LEVELS OF STRESS AND COPING STRATEGIES USED BY THE PARENTS OF MENTALLY HANDICAPPED CHILDREN

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DECLARATION

Certified that the dissertation entitled " **Levels of Stress and Coping Strategies Used by the Parents of Mentally Handicapped Children**." submitted by Sunil Kumar is in partial fulfillment of the requirements for the award of the degree of **Master of Philosophy** of this university. This dissertation has not been submitted for any other degree of this university or any other university, and is his own work.

We recommend that this dissertation may be placed before the examiners for evaluation.

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Dedicated to all for whom

I am important !

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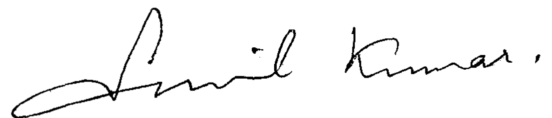

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ABSTRACT

This study was designed to investigate different levels of stress and coping strategies used by the parents of mentally handicapped children. The study looked at whether parents of mentally handicapped children differ in their levels of stress, resource utilisation and use of different coping strategies across two age groups of the children studying in special school. Also, to know about the relationship existing between levels of stress and use of different coping strategies.

It was assumed that as the age levels of children vary there might be some variation in the levels of stress and coping strategies used by the parents.

A correlational research design was employed. The sample was selected from one special school in Lajpat Nagar. Size of the sample was one hundred parents.

For the purpose of data collection following tools were used :-

1. Demographic Questionnaire (Parents Personal Information Sheet.)
2. Questionnaire on Resources and Stress (Short- form)
3. Coping Strategy Scale (COPE – Scale)
4. Interviews with ten parents

Data were statistically analysed using standard deviation, correlation analysis, mean and t-test. General conclusions were drawn from the details provided by the parents during interviews.

Following were the conclusions of the present study:-

1. Mothers expressed more stress than fathers on Questionnaire on Resources and Stress.

2. All the four factors of Questionnaire on Resources and Stress are highly correlated with one another.

3. Parents of younger children expressed more stress in comparison to older children.

4. Parents working outside expressed less stress than those who were living with the children all the time.

5. Active coping, religiosity and support from outside the family were the prominent coping strategies used by the parents.

6. Mothers and fathers were not significantly different in their use of different coping strategies.

Some limitations of this study were that both the parents of the same child could not be included, effect of gender of children could not be examined and nature of disability also could not be thoroughly examined.

Chapter I

Introduction

CHAPTER - I
INTRODUCTION

The Changing Conception of Mental Retardation

The 1992 American Association on Mental Retardation definition and classification system is different from the previous classification system in that (a) a single diagnostic code of mental retardation is used if the person meets the three criterion of age of onset (18 or under), significantly subaverage abilities in intellectual functioning and related limitations in two or more adaptive skills areas, (b) the persons strengths and weaknesses are described in reference to form dimensions. Intellectual functioning and adaptive skills, psychological and emotional well beings; health, physical well being and etiology; and life activity environments; (c) a profile of needed supports is developed across the four dimensions.

The concept of mental retardation and its definition have undergone numerous changes in terminology, IQ cut off level, and the diagnostic role of adaptive behaviour over the last four years. Each change has reflected the fields continuing attempt to develop a clearer understanding of the condition of mental retardation and to implement a more precise and applicable terminology, classification and rehabilitation oriented system.

Since 1983 when the last terminology and classification manual was published by Grossman (1983), there has been a significant paradigm shift within the field of mental retardation. An essential element about that shift relates to the conception of mental retardation not as an absolute trait expressed solely by the person, but as an expression of the functional impact of the interaction between the person with limited intellectual and adaptive skills and that persons environment. (Baumeister 1987).

The new emerging conceptualisation of mental retardation necessitates two significant changes in ones thinking. First, exclusively person referenced categories

based on only one aspect of the person (e.g. level of severity of mental retardation) are not sufficiently descriptive or predirective to fully characterise individuals with mental retardation. Second, the new emphasis on actual functioning requires greater clarity in describing those adaptive skills and limitations that influence everyday living, thus resulting in the need to identify the specific adaptive skills areas considered critical for coping with ones environment.

According to the changing trends that have coalesced into a fundamental redifinition of services that reflect person-centred planning and a functional support model within the community. So, the new conception of mental retardation also relates directly to the patterns and intensity of the individuals needed supports.

Luckasson et al (1992) have shown a diagramatical presentation of this paradigm shift. They have mentioned that this paradigm shift focuses attention on the three key elements of the current conception of mental retardation; capabilities, environments, and functioning. In this triangular presentation functioning is the basis of the triangle to emphasise that the 1992 system is primarily a functional model. Capabilities are shown on the left side of the triangle to indicate that functioning in mental retardation is specifically related to limitations in intelligence and adaptation skills. The right side of the triangle represents the environments in which individuals with mental retardation live, learn, play work, socialise and interact. The model also shows that support reflect how the person functions and that the presence or absence of supports can influence functioning reciprocally. The equilateral nature of the triangle indicates that a description of all three aspects is necessary for a full understanding of the concept of mental retardation.

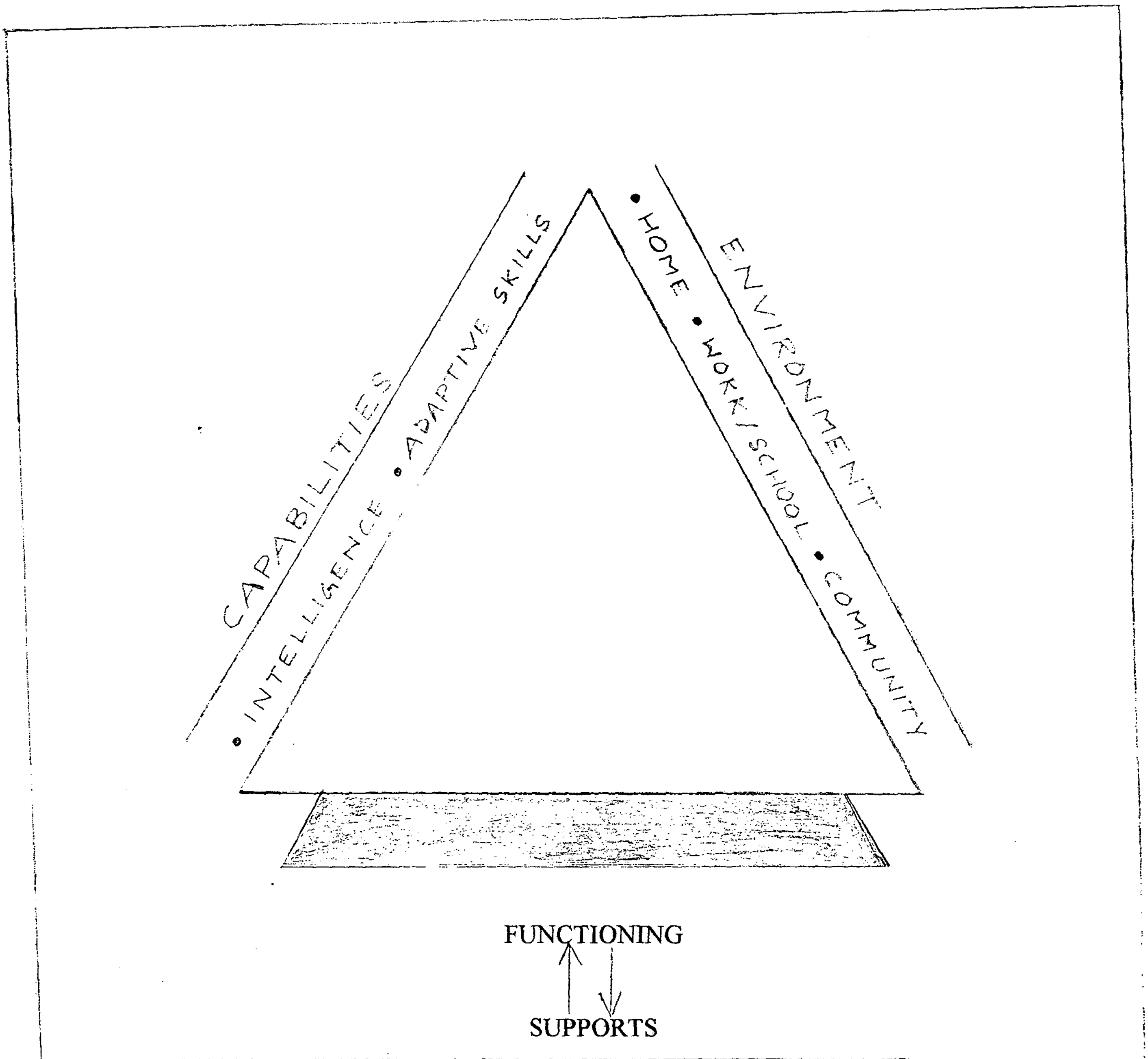


FIGURE 1 : General structure of the definition of mental retardation by Luckasson et. al. (1992)

In 1992, American Association on Mental Retardation adopted a new definition and classification system based on the changing conception of mental retardation which refers mental retardation as -

> "Substantial limitations in present functioning. It is characterised by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skills areas; communication, self-care, home living, social skills, community use, self direction, health and safety, functional academics, leisure and work".

There are four essential assumption regarding the application of this definition :

1. Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioural factors.
2. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individuals age peers and is increased to the persons individualised needs for support.
3. Specific adaptive limitations often contrast with strengths in other adaptive skills or other personal capabilities and,
4. With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

The 1992 system involves a three step process that includes the diagnosis description of individual strengths and weaknesses and identification of needed supports.

Step One - Diagnosis of Mental Retardation

Mental Retardation is diagnosed if :

A. The individuals intellectual functioning is approximately 70-75 or below.

B. There are significant related limitations in two or more adaptive skills areas.

C. The age of onset is 18 or below.

Step Two - Classification and Description –

A. Describes the individuals strengths and weaknesses in reference to psychological/emotional considerations.

B. Describe the individuals overall physical health and indicate the condition etiology.

C. Describe the individuals current environmental placement and the optional environment that would facilitate his/her continued growth and development.

Step Three - Profile and Intensities of Needed Supports –

Identifying the kind and intensities of needed supports for each of these four dimensions -

A. Intellectual functioning and adaptive skills.

B. Psychological/emotional considerations.

C. Physical/health/etology considerations.

D. Environmental considerations.

The above mentioned approach is different from the previous AAMR classification in the sense that,

1. A single diagnostic code of mental retardation is used if the person meets the criteria of age of onset; significantly subaverage ability in intellectual functioning, and related limitations in two or more adaptive skills areas.
2. A multidimensional approach is used to describe the persons strengths and weaknesses and,
3. A profile of needed supports is developed across the four dimensions.

Coulter (1996) have focused on the importance of the etiology of mental retardation and he has tried to rethink the etiology and prevention by relating them to a paradigm of support. He proposes following reasons for the etiology being important for practice and research –

A. The etiology itself may be treatable as in Phenylketonuria.

B. The etiology may be associated with the other conditions that are treatable (e.g. heart disease associated with Downs Syndrome).

C. Data on incidence and pretence of various etiologies are needed to design and evaluate efforts at prevention.

D. Classification by etiology facilitates formation of maximally homogeneous classes for research.

Coulter (1996) further explained the changing ideas about the etiology of mental retardation. He states that formerly mental retardation was considered to be a deficit or disorder present only within the individual, then the search for etiology was limited to conditions that could affect the individual. But in recent years these conditions are divided into two categories of etiology. Mental retardation of biological origin which includes biomedical disorders. Such as Phenylketonuria, Down Syndrome, Fragile X-syndrome, or prenatal brain injury. In another category there is mental retardation due to psychosocial disadvantage which includes the effects of adverse financial, cultural and social conditions.

The changing ideas about the etiology has at least two characteristics. One characteristic based on the common clinical observation that individuals with the same biomedical condition often function at very different levels. For example, some people with Down Syndrome may have severe impairments and require extensive or pervasive supports, whereas others with the same biomedical etiology live and work in the community, write books, or act on television. Thus designation of the

biomedical condition alone may not be sufficient to explain the cause of the functional impairment resulting in mental retardation.

Second characteristic is based on the common clinical observation that an etiology is not apparent in many cases. In a review of 13 recent studies of the epidemiology of mental retardation, Mc Laren and Bryson (1987) found that the etiology was unknown in 25 to 40% of the individuals with IQs below 50 and in 45 to 62% of those with IQs between 50 and 70. Most investigators reported only what they considered to be the most likely etiology. In some other studies Mc Laren and Bryson (1987) have mentioned that more than one possible casual factor was present in up to 50% of cases. They observed further that mental retardation often seemed to reflect the cumulative or interactive effect of more than one casual factor and offered the following conclusions :

> "We suggest that a better understanding of all forms of mental retardation will be achieved by the use of multivariate research design. These offered the opportunity to evaluate the relative contributions of psychological and biological factors and the interactions thereof. It might also be fruitful to examine more clinically homogenous groups and to focus on the underlying risk factors rather than simply attributing a casual category"

Furthermore, Scott (1988) argued that from a public health perspective the data do not support separating the etiology of mental retardation into biological and psychosocial categories. He noted that this arbitrary separation must be replaced by a broad bio-psychosocial perspective, using the methods of modern epidemiology to access etiology. Scott (1988) proposed a multiple risk factor approach, in which the risk factors are indicators of statistical identifiers that may direct more basic research toward the discovery of underlying etiological mechanism.

The AAMR defined four categories of risk factors that can exist and interact to cause impaired functioning in persons with mental retardation (a) biomedical factors that relate to biological processes e.g. nutritional or genetic disorders, (b) social factors that relate to social and family interaction; (c) behavioural factors that relate to potentially casual behaviour (such as injuries or substance abuse), and (d) educational factors that relate to the availability and adequacy of educational support.

Luckasson et al (1992) have noted that these risk factors can exist and interact in different generation to cause mental retardation. Thus factors present in one generation (e.g. parental experiences of childhood, poisoning, malnutrition, or abuse) can potentially influence the development of the next generation and result in mental retardation.

Luckasson et al (1992) have developed a multidimensional model to explain the etiology and prevention of mental retardation. This model demonstrates how multiple categories of risk factors exist in different generations, including the parents of the person with mental retardation. This model provides following types of presentation -

(A) Primary - Prevention of the condition

(B) Secondary - Prevention of the disabling effects of an established condition.

(C) Tertiary - Minimising the disabling effects of an established condition and prevention of secondary condition related to disability.

In general primary prevention is the most difficult but also the most effective type of prevention activity. Secondary prevention receives much attention and can be effective in many cases. Tertiary prevention deserves more attention and can be accomplished in the context of comprehensive care for individuals and families.

Coulter (1996) in his paper have mentioned about another new way of thinking about what mental retardation is and about what causes it. This new

approach is known as the functional approach to understanding the nature of mental retardation emphasises the interaction between individual capabilities and the environments in which individuals live, learn work, socialise, interact and recreate. In this approach mental retardation is a consequence of both individual limitations and environmental limitations.

This new approach to prevention can be described as ecological because it incorporates two separate components -

(1) an ecological understanding of how the interaction between individuals and their environments result in mental retardation and

(2) an ecological understanding of how risk factors from multiple dimensions interact across generations in mental retardation.

While criticising the 1980 definition of American Association on Mental Deficiency Baumeister (1987) expressed that the definition reflects the view that intelligence is a general and primary unitary attribute. The intense and sometimes acrimonious debate over the nature of intelligence has profound implications for defining mental retardation.

He has further pointed out the thorny issue that intelligence tests are biased against minority children and these tests are banned in California. Special Education Classes only because they express a history of 'racial prejudice'; 'Social Darvinism' and the use of 'scientific mystique' to legitimate such prejudices.

While concluding his arguments Baumeister (1987) mentioned that about the recent history of behavioural research in mental retardation which provides a two layer conclusion. The issues of behavioural and cognitive expression of mental retardation are enormously complex and that a new conceptualisation of this human condition is needed. If Psychologists have to search for a theoretical understanding and a narrow one, then have to raise the performance levels of children and adults. If

there is the problem of identification that who is at risk and to intervene effectively then one should enhance an individuals ability to adapt generatively. If the problem is to understand how language, social and cognitive processes interact and combine, across ages and disabilities to produce good or bad adaptation - then one should use the combination of all the methods available, including experimental analysis, direct observation, laboratory studies and structured observation. He has complaints that the dominant systems of definition and classification have not changed radically over the past two decades and the focus continues to be on subaverage general intelligence and deficits in adaptive behaviour which is a person oriented conception basically. Baumeister (1987) have suggested that after bringing together the recent developments in the legal-social sphere with a greatly enlarged scientific knowledge base it can be expected about increasing pressure to fundamentally revise the conceptions of mental retardation; which will lead to new methods for valid diagnosis and classification. It can be anticipated that classification system will emerge with a much more balanced emphasis on both the individual and the demands and constraints of specific environments. In his own words, "mental retardation is more than failure to behave appropriately, certainly it is more than an individuals psychology. Mental retardation is rooted in our culture and in our biology. Simplistic unidimentional models of research, intervention and policy will never be adequate if our society is ever to come to grips with this most complex and difficult problem" Baumeister (1987).

