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ORIGINAL ARTICLE

Parental Attitude as a Determinant of Psychological Disorders among Young Adults

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ABSTRACT

Background: Psychological disturbance among young adults is a critical challenge nowadays and the reasons for this group being suffered from such issues are complex.
Aim: To explore the determinant of psychological issues among Pakistani youngsters. Focusing on the causes of mental turbulences related to anxiousness, oppositional defiance disorder, intermittent explosive disorder, borderline personality, bipolar disorder, and psychosocial stressors, the attempt investigated: understanding of the problem and risk factors, social support and contextual factors, factors being perceived as alleviating low mood, despair, rage, pain, hopelessness, et cetera.
Method: Three case studies of two boys and one girl aged 20-25 having been diagnosed with the above-mentioned disruptive and depressive disorders are presented incorporating a qualitative approach. It includes semi-structured interviews, a survey, and phenomenological considerations.
Finding: The thematic analysis and thorough review of case studies present the indifferent attitude of parents and their harshness are the dominant and consistent determinants of ill-functioning among the involved participants. All complaints of participants were directly or indirectly associated with familial practices, particularly with parental attitude.
Practical Implications. The significant role of parents in the childs' development can never be denied. Therefore, the study provides an insight for the proper exploration of the parent-child relation and attempts to reduce or vanish the discrepencies, must be the goal of therapy. Also, awarness or the specified sessions as a reminder for good parenting regarding thepotential influence of parental attitude and involvement might be the effective attempt for the healthy functioning of the child.
Conclusion. Consequently, a comprehensive model with parental involvement and realization of their influences on an individual's mental health should be formulated and emphasized for the prevention of further cases and management of current ones.
Keywords: Case studies, determinants, disorders, mental health, parental attitude.

INTRODUCTION

Psychological dysfunction in the form of anger, irritability, aggression, emotional outbursts, and disruptive tendencies are consistently recognized as the characteristics of clinical diagnosis among youth across the globe. Particularly, associated with disruptive mood dysregulation disorder (DMDD), oppositional defiant disorder (ODD), conduct disorder (CD), and depression [1]The characteristic features of DMDD include severe temperamental outbursts within a week along with considerable distress being disproportionate to that emotional trigger. Also, mood disruption is consistent with irritability for at least 50% of the working period. These irritability symptoms need to meet the criteria of at least one year and symptom-free intervals for more than 3 months making it clear in terms of diagnosis purpose. Thus, a significant overlap exists between the symptoms of DMDD, mood disorders, and disruptive behavior[2].

Moreover, habitual and impulsive tendencies are recognized under intermittent explosive disorder as per the criteria of the ICD10 classification. It includes the inability to resist harmful impulsive drives or attempts toward oneself or others. An increasing tension is experienced by the individual before the commitment of that harmful act but the sense of gratification or pleasure is gained during and following the impulse[3]. Generally, loss of control and irresponsible attitude toward that sense of control by blaming the victim, situation, or any other party causing anger are the additional considerations in this disorder. The central aspect is the lack of self-control and poor tendency to accept the associated responsibility would alleviate guilt and also reduces the individuals' capacity to make desirable changes.

Over the past decades, the substantial comorbidity of impulsivity with personality disorders, mood disorders, anxiety, and related disorders, and eating and substance abuse disorders are being hugely stressed in clinical research. Traumatic head injury is found to be associated with the generation of impulsive tendencies. Also, substance abuse has a significant correlation

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with impulsiveness even though not included in the specification of impulse control disorders by DSM-V. Further, it is also asserted that not all substance abusers develop or exhibit impulse control problems. But the scientific observation presented that the abusers of multiple substances usually have greater impulse control problems than those who are found to be involved in single substance abuse[4].

Several personality disorders like borderline, histrionic, narcissistic, and antisocial are often found to exhibit impulse control disorders. Risk-taking tendencies, self-harming behaviors or attempts, sexual promiscuity, and also attention-seeking activities are all the execution of harmful impulsive drives. As evident from the nature of such tendencies, illegal or criminal behaviors could result from these attempts. It is directed that concurrent comorbidities in the form of psychosis, major mental illnesses, a few personality disorders, drug addiction et cetera in actual increases the chances of unpredictable criminal assaults[5].

