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## A Psychosocial Profile of Mothers of Non-Thriving Children

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### Abstract

Manifestations of the children's response to maternal mental suffering varies depending in part on the child's age and stage. While adolescents might leave school and develop a dependency on alcohol or other drugs, an infant may fail to thrive (*Kush, 1989*). With an under five mortality of 94/1000, a value estimated by UNICEF to categorize Egypt among the countries with a high under five mortality and with the inefficiency of primary level maternal and child care units, the relatedness of infant's failure to grow to their mother's psychological make up is worth attending to.

The present study aims at investigating the relationship between maternal psychiatric morbidity and their infants' rate of growth. The former will also be discussed in the socio-economic context and availability of health services for those mothers.

**Introduction** While there is evidence of progress, health for all by the year 2000 has not been fully realized by many developing nations, as evidenced by the continuous underdevelopment of health and health care resources in many areas of the world. The consequences of such underdevelopment often affects the most vulnerable members of the community at a disproportionate rate. Gender specific analysis of health and health care utilization in developing countries reveal significant disparities between women and men. Women in developing countries often suffer poorer health, but consume less health care resources than their male counterparts. In addition to the usual threats to health in a developing country such as infectious disease, poor sanitation and inadequate food and water supplies, women are frequently confronted with a myriad of socio-cultural factors and gender specific tasks which heavily affect their physical well-being and accessibility to appropriate health care (*Januga and Gilbert, 1992*). child care is definitely one of the most draining and emotionally laden tasks. The complexity of interaction of organic genetic and environmental factors in the development of psychopathology

in individual children is well demonstrated in infancy. At this early stage it is possible to observe the beginnings of the interactive processes before they become obscured by the passage of time. Attachment, persistent crying and failure to thrive are manifestations thereof (*Pearce and Garfinkel, 1992*). The continuous care and attention of an infant is a demanding task that necessitates good health and vitality of the mother, and yet women in our country do not come on the priority list of many specialities. Mental health is no exception.

The association between maternal problems and child health has been described in different settings (*Brown and Davidson, 1981* *Beautrais et al., 1982* *Fergusson et al., 1984, 1985* and *Reichenheim, 1988*), and yet little evidence is available about the mental condition of mothers caring for young children especially in poor urban areas of developing countries where the risk of mental ill health might be expected to be high.

Can a woman subsisting on marginal nutrition and exhausted by repeated childbearing and other psychosocial factors find enough energy to devote to the needs of a young child? This study hypothesizes that she cannot. The

present study was carried out with the aim of studying the sociodemographic and anxiety and depressive symptom profiles of mothers rearing under five children. A regular growth rate was chosen as one of the many indicators of child welfare.

### Material and Method

**Location of Study** The present study was carried out in a primary health care centre in a poor urban area to the East of the peripheries of Cairo. The population of the area is crudely estimated to be around a million. The population of the area is rather heterogenous, consisting mainly of citizens from occupational classes 4 and 5, in addition to a number of professionals and semiprofessionals who could not afford settling down in the centre of the city and so reside in modern apartment buildings in one sector of the area. The area contains around 120 clinics, 4 specialized small hospitals, 2 community development associations and half a dozen schools.

The immediate target population of the centre can be estimated around 5000 inhabitants, of whom mostly women and children attend the clinic. Services offered at the clinic include a GP clinic, an antenatal care clinic, a child follow up clinic and counselling service for women in addition to a local social worker recruited from the area.

**Subjects** Our sample included women who regularly brought their children for follow up on a monthly basis to the child care clinic. The follow up of the children included weighing the child every month and marking the new weight on a growth chart which the mother keeps with her. The mothers in our study included 82 mothers of regularly growing children and 38 mothers whose children failed to show a normal growth curve, in the absence of a physical condition that could explain this underweight. Both groups were compared with each other regarding sociodemographic data, data related to reproductive history and anxiety and depressive symptoms.

**Tools** Sociodemographic data were obtained from the social sheet that is being filled regularly for all clinic attendants.

Depressive and anxiety symptoms were measured using the Zung and Taylor scales respectively. The findings of *both* groups were compared using the mean and standard deviation and the t-test of significance.

