phil., Roll No.: 150593 Session-2015-16
Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India
E-mail: anjalisamdashi@gmail.com

ABSTRACT

For a child to be considered mentally healthy, they must be able to deal with stress in any given circumstance, participate in activities at school, at home, and in the community without experiencing negative emotions such as rage, anxiety, or depression (Mental Health Foundation, n.d.). A sound mental state during one's formative years is essential to a child's overall growth as well as to realising one's own full potential as an adult. Changes or traumatic experiences that occur in the life of a kid are frequently what sets off the development of mental disorders rather than the diseases developing on their own.

Keyword: diseases, developing, traumatic, experiences,

INTRODUCTION

Anxiety, depression, thoughts of self-harm, attention deficit hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) are examples of common mental diseases that can manifest themselves in early infancy (Centers for Disease Control and Prevention, 2018). Beginning elementary school or relocating to a new house are two significant life events that might trigger mental health problems in children. A child's emotional and physical upheaval throughout puberty can put them at increased risk for developing mental health issues later in life. Puberty is a developmental stage. The breakup of a couple's marriage is one example of a traumatic occurrence; others include the death of a loved one or exposure to natural catastrophes, acts of violence, or even war. Children's vulnerability to developing mental health issues is significantly increased when they are subjected to violent environments. Children all around the world are increasingly being put in dangerous situations, which has a negative impact on their

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

emotional and mental health (Flannery, 2018). This exposure could be direct, in the form of the individual experiencing physical, sexual, or emotional violence in their community, at home, or at school; it could also be indirect, in the form of the individual witnessing violence and hearing or watching violent events on social media, television, or radio.

Problems with children and teenagers' mental health are frequently disregarded owing to a lack of understanding or an existing stigma associated with mental disorders, and as a result, they go untreated. It is possible for mental problems to have a wide-ranging and detrimental impact on a young person's development, educational success, and transition to adulthood if they are not addressed (World Health Organization, 2018b). The presence of mental problems in children at a young age can further lead to prejudice, stigma, and exclusion, and may even result in limited access to social, educational, and health resources; this is a significant violation of children's rights. Therefore, there is a tremendous need to promote information on mental diseases that can occur throughout children, as well as how to recognize them and what to do if they are found.

What is being done to combat mental health issues among children

Despite the fact that mental health is essential to physical health, it has been mostly ignored for a significant amount of time and continues to be subjected to stigma and discrimination on a global scale (Ives, 2018). Recently, international and national stakeholders have begun to pay attention to the effects of mental health on the global burden of disease and have begun to make promises to transform policies and programmes to account for mental illnesses, particularly among children and adolescents. This shift in focus is a positive development. The promotion of mental health and well-being is called for in Target 3.4 of Goal 3 of the Sustainable Development Agenda (United Nations, n.d.). In order to successfully complete objective 3.4, it is of the utmost importance to take action to improve the mental health of children around the world.

The World Health Organization's Mental Health Action Plan 2013-2020 emphasises the vital role that mental health plays in achieving total wellbeing (World Health Assembly, 2013). The plan outlines the necessary steps to close the gap in meeting the needs of children and adolescents who suffer from mental health issues. These steps include providing comprehensive, integrated mental health and social care services in community-based settings; implementing strategies for promotion and prevention; strengthening information systems, evidence, and research; and providing more effective leadership and governance for

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

mental health. The recommendations outline important initiatives that must be taken in order to achieve sustained growth in policies, programmes, and research pertaining to mental health.

In a critical monograph published forty years ago, Michael Rutter emphasised the risks to the development of children whose parents had a psychiatric disease. These risks could affect the child later in life. 1 Since that time, a significant amount of investigation has been concentrated on these children as well as their parents. The policies intended to assist and support these families, however, have been slow to catch up. Two new assessments that were produced by national bodies in Australia and the United Kingdom have, albeit belatedly, offered some significant suggestions. 2,3 Despite this, there is still a lot of work to be done, both in terms of policy and the creation of therapies that are supported by evidence.