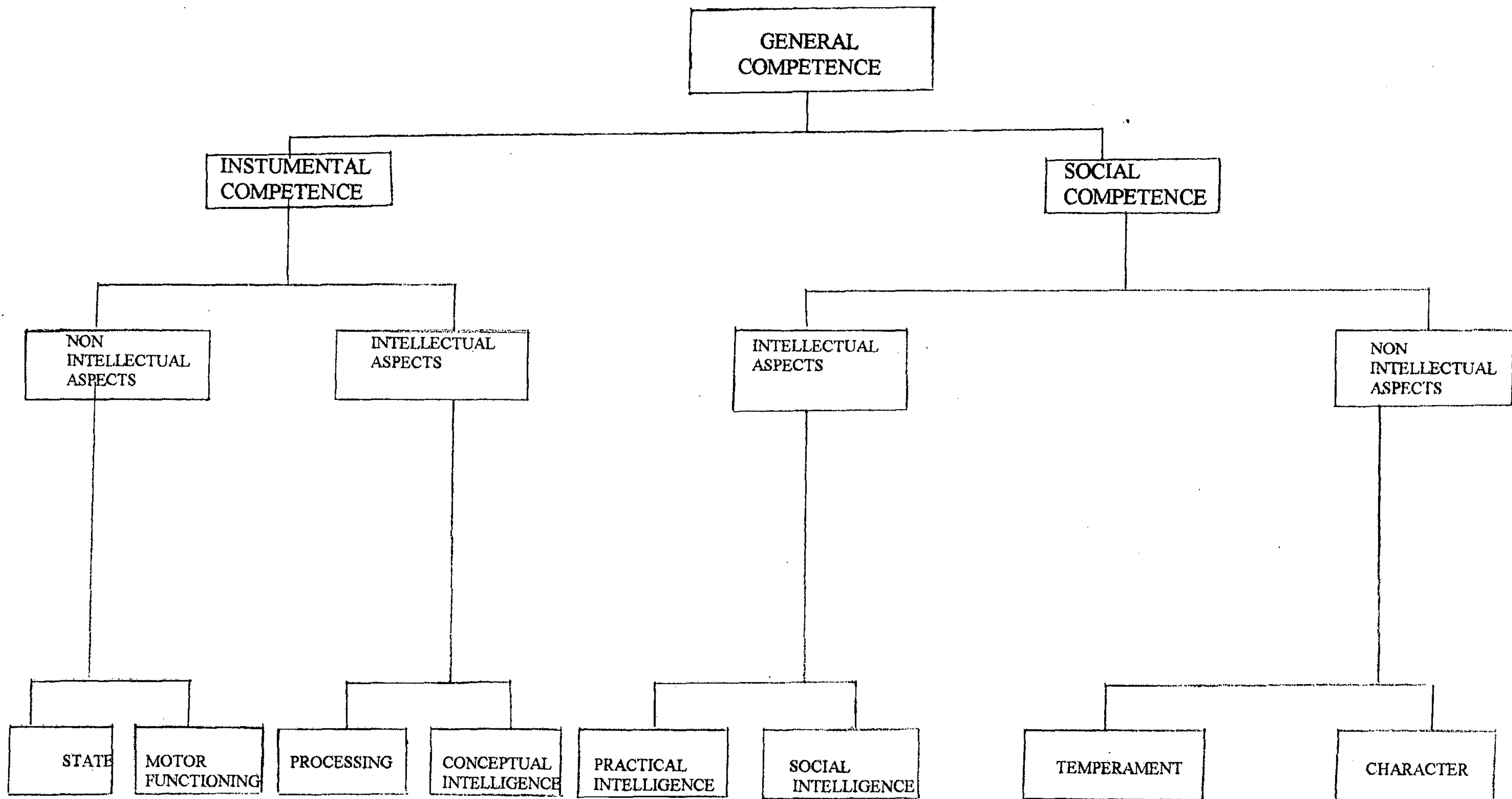
The first attempt to broaden the concept of mental retardation drew inspiration from the epidemiological findings that mental retardation, unlike other nonfatal conditions, decreases in absolute prevalence after adolescence. This suggests that the inability to perform certain crucial social roles (e.g. worker, friend, neighbour) more than the inability to master academic tasks (e.g. reading and writing) is what ultimately determines whether or not someone with low IQ is seen as really belonging to the class of persons with "mental retardation". This was an attempt by Heber (1961) which may be seen as to forge a synthesis between the modern use of

psychometric technology (as presented by the IQ) and the pre-20th century reliance upon intuitive judgement in determining who among one's neighbours had difficulty functioning in age-appropriate social roles.

Greenspan and Granfield (1992) have described a model of social competence. They seem to be influenced by Doll, who wrote as early as 1936.

Doll (1936) in his presidential address to American Association on mental deficiency challenged the use of Binet intelligence test as the sole diagnostic criterion of mental retardation. He argued that the concept of Mental age did not adequately reflect the social aspects of an individuals functioning. Doll (1936) believed that one must broaden the concept of intelligence to include those aspects of social functioning that truly distinguish individuals at different levels of mental retardation. He further cited that these different levels were not gradients on a continuum but they fluctuated on the basis of ones social maturity. Degree of social incompetence was more important than of impaired intellectual ability. So, it was possible for Doll (1936) to reject the diagnosis of mental deficiency for individuals with mental retardation if the individual had normal social competence.

Greenspan and Granfield (1992) have critiqued the earlier classification proposed by the American Association on Mental Deficiency which is based on IQ level of the individual. They have focused their attention on social competency of the individual and have proposed the following social competency model -


GENERAL COMPETENCE
INSTUMENTAL COMPETENCE
SOCIAL COMPETENCE
NON INTELLECTUAL ASPECTS
INTELLECTUAL ASPECTS
INTELLECTUAL ASPECTS
NON INTELLECTUAL ASPECTS
STATE
MOTOR FUNCTIONING
PROCESSING
CONCEPTUAL INTELLIGENCE
PRACTICAL INTELLIGENCE
SOCIAL INTELLIGENCE
TEMPERAMENT
CHARACTER

They have suggested that only the intellectual aspects of social competence (practical and social intelligence) and of instrumental competence (IQ and information processing) would be included in the diagnosis of mental retardation. Non intellectual aspects of general competence, although useful for training/rehabilitation purposes, or for identifying other disabling conditions, should not be viewed as relevant to a diagnosis of mental retardation.

While concluding it may be said that mental retardation is a kind of disorder occurring during the developmental period which has the characteristics of broad deficits in the practical and social intelligence (the intellectual aspects of social competence) and in conceptual intelligence and information processing (the intellectual aspects of instrumental competence). Individuals may be at risk for deficits in non intellectual aspects of social competence. Such deficits may not necessarily be present and are not essential for an appropriate diagnosis while keeping the aspect of IQ in mind as a primary deficit the traditional definition of mental retardation can be defined as a condition marked by deficits in three broad areas of intelligence – social, practical and conceptual.

An alternative conceptualisation of mental retardation may be derived by the interaction between trait based and an outcome based approach. This type of approach can specify those aspects (i.e. intelligence broadly defined) that are central to the diagnosis, while avoiding some of the problems inherent in using a more molecular or psycho metric approach. An outcome orientation toward designing someone as "normal" or "disabled" emphasises the individuals relative ability to succeed independently in playing important social roles and to function effectively in normative social settings (Greenspan and Granfield, 1992).

The Nature and Concept of Stress

Whenever we feel that in the path of our biological and psychological needs there are many obstacles and we are unable to overcome. In that condition the mental trauma which we face is known as stress.

This concept was for the first time introduced in the life sciences by Hans Selye (1936). This concept is actually borrowed from the natural sciences. Word stress is derived from the Latin word 'stringere', and was popularly used in the seventeenth century to mean handicap, strain, adversity or affliction.

Selye (1956) has defined stress as any external event or any internal drive which threatens to organismic equilibrium is stress.

The state of stress exists when unusual and excessive demands threaten the situation and there is danger that coping capacities will be overwhelmed with the consequence of disturbed functioning pain or anxiety, illness or even death. Stress is defined neither by the condition acting on the person (the stressor), nor by the state of the person (coping resources, ego strengths etc.), nor by his reactions (stress response), but rather by the interplay of the three. The intensity of the same stressor is different for different individuals. Stress can originate in physiological, psychological and social conditions and can threaten the integrity of the body, the personality or the social system.

According to Rabkin and Struening (1976) stress can be defined as the individuals response to the strains of life, demanding events, or crisis consisting of a pattern of physiological and psychological reactions that can be both immediate and delayed. Marital problems, parental worries and family problems are some of the resources that can be considered as indicators of high levels of stress. (Bristol et al. 1979).

There are some models which explain the changes and growth in the family life cycle. Hills (1949) ABCX model has served as the foundation for the development of family stress theory. Although Hills (1949) model described families reaction to stress but it has some of the limitations that first its consideration of only negative outcomes and considerations of adjustment at only one point in time. Remarkable resiliency is demonstrated by the families in stressful conditions both to ordinary daily "hassles" and extreme unexpected crisis. A model that predicts only negative post crisis is complete.

According to some other models like Mc Cubbin and Patterson's (1982) Double ABCX or family adjustments and adaptation response and Crnic etal. (1983), Adaptation model for families with children who have mental retardation, that highlight the role of coping behaviour in mediating the impact of stress.

Such models suggest that stress can lead to family distress, but also allow for the possibility that stress may result in more sophisticated family functioning if coping resources are sufficient.

Types of Stress : Frustration and Pressure

Frustration occurs when ones desires are blocked either by obstacles that stop progress toward a desired goal or by absence of an appropriate goal. There is a wide range of obstacles that lead towards frustration like inflation, group prejudice and discrimination etc. Physical handicaps, lack of needed competencies, an inadequate self control are some sources of frustration that can result from our personal limitations.

Sometimes it becomes a necessity to chose between needs or goals. In that condition conflict develops. Usually the choice of one alternative means frustration with regard to the other.

Pressure as a type of stress :- In general pressure force an individual to speed up, intensify or change the direction of goal oriented behaviour.

Pressures are harmful for our general well being and if become excessive, they may lead to physiological abnormalities and breakdown. Pressure to some extent is acceptable because it enhances our performance, but a person should avoid the extreme of it.

To distinguish psychological stress from other types Lazarus (1966) introduced a concept of an intervening variable of threat – a state in which an individual anticipates a confrontation with a harmful condition of some sort, that radically changed the social psychological understanding of the interaction between the individual and environment. Very recently a scientific paradigm with neurotic usefulness and conceptual soundness has been designed by Lazarus and his associate. (Cohen, 1977).

Stress implies a particular kind of relationship between individual and environment. Cognitive phenomenological analysis of this commerce reveals several varieties of relationship that occur between the person and the environment. They are being mediated by cognitive appraisal process. This relationship refers neither to person nor environment as separate sets of variables but there is an equilibrium of environmental demands (external events that impose adaptive requirements) or internal demands (desirable values, goals, commitments programmes or tasks built into or acquired by an individual) exceed the resources of a person.

Factors affecting the Severity of Stress :

According to Korchin (1965), there are some general classes of stressful situations which can be distinguished as :-

1. Uncertainty and Under-stimulation - If a person is highly motivated or anxious, in that condition, ambiguous and vague situations are a powerful

source of stress. When animals or man come suddenly into contact with a new and unknown situations and whether danger is present or not, has been found to be disturbing in the studies of sensory deprivation. Because of the complete lack of stimulation several gross emotional and behavioural disorganisation's can occur.

2. Information Overload – When an organism is flooded with intense competing, and demanding stimuli then he faces stress, because our capacities to process information and act discriminatively is still very limited. Condition of distraction time, pressure, excessive stimulation, or multiple tasks are all illustrations of information overload.

3. Danger – Whether existing or anticipated either to physical well being or the satisfaction of central needs is an obvious source of threat.

4. Ego-Control Failure – The important function of the ego system is to control the primitive impulses. Whenever a threat is given to the capacity of control, as in the situations of temptation or drive arousal, it becomes stressful.

5. Ego-Mastery Failure – 'Mastery' in a situation intends towards moving forward the personality view which emphasises the exercise of competence or Maslows (1967) concept of self-actualisation is worth to take it differently. If an individual is blocked from being mastering new goals, developing and exercising new talents, even without threat to present context or well being can be an important source of stress.

6. Self-esteem Danger – The importance of the self esteem suggests separate emphasis for situations which lower a persons view of himself. In experimental studies of stress there are often continued failures in seemingly important tests.

7. "Other" Esteem Danger – A parallel source of stress is threat of losing the love and affection of others, being ridiculed, being rejected, or thought unworthy.

Selye (1946) have proposed a very comprehensive model to explain the organisms mental and physiological state when he confronts the stressful situation. This model is known as 'General Adaptation Syndrome'. Basic conceptions of GAS are as follows :-

1. **Alarm Reaction** – In the initial phase of this stage which is called as 'initial shock phase' where different defence mechanisms become active. The basic characteristics of alarm reaction are autonomous excitability, adrenaline discharge, increased heart rate, increased muscle tone and blood content and gastrointestinal ulceration. Nature and intensity of the threat and the condition of the organism decide the period of resistance and the security of the symptoms may vary from 'mild invigoration to 'disease of adaptation'.
2. **Stage of Resistance** – In this second stage of stress reaction maximum adaptation and resistance is found. All the above mentioned bodily reactions of the 'alarm reaction' stage disappear. Resistance is found to be above normal in this stage.
3. **Stage of Exhaustion** – In this stage after a long resistance stage if organism still do not feel any improvement then the adaptation energy is gradually exhausted. Symptoms of the 'alarm reaction' reappear and the resistance levels begin to decline irreversibly. Finally the organism collapses.

The Nature and Concept of Coping :

Lazarus (1974) have defined coping as "a concept used to denote the way of dealing with the stress, or the effort to 'master' the conditions of harm, threat or challenge when a routine or automatic response is not readily available".

These are two different concepts coping traits and coping strategies. Coping traits denote some stable way of dealing in stressful situations where coping styles denote to a broader, more surrounding quality. But both traits and styles are fundamentally similar ideas. Coping strategies refer to a characteristic way of

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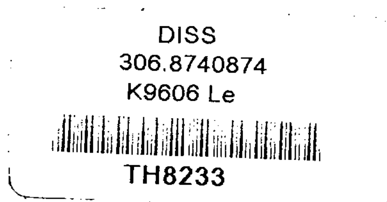
handling stressful situations. They are stable characteristics which provide a base to know about an organisms particular way of handling a stressful situation. Psychologists have identified two major ways of dealing with a stressful events. According to first approach a person under stress may decide to deny and suffer passively the stressful event, this is known as the "passive approach". According to another which is called as 'active approach', where organism decides to face the realities of experienced stress and attempts of clarify the problem by negotiating it with other members. (Pareek, 1983).

Moos and Billings (1982) have described different dimensions of appraisal and coping used in measurement procedures into three categories -

1. **Appraisal** – focused coping – In this dimension the organism tries to provide a meaning to the situation, and may adopt coping strategies like logical analysis and cognitive redefinition.
2. **Problem** – focused coping – This coping dimension seeks to modify or eliminate the source of stress to deal with the tangible consequences of a problem or actively change the self and develop a more satisfying situation.
3. **Emotion** – focused coping – In the third dimension there are some responses whose primary function is to manage the emotions around by stressors and thereby to maintain effective equilibrium.

These categories are however not mutually exclusive. Their primary focus is on weighing and understanding the situation and coping successfully with the realities of the situation.

According to Lazarus (1984) in stressful encounter there are three processes involved :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First is primary appraisal when organism perceives the situation as a threat to himself. The person evaluates whether he or she has anything as a resource in this encounter. For example, is there potential harm or benefit with respect to commitments, values, or goals? Is the health or well of a loved one at risk? Is there potential harm or benefit to self esteem? In secondary appraisal the person evaluates the situation first then tries to find out that what can be done. He may try to overcome or prevent harm or to improve the outlook of the world for benefit. The individual tries to find out different options regarding coping strategies. For example the option may be altering the situation accepting or receiving more information or holding back from acting improductively and in a counterproductive way. Primary and secondary appraisals converge to determine whether the person environment transaction is regarded as significant for well being, and if so, whether it is primarily threatening or challenging.

The above mentioned two dimensions may not necessarily be exclusive, in types or areas, activities of cognition. These dimensions may be overlapping in occurrence, happening simultaneously.

The secondary cognitive appraisal involves three main classes of factors:

1. The quality of the event and its degree.
2. The factors in the stimulus configuration or situational variables.
3. The factors within the psychological structure of the individual.

Secondary appraisal influences the primary appraisal by reducing or increasing individuals perception of the quality of the event and its degree apart from the determination of the nature and pattern of coping technique to be, or not at all to be, exploited. The secondary appraisal on account of being oriented to possible coping resources and options and the consequences, influences the primary appraisal process itself, thus mitigating or enhancing threat or the sense of harm and in effect shapes coping activity (Lazarus 1966, 1979).