Risk and Protective Factors: A group of researchers presented the bio-psycho-social factors like learning difficulties, perinatal difficulties, hyperactive tendencies, and violence being experienced or observed at home as significant risk factors in the development of disruptive disorders among young adults. Expression of emotions and good familial interactions particularly relationships with grandparents are the protective factors against such disorders. Another study was conducted on the Finland Birth Cohort 1986 incorporating the school age to lifetime version interview schedule for affective and psychotic disorders. The sample included four groups with a disruptive behavior disorder, DBD (n = 44), Attention deficit hyperactive disorder, ADHD (n = 91), the third group included both (n = 72) and the last one with no disorder (n = 250) to identify risk factors associated with these problems. The study concluded the differential consideration for DBD and ADHD risk factors and emphasized the parental factors as a key determinant in the case of DBD along with the suggestion to pay more attention to it than before[6].

Furthermore, DBDs like ADHD, ODD, and CD are recurrently reflected as chronic disorders having significant overlap

in etiological and presented factors. A careful review of 47 research papers from the initial pool of 9806 presented an integrative investigation of environmental risk factors associated with these DBDs. The attempt suggested a strong link between life factors and DBDs like prenatal smoking, alcohol usage and viral infections, maternal psychological sufferings, parental stress, and the typical parental attitude particularly parenting styles during infancy, adoption, and separation from parents along with other kinds of early deprivations as consistent risk factors in this regard[7].

A group of researchers identified some other psycho-social aspects as the risk factors associated with psychological disorders. Social support, the social status of individuals, and familial setups were found to be influential features in terms of mental health. Social support in the form of good relationships and familial interaction appears to be a buffer against psychological disorders. However, economic problems and familial or relational conflicenhanceces depressive symptoms and psychological complications[8].

Pakistani Studies: A group of researchers explored the prevalence of psychological problems in terms of depression among Pakistani individuals along with the associated social complications. A two-phase survey comprised of 259 participants was performed and the findings of the study concluded that financial issues, lack of education, larger family size, and related social adversities generally result in psychological complications among youngsters[9].

A systematic review was conducted to assess etiological factors, treatment possibilities, and preventive remedies along with the prevalence of anxiety and depression among Pakistanis. Results reflected the overall prevalence of said disorders as 34% in the community where the ranges for women, 29,-66%, and 10-33% for men are revealed. Twenty studies presented that low educational status, female gender, middle age, relational conf, lists, and financial issues are the risk factors associated with psychological problems. The major social factor identified as a buffer against such complications is support from family and friends. Close confiding relationships were mentioned as a protective factor against psychological or mental difficulties[10].

Another study was conducted on depression as the co-morbid factor of different chronic illnesses like anemia, asthma, diabetes, hypertension et cetera. A cross-sectional study was conducted with the patients suffering from mentioned chronic disorders in Karachi, Pakistan. Findings presented that anemia and diabetes significantly predicted depression, asthma predicted depression among males only and hypertensive individuals reported less likelihood of depression than non-hypertensive ones. Overall influence to develop depression was greater among females than males. These findings have a great potential for medical practitioners to treat depressive disorders and chronic illnesses collectively and consciously rather than as independent entities[11].

A study was conducted in three capital cities of Pakistan to consider the psychological complications. Six months, a telephonic survey incorporating 820 participants with randomized sampling revealed regional variation in terms of psychological disturbance particularly depression among the targeted cities. The highest rate of psychological disturbance was reported (53.4%) in Lahore, then (43.9%) in Quetta, and then (35.7%) in Karachi. The study concluded that the cultural influence on the location, geographical differences, and social complexities are the important determinant of psychological complications in different areas. Education, gender, and age are the consistent risk factors for developing psychological problems. The author also directed that there I a strong need to revise the existing health policy by the government of Pakistan[12].

Ample research evidence concluded that stressful life events are generally found to be strongly correlated with psychiatric morbidity whereas, social support and education are the protective factors against such issues particularly, depression[13]. Also, low educational background, financial problems, lack of confidence, and fam and iliallifestylee are the risk factors associated with psychiatric complications[14]. Another study revealed that high socio-economic status, social conditions, and relational complications are the significant contributors to mental health problems in both females and males however, females are reportedly more vulnerable to stressful conditions due to lack of empowerment and their submissive style of life than males[15].