Adults who are of the age to be responsible for the care and upbringing of children are at risk for a number of common psychiatric diseases, including depression, anxiety, and eating disorders. It has been demonstrated that these illnesses significantly impede social and psychological functioning, which can result in challenges in one's professional and personal life. 4 In recent years, there has been a marked increase in the acknowledgment of the possible influence that a parent's mental illness might have on a kid. Multiple facets of a child's growth, including their physical, cognitive, social, emotional, and behavioural development, are susceptible to being hampered by environmental factors. 5,6 Even though there are a number of genetic and environmental mechanisms that play a significant role in the link between a parent's mental illness and their child's challenges, there is strong evidence to suggest that the quality of parenting and the interaction within the family are key mediating variables. 5,6 The most severe forms of mental illness, and in particular those parents who had to be confined to a hospital because of their condition—typically those with schizophrenia or bipolar disorder—have been the primary focus of much of the attention paid to health policy in this area. On the other hand, other illnesses that are significantly more prevalent have received very little attention.

In order to provide assistance to children whose parents have a mental illness, the children themselves must first be recognised. This can be a challenging endeavour. Patients admitted to the hospital are rarely questioned about the number of children they have, and the information on their children is frequently omitted from their medical records. 8 There is typically no provision made for children to visit their parents while they are being treated in

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

psychiatric facilities for adults. It is much more difficult to locate children whose parents have a condition but who do not require hospitalisation or who are unknown to health services. These children are a particularly difficult group to find. In spite of the fact that there are examples of exemplary practise in some sectors, there are still severe inadequacies. The influence that a parent's mental illness can have on their children is not commonly covered in medical education, nor is there much emphasis placed on teaching students how to have sensitive conversations about parenting concerns. The persistent stigma that is attached to mental illness is another factor that makes it challenging to have conversations about these topics. When problems arise, it is important for parents to feel comfortable discussing them with their family doctors or even with their children's teachers. It is essential to triumph over this stigma as well as the other obstacles. The importance of identifying and helping these children is of wider benefit than to the child alone. For instance, child psychiatric problems continue into adulthood in an appreciable minority of cases, and the consequent increased health expenditure means that the entire community is affected. Therefore, it is important to recognise these children and provide assistance to them. There is a window of opportunity for prevention.

In two recent reports, one from the Royal College of Psychiatrists in the United Kingdom and the other from the Australian Infant, Child and Family Mental Health Association, steps have been identified. These organisations are located on different continents.

The more comprehensive Australian report highlights the need for improved recognition of children of parents with mental illness, the need for better identification of problems in these children, and the provision of help for those problems. Additionally, the report emphasises the need for improved recognition of children of parents with mental illness. In addition to this, it emphasises the need for additional assistance for this set of parents as they fulfil their parental responsibilities and outlines the particular actions that could be implemented to accomplish these objectives. In order to put these recommendations into action, there will need to be modifications made to the provision of services. These modifications will include a closer collaboration between primary care services and mental health services for adults and those for children, education of healthcare staff, and the combating of stigma in order to make it possible for parents to even discuss their parenting without being afraid that their children will be removed from their care.

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

We are of the opinion that these new service developments should be accompanied by high-quality research on health services in order to track changes and determine the approach that is the most effective, economical, and equitable in terms of providing treatment to the wide variety of children and families involved. It will be necessary to implement all of these and other changes in the identification and treatment of children who are at risk in a manner that is sensitive. By giving the impression that one is adopting a blame-shifting stance, it would be simple to make the situation for parents dealing with mental health issues even more stigmatising. The message can and should be one of hope, conveying to parents struggling with mental illness that they and their children have the potential to be helped and deserve to have better options available to them.

Can you explain what a mental illness is

Your ability to think clearly, handle your emotions, and act in appropriate ways are all components of your mental health. A pattern or change in thought, feeling, or behaviour that is distressing to the individual or disrupts their capacity to function is considered to be a mental disease, also known as a mental health problem.

Disorders of mental health in children are commonly defined as delays or disturbances in the development of age-appropriate thoughts, behaviours, social skills, or emotional control. This definition applies to both children and adults. Children suffer emotional distress as a result of these issues, which interferes with their capacity to perform normally at home, in school, and in other social settings.