According to Lazarus (1979) there is clear distinction between coping and adaptation because in coping circumstances organism finds himself in a situation for which the appropriate, sufficient response is unclear, unavoidable, difficult to mobilise or its adequacy doubtful. Lazarus and his associates have been emphasising coping in this sense by explaining it as consisting of efforts both action oriented and intrapsychic to manage (i.e. master, tolerate, reduce minimise) environmental and internal demands, and conflicts among them, which is labelled as a person resources.

There are two major functions of coping strategies. The first function is known as "instrumental function" where there is the process of the nature of problem solving and attending to or managing the situation. In this context the situation may contain the problem event the environment and the individual himself. The second function is known as "palliative function" which has the nature of management and regulation of somatic and subjective components within oneself.

Lazarus and Launier (1979) have suggested four types of coping modes. Each of these modes of coping serves both problem solving and emotion-regulatory functions, each mode is capable of being oriented to self or environment and each is concerned with either past, present, or future.

1. First type of mode is information seeking which provides a basis for action to change the transaction or to make the person feel better by making transaction seem more under control.
2. Direct action means all the overt actions to handle the stressful event. Examples may be like building storm shelters, to protect against tornadoes, or to design to regulate an emotion by taking drug and alcohol.
3. Inhibition of action aims at an accord with environmental and intrapsychic characteristics with holding strong natural impulses to act.

4. Intrapsychic processes consist of cognitive processes defined to regulate emotion such as self deception mechanisms as well as detachment from a threat to achieve a feeling of having acquired control over it.

According to Carver et al. (1989) there may be following dimensions of coping:

1. Active coping is the process of taking active steps to try to remove or circumvent the stressor by taking direct action and by increasing ones efforts etc.
2. In planning individuals think about what steps to take and how to handle the situation. This is a kind of problem-focused strategies. Another aspect may be suppression involvement in competing activities or individual may suppress the processing of competing channels of information in order to concentrate more fully.
3. In the suppression of competing activities people put other things aside that can distract them in coping with the stressor.
4. In restraint coping individual waits until an appropriate situation arises when he can cope effectively with the stressor. This may be both active and passive coping planning in the sense that individuals do not respond prematurely and is passive in the sense that they wait for the appropriate situation to arise for the response.
5. In the fifth category there is seeking support for instrumental reasons like seeking advice, assistance or information etc.
6. Another strategy is seeking social support for emotional reasons where individual gets involved in moral support, sympathy or understanding. But often this strategy is used for ventilating ones feelings towards some individual.
7. Other strategy is focusing on and venting of emotions where there is tendency to focus on the kind of distress one is feeling and releasing those feelings,

e.g., in the beginning an individual mourn the death of a loved one but after some days he tries to accommodate with the circumstances.

8. Behavioural Disengagement is very similar to helplessness where individual even tries to avoid those activities which can lead to a solution. In behavioural disengagement organism stops taking active attempts.

9. In the mental disengagement coping strategy people engage themselves in alternative mental and other activities to avoid mental distress like, day dreaming, escaping through sleep, or immersion in T.V. Although mental disengagement in coping is sometimes highly adaptive behaviour but often it leads to more distress.

10. Positive reappraisal is a type of emotion focused coping in which there is the goal of managing distress emotions instead of dealing with the stressor.

11. Denial is sometimes found to be useful in minimising stress and thereby facilitates coping. But sometimes it can create additional troubles if the stressor is not profitably ignored. Often denying the event allows it to become more serious and making more difficult the coping. In early stages of transaction it may be useful but it impedes coping later on.

12. Acceptance is a coping style which is opposite to denial. In acceptance a person accepts the reality of a stressful situation and makes an attempt to deal effectively with the situation. In acceptance there are two aspects of the coping process as (1) acceptance of a stressor as real is a primary appraisal (2) acceptance of a current absence of active coping strategies. In the accommodating kind of circumstances a person might expect acceptance to be particularly important.

13. In the last strategy we can include turning towards religion where religion might serve as a source of emotional support, or as a positive reinterpretation and growth or as an active coping.

Mental Retardation : In Brief Historical Perspective :

If we look into the history of mental retardation then we find that the persons who were examined for diagnosis of mental retardation were unable to adjust properly in their culture and social life and they were called as stupid, dumb imbecile and not given proper place in the society.

Tredgold (1952) have mentioned that before the beginning of nineteenth century nothing was being done for the welfare of the identified mentally disabled people. Itard, a French educationist found a child in the forest of Aveyron in 1798, who used to behave like animals. Pineal, a physiologist examined the child and identified him as an "idiot" and told that he will not be able to getting education and learning. Itard (1801) spent a lot of labour to train the child and to some extent the child learnt to speak but lacked confidence.

He had deficiency of social and emotional adjustment. Finally Itard concluded that this child was not reared properly and had some innate difficulties.

After the publication of this study some scholars like Voisin, Esquirol et al were attracted towards the problem of mental deficiency. At that time Seagart in Berlin and Guggenbohl in Switzerland started treatment of this mentally retarded children. Seguin (1846), the pupil of Itard, started the task of providing education to a mentally backward child. Later on Segiun had taken the responsibility of educating mentally retarded children. After his effort many children did show an improvement.

But intelligence tests actually developed scientifically in France – Alfred Binet was the first person to measure intellectual deficit in mentally handicapped children. He developed the first intelligence scale known as Binet – Simon scale in 1905.

The most acceptable definition of mental retardation was proposed by the American Association on Mental Deficiency. It was defined by the AAMD as

"Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period" (Grossman, 1983).

This definition denotes a level of behavioural performance without reference to determining factors – which may be biological, psychosocial or socio-cultural in nature or a combination of the above three. Major terms which are used in the definition are:-

1. **General Intellectual Functioning** – This refers to an intelligence quotient and the scores obtained on an individually administered intelligence test.
2. **Deficits in Adaptive Behaviour** – Significant hurdles and drawbacks are found in general maturation or major limitations in school learning, personal freedom and social responsibility.
3. **Developmental Period** – Though in earlier AAMD definitions this period was demarcated from birth to eighteen years; the current version extents backward to this conception. The author is unaware as how one can measure general intelligence and adaptive behaviour prior to birth. In the absence of such procedures, it can be presumed that the more traditional period will be accepted, though some biological abnormalities typically associated with mental retardation are detectable before birth like chromosomal disorder and Down Syndrome.

In the 1973 classification four levels of mental retardation have been identified–

1. **Mild Mental Retardation** – In the first category IQ level is found to be between 52-68. Those falling in this category are known as educable. They can reach at least to the adaptation level of adolescents. The number of such retardates is greater.

2. **Moderate Mental Retardation** – In this category IQ level is found to be between 36-51. Generally in the special training centres the children of this category are kept because they are trainable. Its very difficult to teach them but after a deep training they can at least adjust in the normal life of the family. But parental help is must for them.

3. **Severe Mental Retardation** – IQ level of severely retarded children is between 20-35. Children of this category are referred as 'dependants' because they are unable to perform the common self-help skills. Motor and speech disorders are common among these children.

4. **Profound Mental Retardation** – IQ level of these children is below 20. This is the lowest form of mental retardation. Profoundly retarded children have both physical and mental deformities. These children must need hospitalisation and there always has been a low life expectancy.

Significance of the Study :

The present study is mainly concerned with the parents of mentally handicapped children. Different studies whether conducted in the Indian context or in other countries have indicated about different aspects of socio-psychological perspectives regarding families having children with mental disability. It is certainly correct that the entire socio-psychological structure of the family is affected by having this kind of child. Every member of the family has to adjust according to the new demands and circumstances created by this kind of children.

Many studies have shown that family members and especially parents of these children are adversely affected and they experience a lot of stress. Mothers are found to be more stress prove because of different kind of ways of thinking about their children.

So, the present study is an attempt to explore further regarding the perception of stress and different coping strategies used by the parents. This study is also an

attempt to know about the expectations of parents from society, different organisations and different institutions so that their problems can be understood in a better light and something can be done not for only the mental health of children but parents also. Another expectation of this study to explore some of the possibilities that can add something regarding empowerment of these families.

Chapter II

Review of Literature

CHAPTER - II

REVIEW OF LITERATURE

Parenting a child with mental retardation is not an easy job. Parents having a child with mental retardation experience a variety of stressors and stress reactions related to the child's disability. Parents are known to get impacted in many ways because of having a child with mental retardation. These include, parents feeling sad, depressed at various stage of life and experiencing other emotional reactions. Their social life may get affected with recreational and leisure activities getting reduced. Interpersonal relationship with the family members is also adversely affected. Marital harmony gets disturbed owing to various child related reasons such as meeting extra child-care responsibilities and burdens, affecting sexual relationships between parents due to less privacy more fatigue and fear of producing another child with disability. Financial burdens may mount parents' own physical and mental health is reported to be at a greater risk. However, the quality and quantity of the impact experienced may be quite individualised for each of the parents depending upon the nature of support available to them such as emotional, physical and financial support. Other factors such as coping skills of parents themselves, child characteristics such as age, level of mental retardation, presence and absence of associated conditions etc. May also contribute immensely how far parents are able to face the challenge of having a child with mental retardation.

Parents' whole life style gets affected, influencing every aspect of their life including their personal and psychological well being, their careers, other children, family life and routines, relationships with friends, relatives and people in the community. Professionals need to understand the individual needs of each parent in the context to their specific environment and provide individual need based intervention programmes to strengthen the parents in order to constructively contribute in the rehabilitation programmes of their child.

Some families cope better with the situation than others. Research and experience has indicated that approaches which focus on meeting needs of all members of the family are more effective in helping the family to cope with the situation than approaches that focus only on the child with mental retardation. Identifying and supporting the parents in their efforts to meet the needs of all the family members (including themselves) is one of the most efficient way of developing parental skills and which can enhance the development of all family members.

It was found that siblings who have brother's sisters with mental retardation experience number of special concerns and hence special needs. This stresses the fact that we no longer can afford to exclude the siblings when services are provided to the child or the family. In a country like India where there is dearth of formal support services, intervention efforts should lay emphasis on strengthening the informal sources of support.

Lubetskty (1995) have mentioned that to work with mentally handicapped children and their families is challenging and rewarding job. And in the case when these parents have children who have behavioural/psychiatric problems, the challenge becomes far greater. They have suggested the need of an interdisciplinary team for comprehensive assessment, treatment and management in order to be successful in accomplishing goals, providing continuity of case, and supporting the family in the community. In this paper the focus was on the interdisciplinary team concept blended with the family centred approach in a psychiatric setting and provided a case study of a family who had a child diagnosed with mental retardation, autism and severe behavioural problems. Further he has recommended the practical suggestions to demonstrate the implementation of a family centred/interdisciplinary approach.

Shapio and Simonson (1994) in a study have described about the experience and observation based on an ongoing parent education support group for Mexican-

origin Latino parents of children with Down syndrome. Culturally mediated concepts were discussed in terms of their relevance to specific aspects of group functioning, including group structure, membership and leadership. Problems of particular concern to this concept that might adversely affect maintenance and growth of the group were also examined. Finally, the potential value of such support groups for the parent population was considered, as were guidelines for enhancing the group experience.

Herman and Thompson (1995) have observed the factors related to families' perceptions of internal resources when raising children with developmental disabilities. Families enrolled in a cash subsidy programme were surveyed. Parents saw their basic resources for daily life as adequate. However, they reported that time discretionary money, and child-care resources were not adequate for caring their children. Helpfulness of social support, the children characteristics, and income were related to perception of resource adequacy. Findings have suggested that support services must be flexible in the types and amount of services provided.

Rogers and Dulan (1998) examined the role of religion an its relation to adjustment for 52 African-American care givers who had a child with mental retardation. They mentioned that comparative studies of cultural/ethnic contexts of families with a child who has disabilities often cite religion as a salient factor in family adjustment. This finding was expanded upon through (a) a focus on the African-American populations, (b) the relation of adjustment to religious experiences considered relevant to most African-American families, and (c) documentation of the validity and reliability of the participants' responses to the Religious Contentedness Questionnaire. Religion in personal, family life and church support were related to positive outcomes in adjustment. Analysis of open-ended responses co-validated the quantitative outcomes.

Patching and Bill (1993) have describe a study that adopted an interpretativist paradigm as a basis for parents and researchers to co-create a

discourse that outline life experiences as they relate to parenting a child with an intellectual disability. 52 families participated in this study. Parents ranged in age from 27 to 73 years and the 53 offspring's were aged between 1 to 34 years. Repertory grid methodology was employed to inform the process of discourse developed. A model of the five interrelated systems of events or issues that impinged upon the perception of parents was proposed. In addition details about the groups perception of those environmental events are issues that were pertinent to living with and caring for a child with an intellectual disability were reported.

Prieto and Marry (1993) assessed a two factor model of coping, identified predictors of coping and contrasted family characteristics of high and low coopers among 44 Spanish speaking mothers (aged 20 to 55 years) of mentally retarded children (aged 37 to 147 months). The first factor was the efficacy of the problem solving as measured by mother's responses to ten empirically derived vignettes of typical life events. Second factor was mothers teaching skills as measured by the quality of teaching done at home. Multiple regression analysis showed that ratings of support networks, knowledge of professional resources, perceptions of overall support were positively related and mother's age was negatively related to the problem solving measures of coping. No prediction was made for the quality of teaching. Discriminent analysis using a ten-scale family characteristics measure revealed that four scales discriminated high and low coopers on the vignette measure and seven on the teaching measure.

Ali (1994) assessed the personality characteristics and psychological problems of parents with mentally retarded children. Subjects were 76 parents (mean age 42.12 years) of 38 mentally retarded and 38 normal children. A Bengali version of the Eysenck Personality Inventory was used to measure the psychoticism, neuroticism and extraversion-introversion responses of the parents. Parents of mentally retarded children had significantly higher scores only on the neuroticism scale, indicating that they were more emotionally unstable than the parents of normal

children were. Fathers and mothers in each group did not differ significantly except for parents of normal children in the extraversion-introversion scale, where fathers were more extroverted than mothers .

Gallivan-Fenlon, Amanda (1994) examined how transition from school to adult life is experienced and understood by particular young adults with disabilities, families and service providers. Qualitative methods were utilised over a 16 months period to gather and analyse data on the transition process for eleven subjects (20 to 21 years) with disabilities. Eight main themes emerged from the data. These include offering future expectations for young adults with disabilities, inconsistent implementation of special education curricula and lack of inclusive educational practices, lack of transition related knowledge, hastily and poorly co-ordinated transition planning, a prevalence of restrictive views on employment and community living opportunities for young adults with disabilities, low levels of family participation, outcomes of unemployment and isolation for most young adults with disabilities and significant benefits of supported employment and community inclusion.

Bruce (1994) employed a developmental framework to compare 3 age cohorts comprising of 58 mother-father dyads of children or young adults with intellectual disabilities. Cohort one comprised parents with children aged between 1-4 years; cohort two comprised parents with children aged 5-10 years; and cohort three comprised parents with children aged 11-22 years. Measures of intrusive thought avoidance behaviours, current emotional distress over reminders of time of diagnosis of disability and intensity of wishing for what might have been used to reflect the parents grief reactions. Results indicate no significant age related differences in parent's responses but significant gender related differences. Mothers scored higher than fathers did on all measures. However, on the wishing scale, there were no significant differences between mothers and fathers. It was concluded that grieving

was an ongoing feature of rearing a child with intellectual disability and is more intense for mothers than fathers.

Jennifer (1994) taped oral histories of ten close relatives of people aged between 51 to 71 years defined as intellectually handicapped these were collected as part of the New Zealand Ageing and Intellectual Handicaps Study. Many of the individuals with intellectual handicaps were institutionalised from an early age. Some had little or no contact with the family; others lived continuously at home. The qualitative data recorded over fifty years of caring for an intellectually handicapped family member from early childhood through middle or old age and outline concerns or disinstitutionalisation and the future such as life time devotion, blame, guilt, shielding by siblings, self-imposed social isolation, and care after the parents death. Conclusion of this study indicated that families couldn't cope alone; participation of people with disabilities in community life and culture depended on well resourced public policies and programmes of inclusion.

Monica and Cuskelly (1998) examined the experience of brothers and sisters of a child with Down Syndrome. 45 families with a child having Down Syndrome (aged 4.5 to 7.5 and 12.5 to 15.5 years) and 88 comparison families provided information about their children behavioural problems and their involvement in household tasks. In addition, parental stress was measured using the parental domain of the Parenting Stress Index. There were no significant differences between the siblings of a child with Down Syndrome and comparison children on mothers or fathers' report of problem behaviour siblings of a child with Down Syndrome. Also did not differ in their contribution to family task, however for the brother of a child with Down Syndrome. There were significant negative correlations between household tasks and behavioural problems on father's reports. Parents of a child with Down Syndrome reported more stress than comparison parents and stress was related to reports of problem behaviour for some parent groups.

Tomar and Heller (1997) tried to determine whether support provided to care givers by their adult children with mental retardation would influence care giving appraisals and examined how severity of disability of adult child, personal and social resources of the care giver assistance to adult with mental retardation influenced care giving appraisal. Using surveys and interviews, information was collected from 80 primary care givers (mean age 68.2 years) of adult children with mental retardation (aged 30 plus) on care giving burden and satisfaction. Findings have indicated that greater support from the adult child resulted in greater satisfaction and less burden. Adaptive and maladaptive behaviours and caregiving assistance all predicted caregiving satisfaction but only maladaptive behaviours predicted care giving burden.