MATERIALS AND METHODS

Based on the above-mentioned literature, the present attempt explored three case studies to have an in-depth understanding of the psychological complications being experienced by young adults. Focusing primarily on the determinant of psychological problems, this investigation explored three questions: how an does individual understands his/her problem? What are the risk factors associated with the problem? And what are the contextual factors like social support, being perceived as alleviating low mood, despair, rage, pain, hopelessness, et cetera?

Method: To investigate the above-mentioned questions, five case studies were conducted incorporating structured as well as semi-structured interviews, assessment tools, and open conversations. Five young Pakistanis individuals in agan e range of 20-25 having been diagnosed with disruptive and depressive disorders were considered for case studies. The inclusion criteria also considered the experience of recurrent interpersonal complications, difficulties in regulation of emotions, and frequent outbursts during the last six months. The confidentiality of the information was ensured and the right to withdraw at any point was clarified earlier to the participants.

Data Collection|: The data was collected from 2018 to Jan 2020 incorporating interviews in both structured and semi-structured formats, a few assessment tools were also administered and ethnographic interactions like open conversation were conducted. The content was transcribed for content analysis and phenomenological consideration.

Analysis: Phenomenological exploration and thematic analysis were collectively incorporated for the review of cases to understand the subjective experiences and the influences of traumatic incidents. After isolated examination, a combined and integrated approach was employed till the included case studies for the consistent themes, patterns, and similarities or differences across the sample.

RESULTS AND DISCUSSIONS

Case Study-I: The first case study was of 23 years old young Pakistani girl. She was an elder daughter born in a well-settled family with two siblings doing her bachelor's from a renowned university. She was an intelligent student with good school history in terms of performance but shared rapid shifting of different institutes due to her familial issues. She has reportedly y good but limited relationship with her mother only. She has experienced the clinical diagnosis of anxiety-relatedated disorders, bipolar and borderline personality disorder.

She further reported sleep disturbance, emotional outbursts, certainly loss of sense of self,and blackouts making her feel disconnected from reality. She started visiting the doctor a few years ago, her familiar history also included a few mental disorders in her paternal family. She was able to recollect frequently experienced panic attacks rendering her body entirely painful even with certain unsuccessful attempts of controlling such attacks with medications.t he During the conversation she reported

"The increasing panic attacks made me conscious and to visit the doctor again and again, who gave me Xanax which was not very good so, after sometimes it was replaced with valium but with low dosage. It was a great shift in terms of sudden attacks but did nothing to manage my anxiousness and helplessnessless at all"

For medication, most such attempts were unsuccessful and the client struggled a lot with her diagnosis. She continued struggling with self-harm, anxiety, depression, and even impulsive

destructive attempts. The next exploration was about the risk factors associated with the problems which were recognized as parental indifference, terrible childhood memories, and academic failure as the leading concerns. She reported

"My father has no concern with us (family), mother is the chief earner always inclined to fulfill our material needs. I don't want her to interfere in my life now as she didn't consider it earlier. I don't like her advice. She wants me to ignore the situational sensitivities which I can't, I just can't."

Thirdly, for the protective factors the client reported that she has a friend with a like-minded approach, she use to share her problems with her but this would only work when she is a bit normal but during the disruptive phase, she just wanted to be alone. Also, a few academic activities she likes to be involved in certainly serve for calming her down and relishing her mood. She reported

"I have one friend who talks like me on the topic of social adversities and tries to feel the miseries of living beings so, so her presence is a great piece of relief for, me, and talking with mom is always of my interest, it just cherishes my day. Also, the calm places like we had visited northern areas last year and I still remember, I liked one of the top points there and even wished not to come back. That was a sort of distractor for me as well."

The above consideration, on the whole, was augmented with a psychological assessment revealing the anxiety, depression bipolardisorder,r and borderline personality issues of the client. Her familial problems and poor interaction patterns along with a few traumatic incidents are the prominent risk factors whereas, social support, and recreational and educational activities are some of the protective factors identified for devising the treatment plan.