Obstacles in the way of treating mental problems in children and adolescents

Because healthy childhood development is a process that involves change, it can be challenging to comprehend mental health concerns in children. In addition, the signs and symptoms of a condition may change depending on the age of the kid, and youngsters may be unable to articulate how they are feeling or why they are behaving in a particular manner.

Other considerations may play a role in a family's decision not to seek treatment for a kid who has symptoms consistent with a mental disorder. For instance, parents may be concerned about the social stigma connected with mental illness, the usage of pharmaceuticals, as well as the expense and the difficulties associated with providing therapy logistically.

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

DISORDERS THAT ARE PREVALENT AMONG CHILDREN

The following are examples of conditions that may be considered mental health disorders in children or developmental disorders that are treated by professionals in the field of mental health:

Anxiety disorders. Worry disorders in children are characterized by recurrent concerns, anxieties, or anxiety that interfere with the child's ability to participate in activities such as play, school, or usual social settings that are suitable for their age. Occupying a place on the diagnostic spectrum are obsessive-compulsive disorders, generalized anxiety, and social anxiety.

The disease known as attention deficit hyperactivity (ADHD). Children who have attention deficit hyperactivity disorder (ADHD) have difficulties paying attention, engaging in impulsive behaviours, being hyperactive, or any combination of these issues in comparison to the majority of children their age.

Disorders on the autism spectrum (ASD). A neurological illness known as autism spectrum disorder typically makes its first appearance in early childhood, before the age of 3. A child who suffers from autism spectrum disorder (ASD) struggles to communicate and engage in social interaction with others, despite the fact that the severity of the condition might vary.

Eating disorders. A obsession with an ideal body type, disordered thinking about weight and ways to lose weight, and dangerous eating and dieting habits are the hallmarks of someone who suffers from an eating disorder. Anorexia nervosa, bulimia nervosa, and binge-eating disorder are all examples of eating disorders that can lead to mental and social dysfunction as well as life-threatening physical consequences.

Depression as well as other affective diseases Depression is characterised by recurrent emotions of melancholy and a loss of interest, both of which interfere with a child's ability to perform normally at school and engage with other people. Bipolar condition causes dramatic shifts in mood, ranging from depression to intense emotional or behavioural highs, which can be unprotected, hazardous, or harmful. Bipolar disorder is characterised by extreme mood swings.

REVIEW OF LITERATURE

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

Still (1902) had the intention of addressing the problem of immorality, which at the time was seen to be much too advanced for youngsters who were clearly disturbed or mentally incapable. It was hypothesised that immoral behaviour in typically developing children, or at the very least in children who defied labels like "retarded," was an indication of a more serious underlying medical condition. "(1) passionateness, (2) spitefulness-cruelty; (3) jealousy; (4) lawlessness; (5) dishonesty; [and] (6) wanton mischievousness-destructiveness;" are some of the indications that were present. Still believed that these behaviours indicated a certain degree of personal agency on the part of the children who exhibited them. These were not children who disobeyed the moral standards of society because they lacked the cognitive capacity to comprehend those codes due to their lack of intelligence. These young people may have had a good comprehension of the contents of the law, but they chose to defy it regardless of their knowledge. These kids were too bright to be filed away in the standard terminology of stupidity, yet they were too young to be considered "criminal minds." Modern medicine has no way of identifying them, therefore they aren't called anything by that name. The medical evaluation of these "other children" was necessary in order to have a more in-depth comprehension of their conditions.

It is still a matter that needs to be asked as to whether or not these children exemplified an altogether new sort of stupidity or imbecility.

According to Strecker (1929), the following is an illustration of some inappropriate behaviour of the motor type: A boy who is now 10 years old and who suffered from acute encephalitis when he was 7 years old was said to be hyperactive, always moving, roaming the streets at night, wandering around the house at night, whistling and singing; at one point, he dashed up to an infant sister's crib and swung the baby around by the heels. In the severe kind that was researched, one observed extreme aberrations such as stealing, counterfeiting, lying on purpose to achieve a goal, lapses in morality, and running away, all of which were meticulously planned and had a specific purpose. Two extremely different depictions of this child's personality were created by Strecker. On the one hand, it appears that the behaviour of these youngsters was motivated by impulses that were independent of conscious thought or reason. On the other hand, these children showed a certain amount of malevolence in the things that they did; a neurological impairment or lesion gave a source of enjoyment for behaving in a manner that is contrary to social norms.