Catherine (1997) examined family problem solving interactions in families (N=165) of school aged children with mild or moderate mental retardation and a comparison sample (N=52). Results demonstrated a disruptive impact of children with mental retardation in the form of more directness by mothers and fathers, less supportive problem solving by single mothers and less active problem solving by the target children in the mental retardation group. Nevertheless, the absence of high rates of aversive behaviours in sibling's behaviours across the group suggested that families of mentally retarded children were resilient in the face of special demands. Role differences among mothers, fathers and siblings also were highly consistent in the two groups. Evidence of difficulties for single mothers and problem behaviour by other children in the family suggested that mental retardation is one of many challenges that families learn to cope with successfully.

Daniel and Lustig (1997) developed an empirical typology of families based on measures of family resources and family appraisal and a model of family stress, adjustment and adaptation. Parents (aged 39-93 years) of 116 adult children with mental retardation who lived at home completed postal surveys measuring the dimensions of family sense of coherence, social support, family adaptability and family adaptation cluster analysis identified three groups of families, coherent, flexible

and vulnerable. Coherent families (51% of the families in this study) can be regarded as healthy families. Flexible families (42% of this sample) can generally be regarded as healthy concept for measuring low in family sense of coherence. Vulnerable families (7% of this sample) measured low in all four family dimensions. Rehabilitation interventions that focus on strengthening the family's ability to act on their own behalf are recommended in this study.

Hanneman and Robert (1998) examined effects of child characteristics and home environment on caregivers behavioural intentions regarding placement of the children. It was a longitudinal study for hundred families of children (aged 2.6 to 9.1 years at the start of the study) with severe or profound mental retardation. Each family with a child who had mental retardation and was still in the home was interviewed at 5 time points roughly hundred months apart. Results did show that prior behavioural intentions significantly predicted actual placement behaviours independent of other factors. Child characteristics, with one exception, failed to predict intentions of actual placement behaviours. The more normative the child's appearance, the less likely caregivers were to seriously consider placement and to place. Higher socio-economic standing of mothers promoted more serious considerations of placement as did larger number of sibling. Some factors of home quality promoted more active consideration, but did not directly affect actual placements. Stress on caregivers contributed to both placement intentions and actual placements. Support resources, on the other hand, had little affect on placement intentions or placement.

Stores and Rebecca (1998) investigated the occurrence of daytime behaviour problems and maternal stress in a group of children (aged 4 to 19 years) with Down Syndrome compared with a group of their non-intellectually disabled siblings and a group of children with an intellectual disability other than Down Syndrome. The mothers completed the Aberrant Behaviour Checklist and the Malaise Inventory. Overall, the children with Down Syndrome and the children with other intellectual

disabilities also showed significantly higher rates of behaviour disturbance on all five of the total ABC scores. Siblings and children from the general population showed very similar behaviour scores. A number of significant age and sex differences were found in the occurrence of daytime behaviour problems. Maternal stress was significantly higher in the group with other forms of intellectual disability while comparing with other three groups. Number of significant associations was found between parental ratings of daytime behaviour problem and maternal stress in all four samples.

Padeliadu and Susana (1998) assessed the time demands placed on mothers of children with Down Syndrome and the possible relationship between those demands and the stress which the mother's experience. The study sample consisted of 41 mothers (mean age 44.8 years) of children with Down Syndrome living in Northern Greece and a comparison group of 41 mothers of non-disabled children. Following instruments were used for data collection, (1) a questionnaire for biographics information, (2) a self report form assessing time demands placed on the mothers and (3) an adaptation of the Clark Questionnaire on Resources and stress for the evaluation of the stress experienced. The results revealed increased time demands on the mothers of children with Down Syndrome in comparison to the mothers of non-disabled children in terms of recreational, educational activities and total time demands. Furthermore, the mothers of children with Down Syndrome differ significantly from mothers of non-disabled children not only on the level of the stress which they experienced but on the activities related to this stress as well.

Nicol and Dossetor (1994) examined the value of expressed emotions as a measure of the relationship between adolescents with intellectual impairment and their parental primary caregivers. This was measured through the completion of an interview conducted upon 92 intellectually impaired adolescents (aged 14 to 19 years). In this interview there were Handicaps Behaviour Skills Schedule. The Social Support Questionnaire and 32 Parental Primary caregivers showed high expressed

emotions. High expressed emotion was significantly related to parental primary caregivers psychological ill health, poor practical, social and insecure style of respite care usage. High expressed emotions over involvement were associated with parental primary caregivers, psychological ill-health, poor practical social support, poor quality of marriage, greater professional support and an insecure style of respite care usage. High expressed emotion criticism was associated with parental primary caregivers having an adolescent of less severe intellectual impairment, more behavioural disturbances, but less professional support.

Hornby and Garry (1994) assessed the support provided by grandparents to families with disabilities. A questionnaire survey of 25 parents of children (aged 3 to 15 years) with severe learning difficulties assessed the levels of practical, financial and emotional support they received from their children's maternal and paternal grandparents. Parents were also questioned about their satisfaction with this support. Although overall levels of grandparental support were low, 61% of grandparents were considered to have provided exactly the right amount of support for the family. Grandparents were more forthcoming with emotional support than with financial support and maternal grandparents were more involved than paternal grandparents. However, 24% of grandparents were considered to have added to the subject's problems and almost 22% of subjects expressed a wish for a lot more support from the grandparents.

Chang (1995) examined the relation between coping and psychological distress experienced by Chinese parents of children with Down Syndrome. 174 parents (aged 22 to46 years) of 108 children (aged 1 to 12 years) with Down Syndrome, language delay or normal development completed measures of parental coping, general health, life orientation, and self mastery. The three groups of parents differed in their use of coping styles. Parents of children with Down Syndrome used avoidance coping more frequently than others, and parents of children with Down Syndrome and language delays reported using more self-reliance strategies.

avoidance and self-mastery were robust correlates of parental distress. Mothers reported more use of various styles and low levels of mastery and optimism.

Smith and Gregory (1995)tested a theoretical model permanency planning based on the double ABCX model of family stress and adaptation using structural equation modelling. Interviews were conducted with 235 mothers (aged 58-96 years) who cared for adult offspring with mental retardation at home. Four variables were confirmed to directly influence their stage of planning; these were i) use of services for offspring, non use of avoidance coping, ii) self perception of being adversely affected by age related changes and iii) help from offspring without mental retardation. Variables found to affect planning indirectly were perceived need for services, mother's subjective burden, extent of caregiving tasks, offspring's disability and mother's disability.

Hornby and Garry (1995) examined father's views about the effects of children with Down Syndrome on themselves and their families. Taped interviews were obtained from 90 fathers (aged 27to 62 years) of children (aged 7 to 14 years) with Down Syndrome. Analysis of the interview data revealed 28 categories of comments made by subjects. The most frequent comment made by 46% of the subjects, was the cheerful personality of their child. About 42% of the subjects talked about the initial trauma they experienced following the diagnosis. 43% of the subjects discussed the restrictions imposed on the family and 30% commented that the child had minimal effects on the family life. The most frequent concern, expressed by 36% of the subjects was the long-term provision for their children. Thus although in this study many fathers experienced some negative affects of having a child with Down Syndrome. Only small minorities of their experienced difficulties were so great that some interventions were needed.

Lehman and Jean (1995) compared the responses of 20 mothers whose adolescent children (aged 10 to 20 years) had been labelled as severely mentally

retarded with those of 20 mothers of non-labelled disabled children. Subjects were interviewed regarding their children's'(1) future living arrangements, (2) employment/ education goals and (3) social relationships. All mothers wanted a promising future for their children that involved leaving the family home, finding suitable employment and having friends. Mothers of non-labelled youths' were generally not pleased with their children's current social lives although they predicted a much brighter future.

Gopal, Rao and Madhu (1994) assessed behaviour disorders in moderately mentally retarded children and their relation to parental attitude. Subjects included the fathers or mothers of sixty moderately mentally retarded boys and girls (aged 8 to 12 years) who completed a Parent Rating Scale (which indicated the presence of learning and conduct problems to a high degree and psychosomatic disturbances, impulsiveness, hyperactivity and anxiety problems to a low degree) and a Parental Attitude Scale toward mental retardation. Findings on the Parental Attitude Scale showed that parents had a negative attitude towards the moderately mentally retarded children.

Atkinson and Leslie (1995) investigated relations among maternal cognitive coping style (approach-avoidance), affective state and sensitivity. Fifty-six mothers and their children with Down Syndrome were followed for two years. Cognitive coping and affective distress inventories were administered and sensitivity was rated on the basis of mother child observations. Results indicated that approach and avoidance have been widely studied under different designation and are stable across time. These cognitive coping variables were found to be mediating the stress of parenting a child with a disability in complex ways. Mothers with a strong tendency to monitor stressors reported greater affective distress than do mothers who adopted a less vigilant coping style. At the same time, cognitive avoidance of stressors and affective distress reduced the behavioural sensitivity of the mothers towards the child.

Wenz-Gross and Melodie (1996) examined the social networks, social supports, family environment and adjustment of 36, 5th and 6th grade preadolescents, 15 with mild mental retardation and 21 without mental retardation. Two interviews with the preadolescents and their families using battery questionnaires were conducted at the home. Results showed no group differences in the size of preadolescents' social network.

In terms of who they turn to for social support, preadolescents with mild mental retardation were more likely to turn to people in the home and adults outside the home for companionship, while preadolescents without mental retardation turned to peers. Further, the more negative the family environment the more preadolescent turned to adults outside the home for emotional and problem solving support. Lastly, preadolescents who received greater emotional and problem solving support from people in the home experienced fewer adjustment problems.

In a study conducted by Hayden (1996) an attempt was made to determine whether stress experienced by families of adults with mental retardation was a function of characteristics of caregivers or care recipients, support service needs and needs for personal care recipients and suppression. Data from interviews with 105 families indicated that the marital status of the caregivers, the level of retardation, frequency of maladapting behaviours, health status of the adult family member with mental retardation and the number and level of service needed were factors in the stress and needs for service providers information essential for developing and funding effective supports to families caring for adults with mental retardation and other developmental disorders.

Floyd (1997) investigated developmental changes in parenting children with mental retardation over time by examining within family consistency in parent child interactions for mothers and fathers of school age children (aged 6 to 18 years) with mental retardation. At one time 98 families with a child who had moderate or mild

retardation completed semi-structured interaction sessions in their homes. Results showed that both positive and negative exchanges decreased longitudinally. Cross sectional comparisons revealed fewer parent commands, less child non-compliance, fewer child negatives and less parent positive reciprocity with older children. Most behaviours were found to be highly consistent between family members and were stable over time. Findings were discussed in relation to parental responsiveness to developmental changes for the child and the coherence of family relationships over time.

Bruce, (1996) analysed grieving as an ongoing feature of parenting with intellectual disability in 49 mother-father dyads. Subjects were interviewed annually over a three year period on scales measuring intrusion and avoidance, persistence of distress, subjects feelings, wishes for their children and the presence and absence of life events affecting them. Results expressed the presence of grief over time. Mothers showed higher levels of avoidance behaviour and intrusive thoughts about the child and were more distressed at recalling the time of diagnosis. Similar intensities were observed for parent's wishes for their children. Findings have suggested the need for further research into gender related differences in grieving responses with reference to psycho-educational support through group work.

Freedman and Ruth (1997) examined the further residential plans and placement preferences of 340 mothers (aged 58 to 87 years) of adult children (aged 18 to 69 years) mental retardation living at home and discussed findings from a three year follow up. The authors also explored whether the types of residential plans and placement preferences of the families interacted with the family's characteristics, functioning, well being and formal supports. Based on the data four subgroups of families were identified, families with and without residential plans who either wanted their adult children to remain in the home for at least the up coming two years or wanted their adult children to move out of the home. Significant group differences were found for background characteristics, maternal psychological well being and

support systems. Results showed that less than 50% of the families had made residential plans and the majority believed their child would still be at home in two years. At the three years follow up, 22% of the families with short-term residential plans had achieved a placement compared with 14% of families without a plan who wanted a placement.

Chen and Theresa (1997) interviewed thirty Chinese mothers of adult children with moderate to severe mental retardation to explore the source and nature of their stress and social support. Results revealed child related and parent related stress specific to these mothers. The most common stressors were future planning and behavioural problems of the target offspring. Mothers received tangible, emotional and informational support mainly from family members and training centre staff. Some evidence was also found for the Optimal Matching Model of Stress Appraisal and Social Support. Regardless of the duration of stress all forms of support were perceived as equally useful for uncontrollable stress, whereas tangible support was regarded as more useful than informational support for controllable stress.

Turner and Stephen (1996) investigated behaviour problem pattern over five years in fifty-five boys and thirty-six girls with Down Syndrome together with maternal appraisal of the seriousness of the problem. Individual behaviours were studied using the Behaviour Problems Questionnaire in 1986/1987 and in 1991 when subjects were 7 to 14 years and 11 to 17 years respectively. Significant decline was noted in overall frequency of behaviour problems and some disturbed behaviours like sleeping, toileting problems and overactivity. However, many problems persisted among the same sample. Mothers viewed few behaviours as definite problems. Some problems were associated with subjects gender, age and developmental level. By time 2, boys showed higher frequencies than girls in disturbed behaviours while girls showed more fears and worries. Results suggest behaviour problems may become set early in life and are most persistent in subjects with lower developmental levels. It is

suggested in this study that families may benefit from early interventions for these problems.

Sarimski (1997) explored the behavioural phenotypes of thirty fragile-X, thirty-five Prader-Willi and thirty-five Williams-Beusen Syndrome children (aged 1 to 12 years) using a psychometric approach. Measures in this study included were, The Society for the Study of Behavioural Phenotypes Postal Questionnaire, The Parental Stress Index and the Family Functioning Style Scale. Results confirmed some distinct behaviours as syndrome specific, but revealed a high degree of within syndrome variability and overlap between syndromes as well. Parental stress was found to be high in each of the groups, but was mediated by maternal dissatisfaction with family relationships. A multi-method approach with detailed syndrome specific observations is recommended for further research.

Turnbull and Ruef (1996) interviewed 17 families who have a member (aged 2 to 36 years) with mental retardation and problem behaviour. The interview was focused on the families definition of problem behaviour, current challenges they face and successful approaches for helping individuals with problem behaviour and their families as well as suggestions from families about what kind of information they believe would help them in addressing and solving challenges.

Swain and John (1996)conducted qualitative research into the sexual development and identity of profoundly disabled young people. This research explored the experiences, feelings, understanding and the formal caregivers to parents as perspectives. Interviews were conducted with seven parents of profoundly disabled teenagers. Parents found it very difficult to deny or not to deny sexuality. The interviews were discussed in two workshops with 60 formal caregivers including teachers and doctors. Formal caregivers drew on briefs about good parenting in reactions to the position of parents. Both groups confronted real dilemmas with

young people who were incapable and may never be capable of informed consent or self-determination in sexual relationships.

Greaves (1996) produced an account of mothers caring for children with Down Syndrome as revealed by their responses on the 11 item Adaptability/ Plasticity Scale of the Child Domain of the Parental Stress Index. Due the lack of coherence, it was questioned whether children with Down Syndrome have such a diverse range of coping strategies in response to environmental demands that the notion of a unidimentiomal scale is not representative of their behaviour. Data of this study was obtained from another study in which 55 mothers who had a child with Down Syndrome completed Parental Stress Index. Factor analysis indicated the set of items of the Adaptability/Plasticity Scale indeed doesn't cohere well, and so, for this sample population, it was difficult to justify speaking in terms of a single characteristics labelled single adaptability/ plasticity.

Blacher and Jan (1997) examined depression among 148 Latin women who have children with mental retardation. A battery of standardised instruments, questionnaires and open-ended questions were administered. Variable interest included child functioning, coping strategies and depressive symptomatology. Results showed that subjects depressive symptomatology was elevated with almost half reporting negative experiences in excess of a commonly used cut of for the Centre for Epidemologic Studies Scale. Depression scores related to variables pertaining to the child, mother's health and level of acculturation and aspects of stress and coping. When mothers were categorised in three groups by Centre for Epidemologic Studies scores, discriminant analysis correctly classified 84% of the low and high group mothers reporting more family problems, worse health, fewer interactions with English speaking persons in their daily lives and more negative feelings about parenting a child with mental retardation.

Bigby (1996) in a study examined retrospectively the nature and implementation of adult children's future plans made by parents (aged 55 to 88 years) with intellectual disability. Someone with whom each subject had long term relationship was introduced. Four types of plans were identified; implicit key person's succession plans, explicit key person's succession plans, functional plans and presidential plans. Most subjects had made plans that were imprecise and nominated someone to take over responsibility for the well being of the adult with intellectual disability. These key person's succession plans were an effective form of planning; they facilitated transition from parental care and often obviated the need for more detailed formal planning.