**Results** As previously mentioned, the two women groups included 82 women with normally growing children (A) and 38 women whose babies failed to attain the required weight for their age

### Characteristics of the sample as a whole

The age of the sample ranged between 20 and 45 years with a mean age of  $30.85 \pm 9.7730$  years. 88.3% of the sample of women were housewives, 3.33% had an occupation of class 2, 2.5% of class 3 and 4.16 of class 5. The size of the nuclear families of the women ranged between 3 and 13 members with a mean number of  $4.36 \pm 2.46$  members, living in houses that had a mean number of rooms of  $2 \pm 1$  and an average crowdedness ratio of 2/1. 15% of the sample had a shared residence. The mean number of educational years spent by mothers was  $4.93 \pm 4.7628$  years, with 38.3% of the mothers illiterates, 20% knew to read and write, 5% had finished primary school, 23.3% had finished preparatory school, 10% had finished secondary school and 3.3% had completed university (Table 1).

As to the marital history of mothers, their ages of marriage ranged between 15 and 30 years with a mean age of  $21.37 \pm 3.8870$ . 91.6% of the sample were married at the time of the study, 6.6% were widowed and 1.6% were divorced. The husbands of the women were older than their wives by a mean of  $7.75 \pm 5.92$  years and had a mean number of years of education of  $5.36 \pm 5.32$ . In more detail, 28% of husbands were illiterate, 40% knew how to read and write, none had finished primary school, 6.6% had finished preparatory school, 13.3% secondary school, and 11.6% had completed university. The occupation of the husbands varied with 15% of husbands being unemployed, 10% of occupational class 5, 28.33% occupational class 4, 38.33% class 3, 5% occupational class 2 and 3.33% class (Table 2).

10% of the sample estimated their marriage to be quite successful, 54% reported problems

enough to describe their marriage as problematic and the rest (36%) described their marriages as "average". As to the reproductive history of the sample, the mean age at giving birth for the first time was  $22.58 \pm 4.07$  years. The mean number of children was  $2.7 \pm 1.95$  with 35% of the sample having one child, 40% having two or three children, 1.67% having 4 or 5 children and 8.33% having more than 5 children. As to the under five children 78.3% had one child under five at the time of the examination, 18.3% had two and 3.4% had three under fives (Table 3).

Taken as a whole, the sample obtained a mean score on the Taylor anxiety scale of  $20.63 \pm 6.13$  and a mean score on the Zung depressive scale of  $43.3 \pm 18.22$ , categorizing the group in the mild anxiety and "no pathological depression" categories respectively (Table 4).

#### **Characteristics of group (A) as compared to group (B)**

Intergroup comparison were drawn between mothers of normally growing babies (A) and mothers of babies unable to attain the normal growth curve (B).

Regarding sociodemographic data, mothers from group A were older than mothers in group B, had almost the same occupational distribution, the same number of family members, lived in similar housing and experienced similar crowdedness.

They had a slightly lower number of educational years. Among these findings only the age difference between the two groups showed a statistically significant difference at the level of  $p < 0.01$  (Table 5).

Mothers in group A married at an insignificantly younger age and the age difference between them and their husbands was similar to that for mothers in group B. Husbands in group A had accomplished more years of education than those in group B, but the difference was statistically insignificant. Husbands in both groups also had a similar pattern of occupation, with occupational classes 2 and 4 being significantly more represented among the husbands of group A (Table 6).\*

Mothers in group A had on average an almost identical number of children like those in group B. They had given birth to their first baby at a younger age than mothers in group B, but this

difference was insignificant statistically (Table 6).

Results on the Zung depressive scale revealed a difference between both groups, group B mothers obtaining a very highly significant higher score than group A mothers. As to the scores on the Taylor anxiety scale again group B mothers obtained a significantly higher score than group A mothers (Table 7).