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

In a randomised, double-blind, placebo-controlled outpatient research, Rapoport et al. (1974) compared the effects of imipramine hydrochloride, methylphenidate hydrochloride, and a sugar pill on 76 boys in elementary school who were diagnosed with hyperactivity. In addition, the pre-drug behavioural examination is investigated in depth in order to supply clinics that examine these youngsters with guidelines. The utility of the psychologist's global estimations of attention and behaviour disturbance was demonstrated by baseline clinic evaluations. These judgements predicted teacher rating of classroom behaviour better than psychiatric playroom observations did. The teacher evaluations that were predicted by parent diaries of activity and family interaction over a period of four days also mirrored how the child responded to stimulant medication. Although the overall opinions of the psychiatrists, psychologist, and paediatrician suggested that both medications were preferable to a placebo, the stimulant drug was the clear winner according to all of the measurements. However, the dose of imipramine hydrochloride that was used in this study was lower than what is typically used in other places; this may limit the importance of the findings.

According to the research done by Conrad (1975), the emergence of hyperactivity, also known as hyperkinesis, may be traced back to the interaction of three societal elements, which are as follows: "(1) the pharmaceutical revolution; (2) tendencies in the medical profession; and (3) government action." Ciba Geneva, the company that was responsible for the synthesis and marketing of Ritalin, addressed a large-scale advertising campaign to the medical and educational sectors alike in the 1960s. This is the company that Conrad's analysis of the pharmaceutical revolution points the finger at as being the culprit. His assessment of current developments in medicine, while not entirely clear, typically relates to a growing understanding of behavioural issues as having a biochemical or organic root. The government action component of Conrad's research draws attention to several government institutions, specifically the United States Public Health Service, which was accountable for formally labelling hyperkinesis as "minimal brain malfunction." Conrad is describing the power of a public institution to contribute to medicalization by decreeing a unified diagnosis, and he is doing so by detailing the function that this government agency plays in the process.

RESEARCH METHODOLOGY

The investigation into the "Clinical, Psychological, and Social aspects of attention deficit hyperactivity disorder in Children" was carried out by the investigator using methodical observations and procedures using the following methodology:

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

AIM

To study the various clinical, psychological and social factors associated with attention deficit hyperactivity disorder.

STATEMENT OF THE PROBLEM

- In what specific areas is the quality of life, stress and self esteem of parents whose children have attention deficit hyperactivity disorder affected?
- Whether there is an influence on parental quality of life, stress and self-esteem in relation to the type of Attention Deficit Hyperactivity Disorder, co-morbid features, family structure, age, birth order, gender of the child, whether or not the child is on a management program?
- Is there a difference in the way fathers and mothers respond to this developmental disorder?

OBJECTIVES OF THE STUDY

- To collect information on the medical, educational, social, and developmental histories of children diagnosed with attention deficit hyperactivity disorder (ADHD), as well as their family histories and birth histories.
- To acquire a cognitive profile of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), which will include their Intelligence Quotient (IQ), Memory, Comprehension, Form Perception, Abstract Reasoning, and Visuo-Motor Functions.
- To investigate the presence of co-morbid conditions, such as a learning disability, autistic traits, a propensity to be a slow learner, and mental retardation.
- To investigate the many risk factors related with Attention Deficit Hyperactivity Disorder by categorising them according to the subtype of Attention Deficit Hyperactivity Disorder, the gender of the kid, and their age.
- To investigate the symptoms and other maladaptive behaviours related with Attention Deficit Hyperactivity Disorder, as well as the disorder's intensity and frequency in relation to the child's age and gender as well as the type of Attention Deficit Hyperactivity Disorder that they have.