Siperstein and Gary (1997) investigated the influence of social behaviour and social cognitive skills on the social status of children with mental retardation by comparing socially accepted and socially rejected children. A sociometric survey conducted with 764 children in 34 regular education class rooms identified 20 socially accepted students (mean age 12.3 years, mean IQ 66.5) and 20 socially rejected students (mean age 12.0 years, mean IQ 68.0) with mental retardation. Accepted children displayed a higher levels of social behaviour and a lower level of sensitive isolated behaviour. Two groups also differed in their social cognitive skills. In response to social problems, accepted children chose friendly submissive goals and generated a low rate of positive outgoing strategies, whereas rejected children chose friendly- assertive goals and generated a high rate of positive outgoing strategies.

Mc Dermott and Suzane (1997) compared the experiences of parents (aged 39 to 87 years) of adults (aged 22 to 55 years) with mental retardation living in the home with those whose adult children are in out of home placements. Interviews were conducted with the parent's 44 adults with mental retardation placed out of home to identify differences in caregivers burden and gratification based on placements. Parental responses indicated that caretakers of adult children with mental retardation were worried and felt responsibilities for their care regardless of

residential placement of the adult child. Researchers h ordinators or care managers who work with families possibility that burdens are experienced by parents regardless daughters are living at home or in out of home placements.

In a study conducted by Florien and Mikulincer (1997) Isra (N=276) completed questionnaires on handicaps, mental health, cognitive ap and way of coping at the beginning and end of a demanding, four month comba training period. Path analysis revealed that two components of hardiness-commitment and control measured at the beginning of the training-predicted mental health at the end of the training through the mediation of appraisal and coping variables. Commitment improved mental health by reducing the appraisal of threat and the use of emotion focused strategies and by increasing secondary appraisal. Control improved mental health by reducing the appraisal of threat and by increasing secondary appraisal and the use of problem solving and support seeking strategies.

Scott and Sexton (1989) investigated the perception of stress in parents. They did not find sex of parents to be a source of variance in stress as measured by the Questionnaire on Resources and Stress. The children in this study were of pre-school age, with diagnosis of cerebral palsy, developmental delay and Down Syndrome. It is possible that the difference between their results and earlier ones may be attributable to more similar roles assumed by the parents in caretaking. Some role comparison studies have indicated a difference between fathers and mothers in caretaking roles and responsibilities for infants and very young children without handicaps and with mental retardation.

While indicating the limitations of earlier researches that they were primarily based on maternal perspective Rousy, Blacher and Best (1992) assessed the perception of stress and coping for both parents of the same child. In this study the short form of the Questionnaire on Resources and Stress was completed separately

by mothers and fathers of children with severe developmental disabilities. to compare responses of mothers and fathers they employed factor analysis of parcels using the parallel analysis criterion rather than the more traditional item level analysis with minimum eigen value criterion. Results indicated that QRS-F differed only slightly in both factor structure and correlates as a function of parental gender. Overall validity of the QRS-F for use with both mothers and fathers of children with severe disabilities was supported.

Donovan (1998) compared mothers' perception of family stress and ways of coping with adolescents who were autistic or had mental retardation (n=36 for both groups). Group differences were found among maternal reports of family stress.

All comparisons of child related stress revealed that mothers with an adolescent who was autistic perceived greater level of family stress than did mothers with an adolescent who had mental retardation. Marital adjustment did not differ by group. Furthermore, maternal coping styles were consistent across groups, indicating that mothers with adolescents who had a handicap relied heavily on community resources professional help for coping.

Minnes (1998) tried to integrate the concepts drawn from family stress theory and current empirical information on families of handicapped children to further understand factors influencing parental adjustment to stress associated with such children living at home. Internal and external family resources and characteristics of the children were examined. Mothers (n=60)were asked to complete four relevant questionnaires. Results of multiple regression analysis indicated that characteristics of the child and the family crisis meeting resources were significant predictors of various forms of stress. Clinical implications of these findings and current research directions are also discussed in this study.

In a study by Cheng and Tang (1995) coping and correlates of psychological distress of Chinese parents of children with Down Syndrome were examined and compared to parents of children with language delays disabilities. Individual parent scores were used for analysis, with groups and gender of child and parents as independent factors. Down Syndrome group parents reported the most frequent use of avoidance coping style, followed by parents of the language delay and no disabilities group. Compared to parents in the no disabilities group, the other parents reported a higher level of psychological distress, were less optimistic, felt less self-efficacious and engaged in more frequent use of self- reliance, avoidance and seeking social support coping styles. Mothers also reported a higher level of distress but lower levels of optimism and self-mastery. intercorrelations among variables showed that avoidance coping style and self mastery emerged as the two robust correlates of parental distress.

It is reported in some studies that when a social role becomes difficult for the individual to bear and a social organisation becomes ineffective, it differentiates into roles that function more effectively in the new circumstances. In the case of the family, when demands on one traditional role are so great as to be beyond the capacity of the individual occupying that role, some of the responsibilities must be assumed by other family members. A consistent finding in the related literature is that these additional responsibilities are frequently assumed by older sisters. Given the trend toward smaller families, additional caretaking demands of a child with severe disabilities may result in a more expanded cretaking role for fathers.(Stoneman 1991, Grossman, 1972).

Stimulated by coping research in western countries Chinese psychologists have also tried to examine the various coping styles of Chinese people. They have argued that some of the coping strategies used frequently by Chinese parents are not reflected in most of the coping scales developed in western countries. On the basis of indigenous sample of adults from Taiwan, Chinese psychologists classified four major

coping styles; relying on self, seeking help from social resources, appealing to supernatural power and adopting a ``do nothing" philosophy. Some psychologists whose research was conducted in Hong Kong proposed two main coping dimensions; reliance on self (internal locus of coping)and seeking help from others (external locus of coping). Reliance on self involves the coping responses of appealing to supernatural power, acceptance and perseverance (e.g.; "forbear and remain calm" and "resign to what is inevitable." Chang and Tang, 1983; Hwang, 1977; Shek and Cheung, 1980).

Frey (1989) have indicated that frequent use of self blame, wishful thinking and avoidance are consistently linked to increased parental distress. As with the general population, mothers were usually found to be the primary caregivers of children with mental disabilities and experience more distress as compared to fathers. Mothers also tend to seek social support from their spouses, relatives or friends.

Shek and Tsang (1993) found no significant difference between mothers and fathers of pre-school children having different types of mental retardation. However in contrast to fathers, mothers in this study had lower levels of marital satisfaction, internal locus of control, and purpose in life. None of these investigations conducted in China have explored the impact of child gender on how families adjust to having children with mental retardation.

Aldwin and Revenson (1987) in a longitudinal community survey of 291 adults, explored the relation between coping strategies and psychological symptoms. Respondents completed the Revised Ways of Coping Scale (Folkman and Lazarus, 1985) for a self named stressful episode. After factor analysis eight factors emerged ; three problem focused, four emotion focused and one (support mobilisation) that contained elements of both. Multiple regression analysis indicated bidirectionality in the relation between coping and psychological symptoms. Those in poorer mental health under greater stress used less adaptive coping strategies, but coping efforts still

affected mental health independent of prior symptom levels and degree of stress. They compared main versus interactive effect models of stress buffering. Main effects were confined primarily to the emotion focused coping scales and showed little or negative impacts of coping on mental health; interactive effects, though small, were found with the problem-focused scale.

The direction of the relation between problem focused scale and symptoms may depend in part on perceived efficacy, or how the respondent thought he or she handled the problem. Implication for the measurement of adaptive coping mechanisms and their contextual appropriateness are also discussed in the study.

Olinger, Martin and Kuiper (1987) in four studies examined the stress-moderating effects of telic versus paratelic dominance, a personality construct derived from reversal theory. Telic dominant individuals were described as serious minded, goal oriented, and arousal avoidant, where paratelic dominant people are described as playful, spontaneous and arousal seeking. The first two studies found that telic dominant subjects displayed significantly higher levels of dysphoric and salivary cortisol when stressful events remained unresolved. Paratelic subjects revealed significantly higher levels of disphoria and salivary cortisol when moderately stressful events were resolved. Additional support for the telic versus paratelic dominance was obtained in study 3, which used task performance, self report, and psychophysiological measures relating to a video task performed under low or moderate levels of social evaluation stress. Study 4 broadened the range of stressful event levels and mood disturbance for the telic- dominant subjects. For paratelic subjects this relation was curvilinear. Paratelic subjects showed an initial decrease in mood disturbance as the level of stressful events increased from low to moderate. At more extreme levels of stress, however, paratelic subjects showed a significant increase in mood disturbance.

Ingram (1987) have mentioned in his paper that cognitive approaches to emotional distress point that specific cognitive factors are critically linked to the etiology, course, or treatment of dysfunction. Although a number of empirical studies have assessed cognitive factors in emotional disorders such as depression and anxiety. He has further directed that researches have yet to assess these variables simultaneously and with identical cognitive measures. Using depression and test anxiety as models of dysfunctional affective states, they examined cognitive specificity on measures of informational processing, attributions, autonomic thinking and cognitive interference. Results indicated a pattern of specificity showing several differences and similarities between depression and anxiety. Specifically, purely depressed individuals showed evidence of selectively processing depressive information, making dysfunctional attributions and engaging in more negative automatic thinking. Purely anxious individuals, on the other hand, showed evidence of selective anxious information processing and increased cognitive interference. Results were discussed in terms of a taxonomy for classifying depression and anxious cognition.

Katz and Epstein (1991) conducted a laboratory experiment upon different groups. They administered a laboratory stress test and found that poor constructive thinkers produced more negative affective and cognitive responses in all experimental periods and a greater increase in such responses in the stress period than did good constructive thinkers. The groups differed in physiological arousal in the recovery period but not in the stress period. Stress- instigated negative thoughts and spontaneous negative thoughts produced different patterns of relations with variables measured in the laboratory and with symptoms reported in everyday life. Discriminating patterns of relations were found between measures of cognition and affect in the laboratory and self- reported emotional, physical and behavioural symptoms in everyday life. The results of this study help explain the relation between maladaptive autonomic thinking, on the other hand, and elevated physiological arousal and emotional, physical, and behavioural symptoms, on the other hand.

Zautra and Wrabetz(1991) investigated the role of coping success on physiological distress in 147 older adults who experienced a major health problem and 82 older adults who reported a major loss in the past six months. Home interviews provided data on satisfaction with coping efforts and negative changes associated with events. Significant predictors of coping success were identified and controlled for in subsequent analysis predicting mental health. It was found that efficacy in coping with loss was associated with less psychological distress. Coping efficacy interacted with coping efforts in predicting distress for those with health downturns. Efficacy in coping was associated with less distress only for those who were actively engaged in coping. Analysis of longitudinal data replicated the cross-sectional for coping with loss.

Pueschel (1994) in a study tried to investigate the family environment and the temperament of children with Down Syndrome. Parents of forty children (aged 4 to 16 years) with Down Syndrome completed the Family Environment Scale (FES). They also filled out the Temperament Assessment Battery for Children (TABC) for both the children with Down Syndrome and their close siblings. A similar questionnaire of the TABC (teacher form) was sent to the children's teachers. There were high scores in categories of cohesion, expressiveness, achievement, moral/religious emphasis, organisation and control of the Family Environment Scale. The result indicated that family members in the study cohort were relationship oriented, provide support for one another , emphasise ethical values , and are able to express. Control group children in this study scored higher in the adaptability and persistence categories of the TABC, whereas children with Down Syndrome achieved significantly higher scores in the approach / withdrawal category.

In another study Wallbott and Scherer (1991) experimentally manipulated several factors considered to be relevant in mediating stress arousal. Subjects selected for the coping styles anxiety denying, low anxiety and high anxiety were

confronted with both low and high arousal including situations, using two different types of stressors (cognitive versus emotional) in each case. Arousal reactions were measured in three response modalities; verbal report of subjective experience, non-vernal behaviour and physiological reactions. The results revealed complex interactions between type and degree of stress, coping styles and gender of subjects confirming findings on vocal parameters of stress. These complex interactions were discussed with respect to the possibility that subject's evaluation of situation characteristics may be influenced by coping styles and gender, resulting in differential reaction patterns.

Bolger and Eckenrode (1991) noted about the common belief that social relationships buffer the effects of stress on mental health but also these apparent buffering effects may be spurious reflections of personality or prior mental health. They investigated this possibility in a prospective study of a medical school entrance examination. Five weeks before the examination, subjects (n= 56) rated their personality (extraversion and neuroticism) and social relationships (number of social contacts and perceived support). They further rated their anxiety for 35 days surrounding the examination, controlling for personality and prior anxiety, social contacts buffered against increases in anxiety, whereas perceived support did not. Further analysis revealed that discretionary social contacts were beneficial whereas obligatory contacts were not.

Brown (1991) in his research on physical fitness tested the stress buffering effect of fitness with subjective and objective indicators of exercise, fitness, and physical well being. For self- reports of health, both self- reports of exercise and objective measures of fitness showed the buffering effect; however, only objective fitness levels buffered stress when visits to a health facility were considered. Additional evidence indicated that this effect was largely independent of measures of physiological distress. Implications for understanding the link between fitness, stress and health status were also discussed in this study.

Pillow and Sandler (1996) examined three groups of subjects to find out whether the relationship between major life events and distress is mediated through minor stressors. Three groups of subjects who participated in this study were, (1) those who experienced the death of a spouse, (2) divorced, (3) were the parent of a child with asthma. Each of these major stress groups were compared with a control group. Path analysis conducted by aggregating the data across major stress groups indicated that major life events exert both direct influence on distress and an indirect influence through minor stressors. On the other hand, the nature of the mediational relation linking major life events with psychological distress through minor stressors was found to be varying as a function of the major life stress situation under consideration.

Holahan (1996) tried to broaden and refine a resources model of coping to encompass negative as well as positive aspects of social relationships and examined this expanded conceptualisation in a four year prospective model with 183 Cardiac patients (140 men and 43 women). Social support and social stressors in the family and extrafamily domains contributed significantly to a common social context, which has a latent construct. In addition, this conceptualisation of social context was significantly related to depressive symptoms four years later. Conceptually, especially important coping strategies functioned as a mechanism through which both social support and social stressors were related to subsequent depressive symptoms. In this study, positive and negative aspects of social relationships made essentially unique contributions in predicting, subsequent coping efforts.

In the study conducted by Davila and Badbary (1997) they applied C. L. Hammen's (1991) stress generation model to depressive symptoms in the context of marriage. The authors predicted that depressive symptoms would lead to increased marital stress, which would in turn lead to increased depressive symptoms. Social support processes were hypothesized to function as a mechanism by which dysphoric

spouses generate stress. Hypotheses were tested in a sample of 154 newlywed couples. Depressive symptoms, marital status, support perceptions and support behaviour (assessed using observational procedures) were assessed initially and one year later. Results of this study have provided evidence of marital stress generation among wives and social support processes functioned as a mechanism of stress generation for wives. Results have highlighted the cyclical course of dysphoria and stress among wives.

Hock et. al. (1986) examined associations between coping dispositions (vigilance, cognitive avoidance) and indicators of the processing of ambiguous stimuli. In the first phase of investigations, 58 male participants were presented with a series of sentences that could be interpreted in a threatening or a non-threatening fashion. The participants had to rate the unpleasantness of the events described in the sentences. Subsequently a previously unannounced recognition memory test for disambiguated (threatening and non-threatening) variants of the sentences were carried out. Evidence based on ratings reactions time, and recognition memory measures indicated that vigilant individuals are characterised by processing activities that favour the intake and storage of the threatening rather than non - threatening meanings of ambiguous stimuli. Highly avoidant non- - vigilant individuals (repressors) showed a disproportionately large number of extremely delayed ratings.

Conclusions

If we look at the above mentioned review of literature we notice that different studies have explained about the different aspects of mental retardation and its impact upon family and society. It is found that mothers are more stress prone and anxious towards their babies, which leads to more psychological and behavioural problems among them. Some parents indicate that although there is a mentally handicapped child in their family yet they feel like any other ordinary parent.

If we look into the Indian context we notice that burden of caring and rearing children either with or without mental retardation lies upon the shoulders of mothers because they are generally housewives and primary caretakers of the child. It is mentioned that resource utilisation and coping strategies used by both parents are different. Mothers are found to be more support seeking outside the family. They relied on the interaction with other parents who have a child with mental disability.

One interesting thing, which is found among parents, is that type of disability directly affects their coping responses. Both mothers and fathers have mentioned affection and support from their spouses as one of the most helpful coping strategy but outside support from other families is also a good resource in coping with stress.

Chapter III

Methodology

CHAPTER - III
METHODOLOGY

Problem Statement:

To investigate levels of stress, resource utilisation and use of different coping strategies of parents of mentally handicapped children across two age groups of the children studying in special school.