CASE STUDY-II

The second case was of 20 years old young Pakistani boy. He was the youngest brother among three born in an affluent family doing his bachelor's from a renowned university in Islamabad. His parents and brothers were all serving in principled professions like academics and medicine. He was a hardworking student with the highest school achievements till matriculation and even was among the top scorers in intermediate but got admission ina discipline he don't like at all due to his familial pressure. His elder brother has currently settled abroad and the other one is working in Lahore. He was not much happy with this hostel life but studyingat the best Pakistani university was the concern of his parents. He tried hard in the start to adapt to this massive change but was facing coa consistentstruggles in all major areas of functioning like health, education, and relationships. He has reportedly good relationship with his parents till the near past but it is deteriorating day by day. He has a clinical history of anxiety disorder and later intermittent explosive and disruptive mood dysregulation disorder.

He came for treatment due to a continuous increase in disruptive tendencies over the previous year, like non-compliance, physical aggression, and repetitive behavioral meltdowns. Temperamental fluctuations like tantrums include yelling, screaming, slamming doors, and crying aloud, most of the time. Triggers could include someone asking for taking care, doing a trivial task, or even taking medication. He noticed being stacked at the time of anger, being unable to move on. He was scoring badly in his studies. Reporting that

"You don't know how much I have lost weight in these few months. I never feel a need to eat or sleep. I am unable to study and have to bear unwanted sudden emotional outbursts and poorly manifested anger attacks. I went home last week and one evening I had to buy something from the market, the shopkeeper was doing some things when I asked what I needed so, he took a few minutes and I started beating him by grabbing his lapel. I am tired of this overly damaging emotional behavior. I often start fighting, arguing, and crying while talking to my father".

He further added, "I was a very social person but after matriculation when I had two months' vacations I was alone at home as everyone was working and at that time I use to miss my whole family, we were very connected and started being ill. When my parents took me to the physician, he made an anxiety and then depression sort of diagnosis. I use to remain quiet for days, least interactive, and most often very low in mood. Then, took admission and got a bit busy and a comparatively better but now, in this university, I am facing all those things again. I just miss my brothers and my parent. I was very much attached to my elder brother. I just find everything difficult without him. They are busy in their lives and I feel their absence."

For protective factors, he reported thatconversations with family, a few good friends, and spending time with brothers are quite helpful. On the whole, one of the potential reasons is the familial issues the client is facing.

Case-Study III: The next participant is 25 years old, Islamabad-born, Pakistani boy. He was born withgoon terms of economic status but a conservative, overly authoritarian parental attitude and controlled familial set-up. He studied in a public school and was just an average student. After passing high school he wanted to pursue media studies but his father refused to pay and wanted him to join a public university. He finally decidedon that public university and started graduation as per his fathers'father'st very soon his father refuse to pay his expenses.

He reported that he was never diagnosed with any kind of mental disorder formally but has experienced the programmatic familial environment, fights with his father,and financial crisis from his late high school to date. So, a history of chronic sadness and depression along with self-harming activities was reported. He explained that

"I am having consistent guilt of being at the wrong place. I don't like what I am doing and have all-time pressurizing concerns about financial issues. It's been a long, I am working for my livelihood in this country where parents pay for their children till their I 40s sometimes. Last week, I went to a mall with my friends and got extreme stress by thinking that they all are enjoying life and I am struggling for even a penny. My father was so harsh and untrusting to us from our childhood. When fought a fight with his mom, he used to refer to paying for our basic needs. Physical and verbal abuse are his preferred approaches to treating his family. Forthe last few months, I am feeling stomach aches and shortness of breath, and vomiting most of the days, and as per doctors have no apparent organic cause. I often feel like crying but am unable to dolly. Recurrent and consistent headaches, low mood, excessive thoughts, and never-ending worries make me so problematic person to connect with and extremely uncomfortable living my life. I am unable to make and keep friendships, have frequent quarrels and don't like myself, can't sleep, facing failure in studies burdening me in terms of finance, and have no interest in living." The only powerful thing for me was to communicate with a few good friends but nothing nowadays.