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

- To investigate the social elements of Attention Deficit Hyperactivity Disorder, such as the impact the disorder has on parents' quality of life, levels of stress, and levels of self-esteem;
- To determine the differences between parental domains in relation to the different types of Attention Deficit Hyperactivity Disorder, co-morbid factors such as difficulties in learning, autistic features, and mental retardation, the gender, age, and birth order of the child, the family structure, and parental disharmony; and
- To determine whether or not a child with ADHD has a learning difficulty, autistic features, or mental retardation; and To determine whether or not a child
- To differentiate between parental domains in terms of whether or not the kid is participating in a management programme; this will be done by determining the difference between the two.
- To ascertain whether or if there is a connection between the several parental domains that were researched.

A schematic representation of the clinical, psychological and social aspects of attention deficit hyperactivity disorder is shown below:

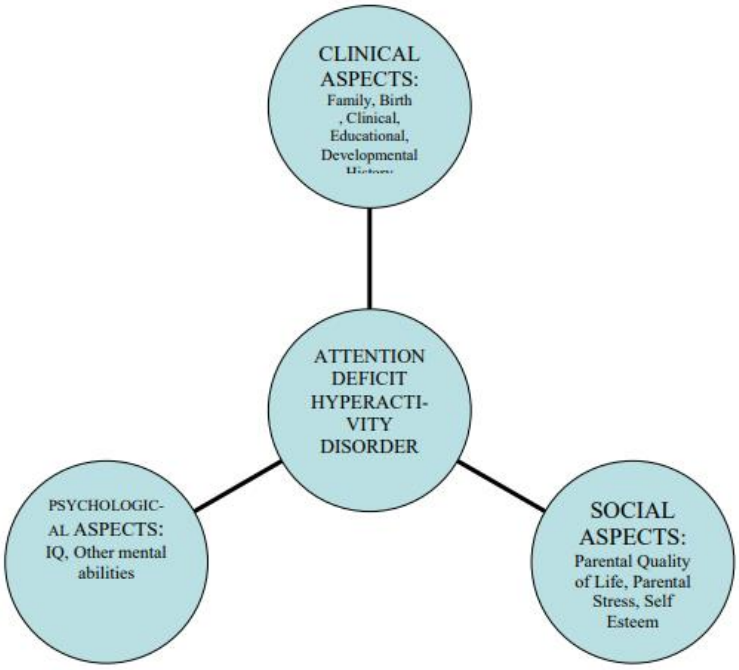


Figure 3. 1 A schematic representation of the clinica

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

DATA ANALYSIS

This chapter discusses the outcomes of the data analyses as well as the various ways the results can be interpreted. The findings will now be discussed in the order listed below:

- General profile of children with attention deficit hyperactivity disorder and their parents
- Clinical factors of children with attention deficit hyperactivity disorder
- Psychological factors of children with attention deficit hyperactivity disorder
    - Family structure
    - Working mothers
    - Parental disharmony
    - Socialization
    - Relationship among parental domains
    - Parental Quality of Life
    - Parental Stress
    - Parental Self Esteem
    - Parental Aspects and Co-morbid features
    - Cluster Analysis
    - Factor Analysis
    - Discriminant Analysis

GENERA PROFILE OF CHILDREN WITH ATTENTION DEFICIT YPERA CTIVITY DISORDER AND THEIR PARENTS

For the purpose of the present research, a representative sample consisting of twenty-two (202) children diagnosed with attention deficit hyperactivity disorder and their parents was selected. There were a total of two hundred (200) mothers and one hundred and seventy two (172) fathers who were willing to fill out the questionnaires. The following tables present the

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

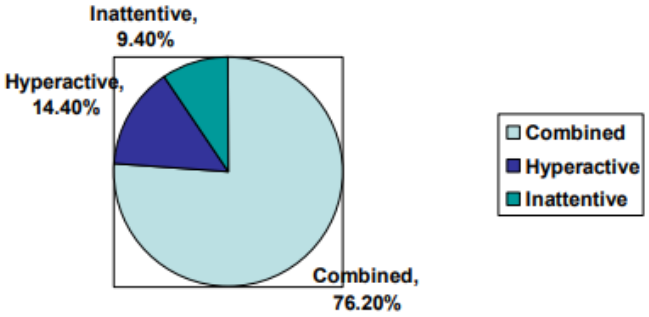
data that was obtained, which includes age, education level, number of siblings, and any other pertinent information that may be applicable.