Assumptions :

1. Parents may differ in their levels of stress at two age groups of the children. There may be more variation in the levels of stress according to the age group variation of the children. It is quite natural that as the children grow parents way of thinking differ and in the case of mentally handicapped children variation can be seen more apparently.
2. When the age group level of the children is changing these may be some change in the coping strategies used by the parents. Because as the time passes, experiences of the parents also change, so it may lead them to think about the solution of the problem in a different light and in a different way.
3. There may be differences between men and women in the levels of stress, resource utilisation and coping strategies as a result of having a mentally handicapped child. This may be probably because men and women are a little bit different in their natural way of thinking on some aspects.
4. Demographic variables like age of the parents, qualification, type of family, birth order of the child, total number of family members in the family are expected to influence coping behaviour and stress levels.
5. Basically this study is concerned with the parents of mentally handicapped children. It is assumed that there may be correlation between age of the children and stress level of parents. Such variations and correlations are noted in the studies of Donovan (1988) and Flynt etal. (1992).

Objectives of the Study :

1. To investigate the different coping strategies utilised by the parents of mentally handicapped.
2. To investigate different levels of stress among parents at two age levels of children with mental disability.
3. To investigate the differences in the scores of mothers and fathers in utilisation of different types of coping strategies and perception of stress.
4. To investigate the effects of demographic variables on parents perception of resources, levels of stress and coping strategies.
5. To investigate the relationship existing among different sub-scale items and item clusters of the two scales used in the study.

Research Questions :

1. Are there differences in the levels of stress in the parents of mentally handicapped children.
2. What are the coping strategies used by the parents at two age levels of children.
3. What are the differences in utilisation of resources by parents across two age groups of the children.
4. Is there any gender difference in stress levels, resource utilisation and coping strategies of the parents.
5. Is there any relationship between levels of stress and coping strategies.

Sample:

According to the aim of the study selection of the sample was purposive and size of the sample was 100 consisting of fifty mothers and fifty fathers. According to the objectives of the study children were divided into two age groups. These were parents of children from one school in Delhi.

In Delhi there are around 91 special schools (both Government and Non-Government) where children having special needs are taught. But out of these 91 schools there are only six schools which are recognised by The Rehabilitation Council of India, (Under the Ministry of Social Justice and Empowerment) Others are run by the Non-Government Organisations.

The Rehabilitation Council of India was set up by an Act of Parliament in 1992 (Act No. 34) and it came into force in July, 1993. The Act empowers the Council to regulate the training of rehabilitation professionals/personnel's, by prescribing minimum standards of education for various categories of professionals in the country. The special schools are (I) Kasturba Niketan (Lajpat Nagar), (ii) Spastic Society of Northern India (Hauz Khas), (iii) Society for the Welfare of the Mentally Retarded children (Okhla), (iv) Institute of Special Education (Nizamuddin), (v) Amar Jyoti Rehabilitation and Research Centre (Vikas Marg) and, (vi) Tamana Special School, (Vasant Vihar).

Hurlock (1978) has divided the entire life of an individual into eleven stages. Out of these eleven stages two age groups of the children were chosen for the purpose of present study. These age groups are (1) 5-10 years (ii) 14-21 years.

The reasons behind selection of the above mentioned age groups were as follows:

1. This study is mainly concerned with the parents of mentally handicapped children so, to see whether parents belonging to these two age groups have different levels of stress and coping strategies, children were divided in two age groups. Variables can be studied more thoroughly if there is variance in the sample. It provides us to study variables in contrast and clear light. This is not an experimental research but is a correlational research where variables are controlled by selection process.

2. Because the sample was taken from the special schools for the mentally handicapped children, so it was not possible to include those parents who have children below five years of age. But in rare cases if some children were found below five years of age they were included in the study sample.
3. Generally parents do not send their below five years of age children to these schools because they don't notice the symptoms of mental disability properly and they think that after the lapse of time their children would become normal.
4. Period between 11-13 years was seen as a different stage in the child's life, when parents have had time to adjust to the child's condition.
5. Due to some practical problems few of the children could not be distributed strictly. For example during sample distribution some children who were below five years of age were kept in the first age group or there were some children who were around 22 years were given place in the second age group. But it did not affect the overall sample composition because their number was quite negligible.

Before the final study a pilot survey was conducted to know whether appropriate samples were available or not, to know whether parents had any difficulty regarding study questionnaires and to know about different types of empowerment training provided to these parents regarding the problems created due to a mentally handicapped child in the family. Parents are actually given a three days training in these school regarding different coping strategies and adjustment with such children.

During pilot survey it was found that there were around 130 children at model school (Kasturba Niketan). So, finally it was decided to draw the sample from Kasturba School consisting 100 parents. Because age of the parents was not a major concern of the study so sample selection was done on the basis of children's' ages consisting of two age groups.

Tools Used : For the purpose of data collection following instruments were used :

1. Parents Personal Information Sheet
2. Questionnaire on Resources and Stress
3. COPE Scale
4. Unstructured interviews with 10 parents

Parents personal information sheet was used for the collection of demographic variables data (i.e. age of the child, parents education, occupation, number of children etc.). The study is centred around these demographic variables and their relationship with other scales.

To get a deeper understanding unstructured interviews were conducted with ten parents.

Basic purpose of conducting unstructured interviews was to add more additional and unstructured information to the structured and quantitative data. Because scale items provide a limited and numerical type of information, so the unstructured interviews were conducted to probe these areas and to investigate the variation in the different scale item scores.

COPE Scale : COPE scale was developed by Carver, Sheiar and Weintraub (1989). This scale has a total of 53 items divided into 14 sub scales. Thirteen sub-scales consist of four items each whereas fourteenth sub-scale has only on item i.e., alcohol-drug disengagement.

A brief description of the fourteen sub-scales is given below :-

1. **Active Coping :** This is the process where an individual takes active steps to remove or circumvent the stressor or tries to minimise its effects.

12. **Behavioural Disengagement** : In this kind of coping strategy an individual simply gives up the actual behavioural attempts to deal with the stressful situations. Individual stops doing activities that can lead him to solution.

13. **Mental Disengagement** : In this type of coping strategy a person tries to shift himself mentally from the stressful situations and focuses his attention on other different kinds of mental activities that provide him pleasure and comfort.

14. **Alcohol-drug disengagement** : This coping strategy consists of one item in the COPE scale. Under this strategy a person takes drug or alcohol in order to avoid thinking about the problem.

Some of the information is available regarding the internal consistency of the COPE sub-scales, which comes from Cronbach's alpha reliability coefficient that were computed for each scale. Generally these values are acceptably high and are about .72 accept the mental disengagement sub-scale which has a scale value of below .6. On each sub scale the maximum possible score is 16 and the minimum score can be 4 because on each sub scale there are four items and maximum possible score on an item is 4 and minimum is 1.

A short-form of the Questionnaire on Resources and Stress :

For the measurement of stress and utilisation of resources this questionnaire was used. This questionnaire was developed by Friedrich, Greenberg and Crnic (1983).

The Questionnaire on Resources and Stress is considered to be a general measure of adaptation and coping as it measures both positive and negative impacts of the child on family.

The Questionnaire on Resources and Stress (Short-Form) consists of a total of 52 items. After factor analysis of the original questionnaire four distinct factors emerged as most reliable. The questionnaire is based on these four factors which are:

1. **Parent and Family Problems :** This factor consists of 20 items that examines the respondents perception of problems for themselves, other family members or for the entire family.
2. **Pessimism** : This factor consists of 11 items with the central characteristics of an immediate and future pessimism about the child's' prospects of achieving self-sufficiency.
3. **Child Characteristics** : This factor consists of 15 items. This factor indicates parents perceptions of the specific behavioural and attitudinal difficulties presented by the disabled child.
4. **Physical incapacitation :** This factor consists of six items. This factor indicates parents perceptions of limitations in the child's' physical abilities and self-help skills.

Procedure – First demographic inventory was completed by all 100 parents after that they were administered the COPE scales and Questionnaire on Resources and Stress. After completion of these data procedure interviews were conducted with ten parents; consisting of five mothers and five fathers.

Variables :

Demographic Variables :

Age of the child is one of the variables which is the major concern of the study. Two levels of this variable were used ; children in age ranges 5 to 10 years and 14 to 21 years. Other major demographic variables are, type of family which may either be nuclear or joint, age of parents, number of children, occupation of parents, qualification of parents, size of family etc.

Mental Retardation - Mental retardation is defined in the Persons with Disabilities Act, 1995 as "a condition of arrested or incomplete development of mind of a person which specially characterised by subnormality of intelligence".

This definition presents a somewhat similar picture as defined by the American Association on Mental Deficiency. In all definitions subnormality of intelligence is one of the principle factors.

Stress - The concept of stress is mainly influenced by the thoughts of Hans Selye (1936, 1956) who borrowed this concept from the natural sciences and defined it as an external event or internal drive that threatens the organismic equilibrium.

Coping - In coping responses people try to deal with the stress or make an effort to master the conditions of harm threat or challenge when a certain solution or response is not available.

Design of the Study - A correlational research design was employed in order to find out the relationship existing among different variables. In correlational design approach no efforts are made to determine whether two or more variables are related by engaging in careful observation of both. In correlational research variables are actually manipulated through selection and in the limits where conditions of research permit. In correlational design method according to Baron and Byrne (1993) – "no attempt is made to vary one of the factors in a systematic manner in order to observe the effect of such variations on the other variables".

In this study there are two groups of children and study is aimed at the parents of these two groups of children. So according to the purpose of the study parents were automatically divided as either parents belonging to the younger or older children.

Statistical Analysis - To find out the relationship existing among different variables correlation analysis was done. Mean and standard deviation were calculated in order to find out the average of scores and deviation in the scores. Besides these statistical analysis t-test was calculated to find out whether scores of two groups are significantly different or not.

Scoring and Coding :

For COPE scale scoring was done as 1, 2, 3, 4 where 1 represents the response category of " I usually don't do this at all." 2 represents " I usually do this a little bit." 3 represents "I usually do this a medium bit." 4 represents " I usually do this a lot."

For Questionnaire On Resources and Stress scoring was done according to the original scoring manual recommended by Friedrich et .al.

For demographic variables following coding pattern was followed :

Age of parent
Between 20 to 30 years- 1, Between 31 to 50 years- 2, Between 50 and above - 3
Age of the child
Between 5 to 10 years- 1, Between 14 to 21 years- 2
Occupation
Government Servant- 1, Business- 2, Self-employed- 3 (including housewives)
Type of family
Nuclear- 1, Joint- 2
Qualification
Under graduate- 1, Graduate- 2, Post graduate and above- 3
Total number of children
Between 1 to 2- 1, Between 3 to 4 - 2, 5 and above- 3
Size of family
Up to 3 members- 1, Between 4 to 6- 2, 7 and above- 3
Birth order of the child
Between 1 to 2- 1, Between 3 to 4- 2, Between 5 and above- 3

Chapter IV

Results

CHAPTER - IV
RESULTS

If we look at table 1 for demographic variables and coping strategies we notice that age of parent is correlated positively with restraint coping and acceptance ($P < .05$, .22 and .21, respectively), which indicate that middle age parents strive more for these coping strategies in comparison to other parents.

Age of child is negatively correlated with active coping (-.21, $P < .05$) which indicate that as the age of the child increases parents use active coping strategies less in frequency. Some other coping strategies are also negatively correlated with age of the child.

Occupation of parents is not significantly correlated with any of coping strategies.

Type of family demographic variable is correlated significantly with active coping (-.22, $P < .05$) and denial (.19, $P < .05$), which indicates that in joint families active coping is less frequently adopted whereas denial is used more.

Qualification of parents factor is not correlated with any of the coping strategies. Number of children variable is also not correlated significantly with any of the coping strategies.

Size of family is significantly correlated with denial (-.22, $P < .05$, and -.19, $P < .05$ respectively) and drug-alcohol disengagement which indicate that in large families parents of mentally handicapped children generally don't strive for alcohol or denial coping strategies.

Birth order of the child is positively correlated with planning coping strategy (.23, $P < .05$) indicating that for younger children parents have much planning.

TABLE – 1

CORRELATION MATRIX FOR DEMOGRAPHIC VARIABLES AND COPE SUB SCALES (FOR BOTH MOTHERS AND FATHERS N=100)

	ACTIVE COPING	PLANNING	SUPPRESSION OF COMPETING ACTIVITIES	RESTRAINT COPING	SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS	SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS	POSITIVE RE-INTERPRETATION AND GROWTH	ACCEPTANCE	TURNING TO RELIGION	FOCUS ON AND VENTING OF EMOTIONS	DENIAL	BEHAVIOURAL DISENGAGEMENT	MENTAL DISENGAGEMENT	ALCHOHOL-DRUG DISENGAGEMENT
AGE OF PARENT	-.00	.08	-.02	.22*	.10	.05	.18	.21*	.09	.03	.07	.17	.02	.06
AGE OF CHILD	-.21*	-.14	-.02	.07	.02	-.15	-.02	.02	-.04	-.09	.05	.11	-.16	.02
OCCUPATION	-.06	-.03	.08	-.13	-.03	-.03	-.06	-.11	-.03	.11	.11	-.04	.10	-.12
TYPE OF FAMILY	-.22*	-.02	.16	.06	-.15	.01	-.11	.04	-.09	.14	.19*	.10	-.10	-.16
QUALIFICATION	.07	.13	-.16	.06	.14	.10	-.01	-.01	.01	.09	.09	.08	.00	.03
NUMBER OF CHILDREN	-.07	.09	.05	.15	.11	.07	.06	-.15	.06	-.07	.13	.16	.00	.10
SIZE OF FAMILY	-.17	-.02	.04	.12	.01	-.03	-.03	.04	-.10	.05	.22*	.18	-.05	-.19*
BIRTH ORDER OF THE CHILD	-.02	.23*	-.14	.07	-.08	.11	.08	.03	.12	.04	.14	.13	.03	.09

SIGNIFICANCE - * P< .05, ** P< .01

Table 2 represents correlation matrix for demographic variables and Questionnaire on Resources and Stress factors. Age of parents variable is negatively correlated with parent and family problems (-.23, $P< .05$) which indicates that parents of middle age group perceived less problems. Age of parent variable is negatively correlated with physical incapacitation variable also (-.20, $P< .05$) that indicate parents have less acute perception of mentally retarded children's problem.

Age of child variable is negatively correlated with parent and family problem (-.22, $P< .05$) and physical incapacitation (-.20, $P< .05$), which indicate that as the age of the child increases parents perception of problems becomes less.

Occupation variable is significantly correlated with parent and family problems (.31, $P< .01$) and pessimism (.05, $P< .20$). It means that type of occupation is one factor that determines pessimism and problem perception.

Qualification variable is highly correlated with all the four factors of QRS-F (.26, $P< .01$, .21 $P<.05$, .29 $P< .01$, .30, $P< .01$) which represents that all QRS-F factors are positively affected by the qualification of parents.

Size of family factor is positively correlated with parent and family problem, pessimism and child characteristics (.31, $P< .01$, .28, $P< .01$, .20 $P< .05$ respectively), which means in the large families these problems are perceived more.

TABLE-2

CORRELATION MATRIX FOR DEMOGRAPHIC VARIABLES AND QUESTIONNAIRE ON RESOURCES AND STRESS FACTORS – (BOTH PARENTS) N = 100

	PARENT AND FAMILY PROBLEMS	PESSIMISM	CHILD CHARACTERISTICS	PHYSICAL INCAPACITATION
AGE OF PARENT	-.23*	-.13	-.14	-.20*
AGE OF CHILD	-.22*	-.18	-.15	-.20*
OCCUPATION	.31**	.20*	.14	.16
TYPE OF FAMILY	.17	.18	.15	.09
QUALIFICATION	.26**	.21*	.29**	.30**
NUMBER OF CHILDREN	-.11	-.05	-.03	-.07
SIZE OF FAMILY	.31**	.28**	.20*	.10
BIRTH ORDER OF CHILD	.07	.17	.14	.01

SIGNIFICANCE - *P < .05, ** P < .01

Table 3 represents correlation among coping strategy scales and Questionnaire on Resources and Stress factors. Parent and family problems is negatively correlated with alcohol - drug disengagement variable (-.33, $P< .01$) which shows that higher the perception of problems the less striving for intoxication.

Pessimism factor is highly correlated with alcohol variable (-.26, $P< .05$) showing negative correlation between these variables.

Child Characteristics is correlated with alcohol and drug disengagement (.29, $P< .01$) which means that more the physical and mental disturbances in the child less the use of intoxicants by the parents. These results are quite contradictory which will be discussed in the reset section.

Physical Incapacitation factor is correlated with positive reinterpretation and growth, turning to religion and focus on and venting of emotions (-.23, $P< .05$, .24, $P< .05$ and .27, $P <.01$ respectively) which means that as the physical problems of the child increase parents positive attitudes becomes less but on the other hand religious feelings increase and emotional expression is also comparatively higher.