**Discussion** Although, controversy still surrounds the definition of failure to thrive, an increasing number of controlled studies show that organic and environmental factors contribute to the aetiology and perpetuation of growth failure in young children (*Bithoney and Dubowitz, 1985; Benoit et al., 1989; Minde and Benoit, 1991*). This suggests that the dichotomy organic vs. nonorganic is both unfortunate and misleading. It also suggests that regardless of possible organic causes, it is essential to examine factors within the caregiving environment that might contribute to the infant's failure to grow. Such "environmental" factors might include a maternal attachment disorder (*Benoit et al., 1989*), maternal psychopathology (*Shapiro et al., 1976; Woolston, 1983*) family overcrowding and poverty, the quality of family and marital relationship, and lack of an adequate social support system (*Bithoney and Newberger, 1987*).

Our results have touched almost all those aspects. Before commenting on the comparison between the two groups of mothers, a reference should be made to the general characteristics of the group as a whole. While some of the characteristics like occupational class, shared residency, illiteracy or low level of education were to be expected in a poor urban area like the one investigated, yet two factors seemed outstanding. First was the attitude of the mothers towards their marriages: Almost half of the sample reported their marriages to be problematic and one fourth did not find a better description except "average". This attitude clearly reflects a dissatisfaction with the institution of marriage as it exists for those women and questions the view that marriage by definition plays a protective role for women, a view that is largely held by society. At least as far as those women were concerned this was not the case. Also, all women without one single exception considered the issue of childbirth and child care

entirely her responsibility. The father was hardly expected to interfere except may be later " when the children bring problems and need someone to control them".

Another point was the prevalence of anxiety and depressive symptoms in the women group as a whole. It is worth noting that none of those mothers thought of seeking help for their insomnia or feelings of oppression. When the question was occasionally posed to some mothers, the answer was usually that these are normal components of a woman's life: who will agree to waste the time, not to mention the money, to go to a doctor and say that she is sad. On comparing the two women groups, two features stood out as significantly different. First was the age which was significantly older in mothers of healthy children. The fact that those mothers might have more experience in raising children could contribute in part to the explanation. However it is not an efficient explanation, as the two groups have started giving birth around the same age and had an almost equal mean number of children. This would raise the possibility that the under five babies of the older mothers in our sample (group A) were probably precious babies, who came at a later age and had been expected or wanted for a longer period of time. The second factor was that related to depressive and anxiety symptoms where mothers of non-thriving children had significantly more symptoms than mothers of thriving children. Two mothers out of group B fulfilled DSM-III-R criteria for generalized anxiety disorder and one mother fulfilled the criteria for a major depressive episode. None of these again thought of seeking neither psychiatric help nor the help of religious or traditional healers, which is commonly resorted to in those areas. While depressive symptoms of those women are frequently referred to childbirth itself, a study done by (Bebbington *et al* 1991) showed that those depressive symptoms do not depend on the obligations of full time childcare, nor follow an oversimplified hormonal theory, but rather are secondary to the effects of social hardships and maladjusted marriages. Also, the failure of the children to thrive cannot be attributed to maternal neglect, especially that those mothers regularly attended the clinic, at least once per month to check the condition of their babies. This link between emotional disorders in mothers and consecutive disorders in

their children has been supported by good evidence in the literature (Richman *et al.*, 1982; Billing and Moos, 1983, Pound *et al.*, 1985). The reasons for this link are not established yet, although Rutter and Quinton (1984) have suggested several possibilities including the influence of maternal emotions on the way the mother and child interact. Maternal depression has been suggested to reduce the quality of the mother child interaction at 19 months (Pearce, 1992). This is because the symptoms themselves may directly interfere with the mother's capacity to relate to the child. In their study on 49 mothers who had depressive disorders in the postnatal year, Stein *et al.* (1991) found a significant association between maternal depression during the postnatal year and reduced quality of mother child interaction, 19 months after the birth of the child. This association held not only for mothers who were still depressed at 19 months, but also for those who had recovered from their depression by then. What are the practical implication of these findings, especially now that social tensions are increasing and the economic adjustment policies in the Third World are accentuating economic hardships and widening the social and economic inequality among social groups. (Markides, 1992). Accordingly, women as a socially-disadvantaged group in society, and in particular poor women, will bear a great proportion of this burden. In our study, other than the encounter they had during the preparation of this study, nobody asked the mothers about their emotional well being after childbirth. Therefore any help that can be provided to those women is best given in primary care, for example by the GP or the midwife or paediatrician who is likely to see the mother and child at the appropriate time. Also, clearly more attention must be given to women's mental health in general and mothers of under five children in particular. The mother should be encouraged to handle her child and express herself as regards any emotional insecurity no matter how trivial. Fathers and other family members should be involved in childcare, not only on an occasional, but on a sharing basis.