TYPE OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

Types of Attention Deficit Hyperactivity Disorder in children

	Type	
	N	%
Combined	154	76.2
Hyperactive	29	14.4
Inattentive	19	9.4
Total	202	100.0

76.2% of the children in the study were diagnosed with the mixed form of Attention Deficit Hyperactivity Disorder, 14.4% of the children were classified as having the Hyperactive type, and 9.4% of the children were classified as having the Inattentive type.



Types of Attention Deficit Hyperactivity Disorder

CONCLUSIONS

The identification of individuals who suffer from attention deficit hyperactivity disorder is not a new development. A persistent pattern of inattention and/or hyperactivity-impulsivity that is both more frequent and severe than what is generally found in persons at a similar stage of development is the key hallmark of attention deficit hyperactivity disorder (ADHD). It is believed that between 10 and 20 percent of children in India's school-age population suffer from attention deficit hyperactivity disorder (ADHD). It is common for people who have attention deficit hyperactivity disorder (ADHD) to also have co-morbid conditions such as specific learning difficulties, autistic traits, mental retardation, or difficulties in learning

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

quickly. In order to effectively treat patients suffering from attention deficit hyperactivity disorder (ADHD), the multimodal approach has been used in India. The most successful method for treating attention deficit hyperactivity disorder is an integrative one that includes participation from the family, teachers, occupational therapists, speech therapists, psychiatrists, and psychologists in addition to paediatricians and psychiatrists. Children who have attention deficit hyperactivity disorder (ADHD) rely heavily on their parents to not only help them make, but also keep the developmental progress they make.

REFERENCES

1. American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders.(Edn.4).
2. Anastopoulos A D, Guevremont D C, Shelton L, DuPaul G.(1992).Parenting Stress among families of children with ADHD. Journal of Abnormal and Child Psychology.
3. Anderson J C, Williams S C, McGee R, Silva P A. (1987).DSM-III disorders in pre-adolescent children: Prevalence in a large sample from the general population. Archives of General Psychatry.
4. Angold. (1998). Perceived parental burden and service use for child and adolescent psychiatric disorders. American Journal of Public Health,.
5. Antshel K M, Nastan R.(2008).Metamemory development in preschool children with ADHD. Journal of Applied Developmental Psychology. 29(5):403-411
6. Attention Deficit Disorder in Adults. (2002). Harvard Mental Health Letter, 19;5:3-6.
7. Baker D A.(1994).Parenting Stress and ADHD- A comparison of fathers and mothers. Journal of Emotional and Behavioural Disorders. 2(1)
8. Baker D B, McCal K.(1995).Parenting Stress in children with ADHD and children with LD. Journal of Child and Family Studies.4
9. Barkley R A, DuPaul G J, McMurray M B.(1990).Comprehensive evaluation of Attention Deficit Disorder with and without hyperactivity as defined by research criteria. Journal of Consulting and Clinical Psychology.58(6),
10. Barkley R A, Edwards G, Laneri M, Fletcher M L.(2001).The efficacy of problem solving communication training alone, behaviour management alone and their

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com

combination for parent-adolescent conflict in teenagers with ADHD and ODD. Journal of Consulting and Clinical Psychology. 69(6)

11. Barkley, R A, Murphy K A. (2005). ADHD- A Clinical Workbook. New York: TheGuilford Press,
12. Braun JM, Kahn RS, Froehlich T, Auinger P, Lanphear BP. Exposures to environmental toxicants and attention deficit hyperactivity disorder in U.S. children. Environ HealthPerspect. 2006 Dec;114(12):
13. Brown T E.(2002).DSM IV:ADHD and executive function impairments. Advanced Studiesin medicine.2(25):
14. Buitelaar J K.(2008). Pre, Peri and Post natal risk factors and precursors of ADHD. Journal of European College of Neuropsychopharmacology. 16(4)

Anjali kumari*, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: anjalisamdashi@gmail.com