TABLE - 3

CORRELATION MATRIX FOR COPE SUB SCALES AND QRS-F (FOR BOTH MOTHERS AND FATHERS N=100)

	ACTIVE COPING	PLANNING	SUPPRESSION OF COMPETING ACTIVITIES	RESTRAINT COPING	SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS	SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS	POSITIVE RE-INTERPRETATION AND GROWH	ACCEPTANCE	TURNING TO RELIGION	FOCUS ON AND VENTING OF EMOTIONS	DENIAL	BEHAVIOURAL DISENGAGEMENT	MENTAL DISENGAGEMENT	ALCHOHOL-DRUG DISENGAGEMENT	MEAN	SD
PARENT AND FAMILY PROBLEMS	-.10	-.06	-.07	.02	.01	-.08	-.14	-.03	.07	.11	-.02	.07	.01	-.33**	11.74	3.88
PESSIMISM	-.04	-.03	-.03	.14	-.00	-.07	-.17	-.05	.05	.18	-.04	.04	.01	-.26**	6.11	2.42
CHILD CHARACTERISTICS	.01	.07	.05	.08	.04	-.06	-.06	.01	.13	.10	.00	.15	-.06	-.29**	7.93	2.51
PHYSICAL INCAPACITATION	-.05	-.04	-.04	.06	-.03	-.10	-.23*	.01	.24*	.27**	-.08	-.03	.03	-.15	2.98	2.31

SIGNIFICANCE - * P < .05, ** P < .01

Table 4 presents the inter correlation among different coping strategy variables.

Active coping is significantly correlated with planning variable (.31 P< .01) showing that those parents who adopt active coping, also adopt planning to great extent. Active coping is negatively correlated with turning to religion and denial coping strategies (-.22 P< .05, -.19 P< .05) which means those parents who use active coping strategy don't use these two coping strategies very frequently.

Planning is positively correlated with suppression of competing activities (.31, P< .01) indicating that parents who use planning coping strategy focus more on the problems of the child. Probably that is why they also adopt denial coping strategy which is correlated with planning (.31 P< .01). Suppression of competing activities is correlated with denial (.20 P< .05) showing positive relationship between these two coping strategies.

Positive reinterpretation and growth is showing positive correlation with acceptance variable (.26 P< .01) indicating that parents try to adjust with the new demands and circumstances. Whereas it is correlated negatively with focus on and venting of emotions (-.20, P< .05) expressing less emotional expression due to better adjustment.

Religiosity is positively correlated with emotional expression (.43, P< .01) indicating that those parents who are religious are more expressive in their feelings. Whereas it is negatively correlated with denial and behavioural disengagement, indicating that more religious parents strive less for these strategies.

Denial is significantly correlated with behavioural disengagement (.37 P< .01) which means that those parents who neglect the problems of the children deny and avoid taking active attempts to cope with the situation.

TABLE - 4

INTERCORRELATION AMONG COPE SUB SCALE ITEMS FOR MOTHERS AND FATHERS (N=100)

	ACTIVE COPING	PLANNING	SUPPRESSION OF COMPETING ACTIVITIES	RESTRAINT COPING	SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS	SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS	POSITIVE RE-INTERPRETATION AND GROWTH	ACCEPTANCE	TURNING TO RELIGION	FOCUS ON AND VENTING OF EMOTIONS	DENIAL	BEHAVIOURAL DISENGAGEMENT	MENTAL DISENGAGEMENT	ALCHOHOL-DRUG DISENGAGEMENT	MEAN	SD
ACTIVE COPING	1.0	.31**	-.07	.09	.03	-.03	.18	.03	-.22*	-.19*	-.04	.03	.08	.05	11.1	2.8
PLANNING		1.0	.31**	-.01	.09	.04	.11	.06	-.08	-.08	.27**	.28	.14	-.07	11.4	2.9
SUPPRESSION OF COMPETING ACTIVITIES			1.0	.03	-.11	-.04	.06	-.00	.12	.11	.20*	.10	.09	-.13	10.9	3.3
RESTRAINT COPING				1.0	.04	-.05	-.05	.03	.12	.12	-.01	.16	.06	.11	10.1	3.2
SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS					1.0	.04	.10	-.02	.08	-.10	-.08	.11	.03	-.05	9.9	3.5
SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS						1.0	.00	-.13	-.14	.04	.05	.13	.02	.10	10.1	3.1
POSITIVE REINTERPRETATION AND GROWTH							1.0	.26**	-.11	-.20*	.04	-.05	.06	.03	9.3	3.2
ACCEPTANCE								1.0	.21*	-.02	.00	-.05	-.20*	-.06	9.6	3.5
TURNING TO RELIGION									1.0	.43**	-.28**	-.31**	-.20*	-.02	10.2	3.7
FOCUS ON & VENTING OF EMOTIONS										1.0	.06	-.12	-.13	.03	10.9	3.3
DENIAL											1.0	.37**	-.08	-.04	9.7	3.2
BEHAVIOURAL DISENGAGEMENT												1.0	.03	-.04	10.8	3.3
MENTAL DISENGAGEMENT													1.0	.10	9.50	3.1
ALCHOHOL DRUG DISENGAGEMENT														1.0	1.21	.67

SIGNIFICANCE - * P < .05, ** P < .01

Table 5 presents the inter correlations among Questionnaire on Resources and Stress factors.

Parent and family problems is highly correlated with all three variable (.76 P< .01, .75 P< .01, .53 P< .01 respectively), indicating that if parents have perceived the problems in their family as high then it directly affects to other three variables of pessimism, child characteristics and physical incapacitation.

Pessimism is highly correlated with all the three variables of parent and family problems, child characteristics and physical incapacitation (.76 P< .01, .68 P< .01, .53 P< .01) indicating highly positive relationship among these variables.

Child characteristics variable is also highly correlated with other three indicating dependency of one variable upon another. (.75 P< .01, .68 P< .01 and .50 P< .01 respectively).

TABLE –5

INTERCORRELATIONS AMONG QRS-F FACTORS (BOTH MOTHERS AND FATHERS) (N=100)

		PARENTS AND FAMILY PROBLEMS	PESSIMISM	CHILD CHARACTERISTICS	PHYSICAL INCAPACITATION	MEAN	SD
1.	PARENT AND FAMILY PROBLEMS	1.0	.76**	.75**	.53**	11.74	3.90
2.	PESSIMISM		1.0	.68**	.53**	6.11	2.42
3.	CHILD CHARACTERISTICS			1.0	.50**	7.93	2.51
4.	PHYSICAL INCAPACITATION				1.0	3.00	2.32

SIGNIFICANCE - * P< .05, ** P< .01

Table 6 represents correlation matrix for demographic variables and coping strategies for fathers. (N=50).

Age of fathers is correlated positively with turning to religion variable (.36 P< .01) which means that fathers who are in their middle and old age are more religious than younger parents. Age of fathers is positively correlated with behavioural disengagement variable also (.28 P< .05) indicating that older parents accept their helplessness regarding their children's' problems.

Age of the children is negatively correlated with turning to religion variable (-.37, P< .01) indicating that for those children who are in 14-21 age group fathers have less religious beliefs and feelings.

Qualification of fathers is negatively correlated with suppression of competing activities (-.44 P< .01) indicating that educated fathers concentrate more on the problems of the child.

Birth order is significantly correlated with planning (.27 P< .05) which means that fathers of younger children have more planning in comparison to elder ones.

TABLE – 6

CORRELATION MATRIX FOR DEMOGRAPHIC VARIABLES AND COPE SUB SCALES (FOR FATHERS) (N=50)

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14
AGE OF PARENT	.00	.13	-.02	.14	.11	.14	.17	.30	.36**	.08	-.03	.28*	.07	-.01
AGE OF CHILD	-.15	-.07	-.16	.01	.16	.06	.07	.11	-.37**	-.10	.15	.17	-.26	-.08
OCCUPATION	-.00	.15	.26	-.22	-.13	.03	-.01	-.29	-.14	.04	.14	.00	.21	-.03
TYPE OF FAMIY	-.26	-.13	.05	.09	-.10	.12	-.11	.14	.10	.26	.09	-.00	-.11	-.16
QUALIFICATION	.09	.08	-.44**	-.04	.16	.09	.04	.07	-.18	-.07	.23	-.00	-.07	.19
NUMBER OF CHILDREN	-.24	.11	.15	.03	-.01	.24	.04	.00	.21	-.05	.09	.24	.02	.11
SIZE OF FAMILY	-.22	-.03	.06	.08	-.00	.06	-.03	.17	-.01	-.03	.06	.12	-.06	-.14
BIRTH ORDER OF CHILD	-.04	.27*	.19	.00	-.25	.03	.18	.11	.17	.01	.07	.14	.15	.16

SIGNIFICANCE - * P < .05, ** P < .01

1 = ACTIVE COPING, 2= PLANNING, 3= SUPPRESSION OF COMPETING ACTIVITIES, 4= RESTRAINT COPING, 5= SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS, 6= SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS, 7= POSITIVE REINTERPRETATION AND GROWTH, 8= ACCEPTANCE, 9= TURNING TO RELIGION, 10= FOCUS ON AND VENTING OF EMOTIONS, 11= DENIAL, 12= BEHAVIOURAL DISENGAGEMENT, 13= MENTAL DISENGAGEMENT, 14= ALCHOHOL DRUG DISENGAGEMENT.

Table 7 presents the correlations among demographic variables & Questionnaire on Resources and Stress factors. No significant correlation can be seen between any of the two variables on any of these questionnaires for fathers.

TABLE 7

CORRELATION MATRIX FOR DEMOGRAPHIC VARIABLES AND QRS-F FACTORS (FOR FATHERS N=50)

VARIABLES	PARENT AND FAMILY PROBLEMS	PESSIMISM	CHILD CHARACTERISTICS	PHYSICAL INCAPACITATION
AGE OF PARENT	-.10	.15	.04	.18
AGE OF CHILD	-.12	.12	-.04	-.06
OCCUPATION	.08	-.40**	.01	-.14
TYPE OF FAMILY	-.10	.10	-.10	.10
QUALIFICATION	.06	.11	-.05	-.09
NUMBER OF CHILDREN	-.03	-.01	.02	.05
SIZE OF FAMILY	.16	.20	-.05	-.04
BIRTH ORDER OF THE CHILD	.03	.21	.21	-.15

SIGNIFICANCE - * P< .05, ** P< .01

Table 8 presents correlations among coping strategy scale and Questionnaire on Resources and Stress variables for fathers.

Parent and family problems is not correlated significantly with any of the coping strategies indicating parents and family problems is not very effective factor in determining coping strategies.

Pessimism (-.31, $P<.05$) is negatively correlated with denial which means more the pessimistic feelings in fathers less the adoption of denial coping strategies.

Child characteristics is positively correlated with positive reinterpretation and growth (.33, $P< .05$) which indicates that fathers whose children have more clear symptoms strive for more positive attitudes. Child characteristics is also correlated with focus on and venting of emotions (-.31, $P< .05$) which means that more the attitudinal and behavioural problems in the child less emotional feeling expression by the fathers.

Physical incapacitation is correlated significantly with active coping and denial (-.32 $P< .05$ and -.27 $P< .05$ respectively) showing more the physical disabilities in the child less the use of active coping and denial strategies.

TABLE-8

CORRELATION MATRIX FOR COPE SUB SCALES AND QRS-F FACTORS (FOR FATHERS N=50)

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	MEAN	SD
PARENT AND FAMILY PROBLEMS	.08	-.12	-.21	-.23	.11	-.14	.10	.22	-.09	-.41	-.11	.01	.25	-.13	8.3	2.2
PESSIMISM	.08	-.07	-.09	.16	.04	-.08	.10	.12	.00	-.06	-.31*	-.11	.08	-.02	4.2	1.6
CHILD CHARACTERISTICS	.26	.15	.21	-.13	-.02	.12	.33*	.05	-.03	-.31*	-.03	.15	.01	-.11	6.0	1.5
PHYSICAL INCAPACITATION	-.32*	-.17	-.10	.09	-.21	-.04	-.17	.04	.20	-.02	-.27*	-.12	.17	.16	1.6	1.0

SIGNIFICANCE - * P< .05, ** P< .01

1 = ACTIVE COPING, 2= PLANNING, 3= SUPPRESSION OF COMPETING ACTIVITIES, 4= RESTRAINT COPING, 5= SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS, 6= SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS, 7= POSITIVE REINTERPRETATION AND GROWTH, 8= ACCEPTANCE, 9= TURNING TO RELIGION, 10= FOCUS ON AND VENTING OF EMOTIONS, 11= DENIAL, 12= BEHAVIOURAL DISENGAGEMENT, 13= MENTAL DISENGAGEMENT, 14= ALCHOHOL DRUG DISENGAGEMENT.

Table 9 presents the intercorrelations among different coping strategies used by the fathers. Active coping is significantly correlated with planning (.36 P< .05) which means those fathers who use active coping, use planning coping strategy also.

Planning is significantly correlated with suppression of competing activities (.30 P< .05) which means fathers who use planning, strive for more concentrated effort on the problem. Planning is significantly correlated with denial and behavioural disengagement also (.33 P< .05, and .27 P< .05 respectively) indicating that more the planning, more the use of denial and behavioural disengagement coping strategy.

Seeking social support for emotional reasons is correlated negatively (-.27 P<.05) with acceptance.

Positive reinterpresentation and growth is correlated with acceptance (.35, P< .05) which means more the positive attitude of fathers more the acceptance of reality.

Turning to religion is correlated significantly with focus on and venting of emotions and denial (.30 P <.05, - .39 P< .01) which means more the religiosity in fathers more expression of emotional feelings and less acceptance of reality.

TABLE – 9

INTERCORRELATIONS AMONG COPE SUB SCALES (FOR FATHERS N=50)

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	MEAN	SD
ACTIVE COPING	1.0	.36**	.03	.16	.01	-.26	.20	.12	-.25	-.18	.01	.03	.01	-.11	11.40	3.20
PLANNING		1.0	.30*	.02	.03	-.10	.25	.11	-.03	-.04	.33*	.27*	.09	-.10	11.40	3.20
SUPPRESSION OF COMPETING ACTIVITIES			1.0	.20	-.13	-.01	.16	.05	.17	.11	.12	-.09	.09	-.19	11.00	3.50
RESTRAINT COPING				1.0	.13	.02	-.13	-.07	.09	.01	-.16	-.15	.19	.21	9.70	3.40
SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS					1.0	-.16	.03	.16	.08	-.19	-.09	-.01	-.03	-.07	9.90	3.50
SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS						1.0	-.16	-.27*	.07	.20	.09	.21	-.02	.12	10.4	3.30
POSITIVE REINTERPRETATION AND GROWTH							1.0	.35**	-.09	-.20	.03	-.09	.09	-.03	9.90	3.10
ACCEPTANCE								1.0	.30*	-.15	-.05	-.03	-.10	-.12	9.80	3.10
TURNING TO RELIGION									1.0	.30*	-.39**	-.26	-.17	.02	9.80	3.60
FOCUS ON AND VENTING OF EMOTIONS										1.0	.07	-.03	-.06	.15	10.10	3.60
DENIAL											1.0	.44	-.05	-.04	9.50	3.20
BEHAVIOURAL DISENGAGEMENT												1.0	.16	-.02	10.60	3.40
MENTAL DISENGAGEMENT													1.0	.12	9.70	3.2
ALCHOHOL DRUG DISENGAGEMENT														1.0	1.40	0.90

SIGNIFICANCE - * P < .05, ** P < .01

1 = ACTIVE COPING, 2= PLANNING, 3= SUPPRESSION OF COMPETING ACTIVITIES, 4= RESTRAINT COPING, 5= SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS, 6= SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS, 7= POSITIVE REINTERPRETATION AND GROWTH, 8= ACCEPTANCE, 9= TURNING TO RELIGION, 10= FOCUS ON AND VENTING OF EMOTIONS, 11= DENIAL, 12= BEHAVIOURAL DISENGAGEMENT, 13= MENTAL DISENGAGEMENT, 14= ALCHOHOL DRUG DISENGAGEMENT.

Table 10 presents the intercorrelations among Questionnaire on Resources and stress variables.

None other factor except parent and family problems is correlated with any other factor. Parent and family problems is significantly correlated with child characteristics (.31 $P < .05$) that means more the behavioural and mental problems in the child more the perception of problems in the family by the fathers.

TABLE – 10

INTERCORRELATIONS AMONG QRS-F FACTORS (PARENT AND FAMILY PROBLEMS, PESSIMISM, CHILD CHARACTERISTICS AND PHYSICAL INCAPACITATION) FOR FATHERS (N=50)

FACTORS	PARENT AND FAMILY PROBLEMS	PESSIMISM	CHILD CHARACTERISTICS	PHYSICAL INCAPACITATION	MEAN	SD
PARENT AND FAMILY PROBLEMS	1.0	.09	.31*	-.14	8.32	2.20
PESSIMISM		1.0	.23	-.20	4.16	1.56
CHILD CHARACTERISTICS			1.0	-.25	5.98	1.55
PHYSICAL INCAPACITATION				1.0	1.60	0.97

SIGNIFICANCE - * P< .05, ** P < .01

Table 11 presents the correlations among demographic variables and coping strategies for mothers.

It is apparent from the table that age of mothers is significantly correlated with restraint coping (.37 P< .01) which means that middle age mothers try and wait for the proper situation to solve the problem. Age of mothers is also negatively correlated with seeking social support for emotional reasons (-.53, P< .01) that means middle age mothers have less will for sharing their problems with others.

Age of child is correlated with active coping (-.38, P< .01) and seeking social support for emotional reasons (-.42, P< .01) which means mothers of elder children strive less for these coping strategies.

Type of family is correlated with suppression of competing activities (.30 P< .05) and turning to religion (-.30, P < .05) which means in large families there is less religiosity.