This all reflected the psycho-social stressors being evident as the etiological factors. The need is to work on these areas of functioning particularly addressing the familial environment and the role of parents, which undoubtedly have a defining role in an individual's personality development. Also, currently, literature advocates that the best suitable treatment for depressive and disruptive disorders is psychotherapy. A few studies presented that if employed alone, it would have a greater and lasting positive effect. Cognitive behavioral and interpersonal therapy could be the best choices. Findings also endorsed medication if indicted as a need or desire by the client[16].

DISCUSSION

The present exploration was destined to consider the etiological relevance in terms of determinants of growing psychological dysfunction among young adults. Almost all such cases involving youth are reportedly found to be driven by poor familial practices and indifferent parental attitudes. Also, educational stressors, conflicts with siblings or peers, financial issues and stress, and

storm intensive age bracket would be the major risk factor among other psychosocial stressors. Lastly, a good familial environment, healthy parent-child bond, positive interaction, and a conducive work environment along with recreational activities (for some) are reportedly the main protective factors against mental complications. Psychotherapy and medication in a combined form if required or cognitive behavioral and interpersonal therapies would exclusively be sufficient for clients' mental health[17].

Three case studies were planned, transcribed, and then thoroughly analyzed to have an in-depth understanding of the investigation destined to know how much young people are aware of their problems and what are the risk and protective factors in their opinion. Currently, one of the burning issues is an increase in the rate of mental complications among youth. Also, it is suggested in several studies that parental involvement has a sound influence on the psychological well-being of children and adolescents in terms of self-confidence, self-esteem, and interpersonal interactions[18]. As presented in the third case that the participant stated that he doesn't like himself, which means his self-esteem and associated self-confidence of the participant were low which interns increases his sadness and badly influenced his psychological health. Literature augmented this fact through different studies presenting that there exists a strong relationship of less adaptive parenting style as perceived by the children as being rejected or anxiously attached with children's psychopathology but a few studies further highlighted the externalizing problems whereas others are advocating the internalizing issues as the most prominent etiological factors[19].

Thus, the findings of the present study as designed to consider the consistent determinants across the three cases found the parental attitude as a leading etiological factor behind the individuals' psychological problems. Lack of social support and poor familial interaction were the prominent risk factors along with academic and financial concerns in one of the cases. As in the first two cases, it is found that the participants are suffering froma lack of social support and they have poor interaction patterns. The first participant reported that her father doesn't bother to interact and now she even doesn't like her mother's interference anymore. Researchers presented that the crucial factors for explaining the psychopathology of someone are parenting style and personality traits of parents as discussed in the case study III, the harsh and aggressive attributes of the father is playing the defining role in the aggressive attributes of the participant[20].

Findings are also supported by the research advocating that in the cases of behavioral problems the prominent etiological factor is mostly parenting style. It is further discussed concerning the interactive model which relates the emergence of psychological disorder with the vulnerability of an individual, physiological factors, psycho-social factors along with specific kinds of life factors[18]. Likewise, the analysis of the association between parental attitude and anxiety and depression among Europeans reflected that poor parental care is consistently found to be associated with mood disorders. Also, the evidence is available for the authoritarian parenting style to be etiological of the externalizing problem among children[21] in line with the cases presented above. Moreover, it is suggested that the families of individuals suffering from disruptive disorders and behavioral disorders shared a few characteristics with distorted or dysfunctional families, particularly disruptive behavior is oftenfound as a feature of parental standards[18].

CONCLUSION

Three case studies were explored to identify the determinants, risks, and protective factors of growing psychological complications among youth. The qualitative approach incorporating semi-structured interviews, surveys, and phenomenological considerations figured the consistent pattern highlighting the positive role of parents and effective interaction style for protecting their children from psycho-social stressors.

Limitations, suggestions, and implications: The present attempt was aqualitative approach to considering the determinants of psychological disorders. Thus, subjective, self-reporting could be a limitation. Also, the generalizability of this study would be compromised. The more integrated and extensive exploration would strengthen the understanding of psychological disorders in terms of determinants along with risk and protective factors. This all would help in better treatment plans and management of such mental complications.

Declaration: It is genuinely declared that (i) the results are original; (ii) the same material is neither published nor under consideration elsewhere; (iii) approval of all authors have been obtained.

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