We thus conclude that mental health must be brought into the domain of primary health care with particular emphasis on mother and child health. Training curricula for health professionals need to include such issues and

health services need to be developed to respond to this new demand, especially in high risk groups like mothers. The possibility of a screening questionnaire for the early detection of psychopathology should be considered. The ideal structure for this approach is for it to be

undertaken holistically within other considerations such as employment, education, social status, the freedom of women to plan their families, equitable access to economic resources and freedom of self expression. Mental health cannot be viewed in isolation from these factors.

**Table (1): Sociodemographic data of whole group of mothers (n=120)**

Item	Value	
<b>Mean age</b>	30.58 + / - 9.7730	
<b>Occupational Class</b>		
Housewives	106	88.33%
Class 2	4	3.33%
Class3	8	6.67%
Class 5	2	1.67%
<b>Mean Educational years</b>	4.93 + / - 4.7628	
<b>Level of education</b>		
Illiterate	46	38.3%
Reads and writes	24	20%
Primary school	6	5%
Preparatory school	28	23.3%
Secondary school	12	10%
University	4	3.3%
<b>Mean Family size</b>	4.36 + / - 2.4629	
<b>Mean number of rooms</b>	2.15 + / - 0.7740	

**Table (2): Some data regarding marital history (n = 120)**

Item	Value	
<b>Marital Status</b>		
Married	110	91.6%
Widowed	8	6.6%
Divorced	2	1.6%
<b>Mean age at Marriage</b>	21.27 + / - 3.8870 years	
<b>Husband older by</b>	7.73 + / - 5.9228 years	
<b>Educational level of Husband</b>		
Illiterate	34	28.3%
Reads and writes	48	40%
Primary school	0	
Preparatory school	8	6.6%
Secondary school	16	13.3%
University	14	11.6%
<b>Mean educational years of Husband</b>	5.63 + / - 5.3626 years	
<b>Occupational class of Husband</b>		
Unemployed	18	15%
Class 5	12	10%
Class 4	34	28.3%
Class 3	46	38.3%
Class 2	6	5%
Class 1	4	3.4%

**Table (3): Reproductive History of Mothers (n = 120)**

Item	Value	
Mean age at first childbirth (years)	22.85 + / - 4.0783	
Mean Number of children	2.7 + / - 1.9515	
Number of children		
1	42	35%
2-3	48	40%
4-5	20	1.67%
>5	10	8.33%
Number of children less than 5 years old		
1	94	78.3%
2	22	18.3%
3	4	3.4%

**Table (4): Scores on Taylor and Zung Scales for the whole Group of Mothers (N = 120)**

Item	Mean Scores	S. D
Zung Scale for Depression	43.3	+/- 18.22
		no pathological depression
Taylor Scale for anxiety	20.633	+ / - 6.13
		Mild anxiety state
<b>Zung Depression Scale:</b>		
< 50 Scores		No Pathological Depression
50 - 60 Scores		Mild depressive state
61 - 70 Scores		Moderate to Marked depressive state
71 & Over		Severe depressive state
<b>Taylor anxiety scale:</b>		
1-15 Scores		No anxiety
16-25 Scores		Mild Anxiety
26-35 Scores		Moderate anxiety
36 & Over		Severe anxiety

**Table (5): Sociodemographic data  
Comparison between Group A and B**

Item	Group A N = 82	Group B N = 38	t	P
Mean Age (Years)	38.84 +/- 8.1293	31.16 +/- 7.8173	4.9453	< 0.01**
<b>Occupation</b>				
Housewives	92.68%	84.21%		
Class 2	2.44%	5.26%		
Class 3	2.44%	0		
Class 4	0	10.53%		
Class 5	2.44%	0		
Mean Number of family members	4.44 +/- 1.6032	4.84 +/- 2.6358	0.8690	> 0.05
Mean Number of Rooms	2.15 +/- 1.6032	2.15 +/- 0.7543	0.0773	> 0.05
Mean Number of Educational years	4.88 +/- 4.8899	5.05 +/- 4.4899	0.1926	> 0.05
<b>Level of education</b>				
Illiterate				
Reads & Writes	36.59%	36.84%		
Primary School	21.95%	15.79%		
Prep. School	4.88%	5.26%		
Second. School	21.95%	31.58%		
University	9.76%	10.53%		
	4.88%	0		

**Group A:** Mothers of normally growing babies

**Group B:** Mothers of babies with improper growth chart

**\*\*;** Highly significant

Table (6): Marital History

Item	Group A N = 82	Group B N = 38	t	P
<b>Marital State</b>				
Married	95.12%	84.21%		
Widowed	4.88%	10.53%		
Divorced	0	5.26%		
<b>Mean age at marriage</b>	20.78 +/- 6.2480	21.31 +/- 3.6325	0.5899	> 0.05
<b>Husband older by (Mean)</b>	7.95 +/- 6.2299	7.32 +/- 5.2510	0.5803	> 0.05
<b>Mean Number of educational years of Husband</b>	5.98 +/- 5.5131	4.89 +/- 4.8868	1.0858	> 0.05
<b>Level of education of Husband</b>				
Illiterate	26.83%	31.58%		
Reads & Writes	39.02%	42.11%		
0	0	0		
Primary School	7.32%	5.26%		
Prep. School	12.19%	15.79%		
Second. School	14.63%	5.26%		
University				
<b>Occupational Class of Husband</b>				
Unemployed	14.63%	15.79%		
Class 5	9.76%	10.53%		
Class 4	31.71%	21.05%		
Class 3	34.15%	47.37%		
Class 2	7.32%	0		
Class 1	2.44%	5.26%		

Table (7): Reproductive History

Item	Group A N = 82	Group B N = 38	t	P
<b>Mean Number of children</b>	2.7317 +/- 2.0730	2.7895 +/- 1.6629		
<b>Mean Age at first childbirth</b>	22.54 +/- 3.7191	23.53 +/- 4.7462	1.1341	> 0.05
<b>Mean number of under fives</b>	1.17 +/- 0.6830	0.0017	0.5803	> 0.05

Table (8): Scores on Zung and Taylor Scales

Item	Group A N = 82	Group B N = 38	t	P
<b>Scores on Zung</b>	38.8049 +/- 17.7433	55 +/- 15.4290	5.0949	<0.001***
<b>Depression Scale</b>	no depres.	mild depres.		
<b>Scores on Taylor</b>	20.2682 +/- 6.0247	23.4211 +/- 6.3783	2.5630	< 0.02
<b>Anxiety scale</b>	mild anxiety	mild anxiety		

\*\*\* very highly significant



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## بروفيل نفسى إجتماعى للامهات التى لم يقدر لأطفالهن البقاء على قيد الحياة

تتغير مظاهر إستجابة الأطفال لمعاناة الأمهات بتغير سن الطفل ومرحلة نموه. فقد يلجأ المراهقون إلى ترك المدرسة أو الاعتماد على الكحول أو المخدرات، أما الصغار فقد لا يستمرون فى الحياة.

وقد قدرت اليونيسيف نسبة وفيات الأطفال مادون الخامسة فى مصر بمقدار ٩٤ فى الألف. وإزاء عدم كفاية الرعاية الصحية الأولية للأم وكذلك العناية بالطفل فى وحدات رعاية الطفولة والأمومة تصبح مسألة العلاقة بين فشل الطفل فى البقاء على قيد الحياة والتكوين النفسى للأم، أمراً جديراً بالبحث.

وتبحث الدراسة الحالية مسألة العلاقة بين المرض النفسى للأم ودرجة بقاء أطفالهن على قيد الحياة، وذلك فى سياق الإطار الإجتماعى الإقتصادى ومدى توفر الخدمات الصحية لهؤلاء الأمهات.