Number of children variable is correlated with restraint coping (.30, P< .05) that means more children directly affects the restraint coping. Number of children is also correlated negatively with acceptance variable (-.32, P< .05) which means more children cause mothers to deny some of the realities.

Size of family is correlated significantly with denial (.35 P< .01) indicating that more the family members more denial by the mothers regarding disabled child.

TABLE – 11

CORRELATION MATRIX FOR DEMOGRAPHIC VARIABLES AND COPE SUB SCALES (FOR MOTHERS, N=50)

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13
AGE OF PARENT	-.06	.02	-.04	.37**	.10	-.53**	.14	.13	-.07	.09	.16	.11	-.07
AGE OF CHILD	-.38**	-.23	.12	.18	-.10	-.42**	-.18	-.10	.01	.04	-.01	.10	-.10
OCCUPATION	-.05	-.19	-.04	-.16	.04	-.04	.01	.06	-.03	.03	.08	-.14	.06
TYPE OF FAMILY	-.14	.10	.30*	-.01	-.20	-.08	-.05	-.03	-.30*	-.10	.26	.16	-.07
QUALIFICATION	.12	.19	.12	.12	.13	.18	.01	-.06	.08	.13	-.05	.12	.11
NUMBER OF CHILDREN	.10	.08	-.07	.30*	.23	-.11	.04	-.32*	-.04	-.02	.17	.10	-.03
SIZE OF FAMILY	-.04	-.00	.04	.10	.02	-.08	.08	-.03	-.27	-.04	.35**	.20	.01
BIRTH ORDER OF THE CHILD	.03	.18	.10	.14	.09	.21	.02	-.03	.07	.06	.20	.10	-.08

SIGNIFICANCE - * P> .05, ** P< .01

1= ACTIVE COPING, 2= PLANNING, 3= SUPPRESSION OF COMPETING ACTIVITES, 4= RESTRAINT COPING, 5= SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS, 6= SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS, 7= POSITIVE REINTERPRETATION AND GROWTH, 8= ACCEPTANCE, 9= TURNING TO RELIGION, 10= FOCUS ON AND VENTING OF EMOTIONS, 11= DENIAL, 12= BEHAVIOURAL DISENGAGEMENT, 13= MENTAL DISENGAGEMENT.

Table 12 consists of correlations among demographic variables and Questionnaire on Resources and stress factors for mothers.

Occupation is significantly correlated with child characteristics (-.37, P< .01) that means that housewives have less seriously observed physical and mental disabilities of the child.

Qualification of mothers is correlated positively with child characteristics and physical incapacitation (.31 P< .05, and .31, P< .05 respectively) that means mothers who are around intermediate and graduate have rated the behavioural and mental problems of their children more accurately.

TABLE - 12

CORRELATION MATRIX FOR DEMOGRAPHIC VARIABLES AND QUESTIONNAIRE ON RESOURCES AND STRESS FACTORS (FOR MOTHERS, N=50)

VARIABLES	PARENT AND FAMILY PROBLEMS	PESSIMISM	CHILD CHARACTERISTICS	PHYSICAL INCAPACITATION
AGE OF PARENT	-.17	-.03	.02	-.02
AGE OF CHILD	.14	-.07	.14	-.08
OCCUPATION	-.03	.09	-.37**	-.03
TYPE OF FAMILY	.09	-.05	.07	-.11
QUALIFICATION	.06	-.11	.31*	.31*
NUMBER OF CHILDREN	-.01	.17	.18	-.02
SIZE OF FAMILY	-.08	-.12	-.10	-.16
BIRTH ORDER OF THE CHILD	-.00	.19	.07	.00

SIGNIFICANCE * P> .05, ** P> .01

Table 13 presents correlation matrix for coping strategies and Questionnaire on Resources and stress factors for mothers.

Only physical incapacitation is correlated significantly with focus on and venting of emotions (.27, $P < .05$) that means if the physical disabilities regarding the child are numerous, it directly affects how their mothers express the feelings.

TABLE – 13

CORRELATION MATRIX FOR COPE SUB SCALES AND QUESTIONNAIRE ON RESOURCES AND STRESS FACTORS (FOR MOTHERS, N=50)

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	MEAN	SD
PARENT AND FAMILY PROBLEMS	-.20	-.13	.13	-.02	-.19	.16	-.11	-.24	-.01	.07	-.16	.00	.02	15.16	1.28
PESSIMISM	.09	.00	.10	-.01	-.09	.11	-.22	-.14	-.14	-.04	.09	.08	.16	8.06	1.28
CHILD CHARACTERISTICS	.04	.11	.04	.14	.13	-.16	-.06	.14	.16	.02	-.07	.14	.01	9.88	1.61
PHYSICAL INCAPACITATION	.23	.01	.00	-.05	.02	-.10	-.17	.08	.24	.27*	.10	-.10	.07	4.38	2.43

SIGNIFICANCE - * P < .05, ** P < .01

1= ACTIVE COPING, 2= PLANNING, 3= SUPPRESSION OF COMPETING ACTIVITES, 4= RESTRAINT COPING, 5= SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS, 6= SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS, 7= POSITIVE REINTERPRETATION AND GROWTH, 8= ACCEPTANCE, 9= TURNING TO RELIGION, 10= FOCUS ON AND VENTING OF EMOTIONS, 11= DENIAL, 12= BEHAVIOURAL DISENGAGEMENT, 13= MENTAL DISENGAGEMENT.

Table 14 presents the intercorrelations among all coping strategy sub scales for mothers.

Active coping is correlated significantly with seeking social support for emotional reasons (.29, P< .05) indicating that search for emotional support from interpersonal relations is an important part of active coping.

Planning is correlated significantly with suppression of competing activities and behavioural disengagement (.31 , P< .05, and .30 P< .05) which indicate that these two coping strategies are an important part of planning.

Suppression of competing activities is significantly correlated with denial and behavioural disengagement (.28 P< .05, .33 P< .05) that means with the help of these two coping strategies mothers have concentrated more on their children's' problems.

Seeking social support for emotional reasons is correlated significantly with turning to religion (-.35, P< .01) indicating less religiosity in the mothers. Turning to religion is significantly correlated with emotional expression (.58, P< .01) that means more religions mothers are more emotionally expressive. On the other hand turning to religion is negatively correlated with behavioural disengagement (-.39 P< .01) that means more religions mother make a greater effort at solving problems.

Focus on and venting of emotions is correlated negatively with behavioural disengagement (-.30 P< .05) that means more the expression of emotions less avoidance from the positive effort by the mothers.

Denial is correlated positively with behavioural disengagement (.31 P< .05) that means a positive relationship between these two variables.

TABLES-14

INTERCORRELATIONS AMONG COPE SUB SCALES (FOR MOTHERS, N=50)

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	MEAN	SD
ACTIVE COPING	1.0	.24	-.24	.02	.06	.29*	.14	-.11	-.18	-.15	-.10	.07	.15	10.76	2.30
PLANNING		1.0	.31*	-.06	.17	.21	-.04	-.00	-.13	-.14	.20	.30*	.19	11.40	2.72
SUPPRESSION OF COMPETING ACTIVITIES			1.0	-.16	-.10	-.09	-.04	-.06	.08	.15	.28*	.33*	.08	10.78	3.13
RESTRAINT COPING				1.0	-.06	.10	.07	.04	.13	.22	.14	-.18	-.07	10.40	3.03
SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS					1.0	-.09	.17	-.19	.08	-.01	-.08	.25	.10	10.00	3.55
SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS						1.0	.15	.01	-.35**	-.13	.02	.04	.04	9.92	2.92
POSITIVE REINTERPRETATION AND GROWTH							1.0	.15	-.09	-.13	.06	.02	-.00	8.80	3.25
ACCEPTANCE								1.0	.14	.18	.06	-.07	-.10	9.42	4.49
TURNING TO RELIGION									1.0	.58**	-.20	-.39**	-.21	10.64	3.87
FOCUS ON AND VENTING OF EMOTIONS										1.0	.04	-.30*	-.17	11.82	2.85
DENIAL											1.0	.31*	-.10	9.82	3.36
BEHAVIOURAL DISENGAGEMENT												1.0	-.10	11.06	3.19
MENTAL DISENGAGEMENT													1.0	9.26	3.05

SIGNIFICANCE * P> .05, ** P> .01

Table 15 presents intercorrelations for Questionnaire on Resources and stress factors for mothers.

No other variable is correlated significantly except parent and family problems which is correlated with pessimism (.33 $P < .05$). This correlation indicates that in general parent and family problems for mothers leads to perception of pessimistic feelings.

TABLE 15

INTERCORRELATIONS AMONG QRS-F FACTORS (PARENT AND FAMILY PROBLEMS, PESSIMISM, CHILD CHARACTERISTICS, AND PHYSICAL INCAPACITATION) FOR MOTHERS (N=50)

VARIABLES	1	2	3	4	MEAN	SD
PARENT AND FAMILY PROBLEMS	1.0	.33*	.05	.05	15.16	1.28
PESSIMISM		1.0	.06	.23	8.06	1.28
CHILD CHARACTERISTICS			1.0	.18	9.88	1.61
PHYSICAL INCAPACITATION				1.0	4.38	2.43

SIGNIFICANCE * P< .05, ** P> .01

Table 16 and 17 represents the differences between the scores of parents of mentally handicapped children on COPE scale and Questionnaire on Resources and Stress factors. According to the plan of the study these are 50 cases of mothers and 50 cases of fathers. First if we look at table 16 that represents t value for cope scales, none of the coping strategies are found different except focus on the venting of emotions whereas scores are significantly different at .05 level of significance mothers have scored significantly more points than fathers.

TABLE – 16

RESULTS OF T-TEST FOR MOTHERS AND FATHERS ON COPE SCALES (N=50 EACH)

SUB SCALES	FATHERS		MOTHERS		T-VALUE	REMARKS
	MEAN	SD	MEAN	SD		
ACTIVE COPING	11.40	3.20	10.76	2.31	1.14	NOT SIGNIFICANT
PLANNING	11.44	3.25	11.40	2.72	0.06	NOT SIGNIFICNT
SUPPRESSION OF COMPETING ACTIVITIES	11.00	3.48	10.78	3.13	0.33	NOT SIGNIFICANT
RESTRAINT COPING	9.72	3.42	10.40	3.03	1.05	NOT SIGNIFICANT
SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS	9.94	3.55	10.00	3.55	0.08	NOT SIGNIFICANT
SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS	10.38	3.29	9.92	2.91	0.74	NOT SIGNIFICANT
POSITIVE REINTERPRETATION AND GROWTH	9.92	3.11	8.80	3.25	1.77	NOT SIGNIFICANT
ACCEPTANCE	9.84	3.56	9.42	3.48	0.6	NOT SIGNIFICANT
TURNING TO RELIGION	9.80	3.62	10.64	3.87	1.12	NOT SIGNIFICANT
FOCUS ON AND VENTING OF EMOTIONS	10.14	3.58	11.82	2.84	2.58	SIGNIFICANT .05 LEVEL
DENIAL	9.54	3.18	9.82	3.36	0.43	NOT SIGNIFICANT
BEHAVIOURAL DISENGAGEMENT	10.56	3.38	11.06	3.19	0.77	NOT SIGNIFICANT
MENTAL DISENGAGEMENT	9.74	3.20	9.26	3.05	0.77	NOT SIGNIFICANT
ALCHOHOL-DRUG DISENGAGEMENT	1.42	0.90	1.00	0.00	0.74	NOT SIGNIFICANT

If we look at table 17 which presents t-values for mothers and fathers, all the scores are highly significant. Mothers have scored much higher than fathers on all the four factors (Parent and Family Problems, Pessimism, Child Characteristics and Physical Incapacitation) of Questionnaire on Resources and stress.

TABLE – 17

RESULTS OF T-TEST FOR MOTHERS AND FATHERS ON QRS-F (N=50 EACH)

FACTORS	FATHERS		MOTHERS		T-VALUE	REMARKS
	MEAN	SD	MEAN	SD		
PARENT AND FAMILY PROBLEMS	8.32	2.21	15.16	1.28	19.00	HIGHLY SIGNIFICANT
PESSIMISM	4.16	1.57	8.06	1.28	13.63	HIGHLY SIGNIFICANT
CHILD CHARACTERISTICS	5.98	1.56	9.88	1.61	12.58	HIGHLY SIGNIFICANT
PHYSICAL INCAPACITATION	1.58	0.97	4.38	2.43	7.56	HIGHLY SIGNIFICANT

Table 18 consists of t-values that is showing the differences among the scores of parents of first age group (younger) of children and second age group (older) of children. On Acting Coping sub-scale parents of first age group of children scored slightly higher than parents of second age group (.05 level, significant). On Behavioural Disengagement parents of second age group scored slightly higher than first age group (.05 level, significant).

TABLE – 18

RESULTS OF T-TEST BETWEEN THE SCORES OF FIRST AGE GROUP CHILDRENS' PARENTS (5-10 YEARS) AND SECOND AGE GROUP CHILDRENS' PARENTS (14-21 YEARS), N=42 AND N=58 SIMULTANEOUSLY, ON COPE SCALE

VARIABLE	PARENTS (AGE GROUP FIRST)		PARENTS (SECOND AGE GROUP)		T-VALUE	REMARKS
	MEAN	SD	MEAN	SD		
ACTIVE COPING	11.76	2.46	10.58	2.93	2.13	SIGNIFICANT .05 LEVEL
PLANNING	11.90	2.93	11.06	2.99	1.39	NOT SIGNIFICNT
SUPPRESSION OF COMPETING ACTIVITIES	10.95	3.37	10.84	3.27	0.16	NOT SIGNIFICANT
RESTRAINT COPING	9.80	2.98	10.24	3.41	0.67	NOT SIGNIFICANT
SEEKING SOCIAL SUPPORT FOR INSTRUMENTAL REASONS	9.88	3.50	10.03	3.58	-0.02	NOT SIGNIFICANT
SEEKING SOCIAL SUPPORT FOR EMOTIONAL REASONS	10.69	3.05	9.75	3.10	1.51	NOT SIGNIFICANT
POSITIVE REINTERPRETATION AND GROWTH	9.42	2.79	9.31	3.51	0.17	NOT SIGNIFICANT
ACCEPTANCE	9.54	3.37	9.68	3.63	0.12	NOT SIGNIFICANT
TURNING TO RELIGION	10.38	3.53	10.10	3.93	0.37	NOT SIGNIFICANT
FOCUS ON AND VENTING OF EMOTIONS	11.33	3.00	10.72	3.54	0.90	SIGNIFICANT .05 LEVEL
DENIAL	9.47	3.21	9.82	3.32	0.53	NOT SIGNIFICANT
BEHAVOURAL DISENGAGEMENT	10.38	3.40	11.12	3.17	2.58	SIGNIFICANT .05 LEVEL
MENTAL DISENGAGEMENT	10.07	2.99	9.08	3.17	1.57	NOT SIGNIFICANT
ALCHOHOL-DRUG DISENGAGEMENT	1.19	0.59	1.22	0.72	0.32	NOT SIGNIFICANT

Table 19 consists of t-values for the parents of first age group (5-10 years) children and the parents of second age group children (14-21 years). Scores on parent and family problems factor for the first age group parents are significantly different with those of second age group (.05 level, significant). On the pessimism and child characteristics factors there are no significant differences between the scores.

On physical incapacitation factor first age group parents have scored significantly higher scores than second age group (.05 level, significant).

TABLE – 19

RESULTS OF T-TEST BETWEEN THE SCORES OF FIRST AGE GROUP CHILDRENS' PARENTS (5-10 YEARS) AND SECOND AGE GROUP CHILDRENS' PARENTS (14-21 YEARS), N=42 AND N=58 SIMULTANEOUSLY, ON QUESTIONNAIRE ON RESOURCES AND STRESS.

FACTORS	AGE GROUP FIRST (5-10 YEARS)		AGE GROUP SECOND (14-21 YEARS)		T-VALUE	REMARKS
	MEAN	SD	MEAN	SD		
PARENT AND FAMILY PROBLEMS	12.76	3.49	11.00	4.00	2.28	SIGNIFICANT .05 LEVEL
PESSIMISM	6.61	2.38	5.74	2.40	1.79	NOT SIGNIFICANT
CHILD CHARACTERISTICS	8.38	2.34	7.60	2.60	1.54	NOT SIGNIFICANT
PHYSICAL INCAPACITATION	3.52	2.55	2.58	2.06	2.04	SIGNIFICANT .05 LEVEL

General Conclusions of Interviews :

1. The ten interviews that were conducted consisted of five mothers and five fathers. Out of those ten parents four had children with Down syndrome one had Microcephaly and others had either speech problems or mild mental retardation.
2. In almost all the interviews parents mentioned that in the beginning they were actually not familiar with the problems their children had but when these children started lagging behind in all activities and were properly examined then they became aware of the disability condition
3. Generally parents replied that if a mentally handicapped child is staying with the family it creates troubles for all family members. Like one parent stated that future of another child is being spoiled because of this child. Because parents are generally more involved with mentally handicapped children than other family members so usually other children are to some extent neglected in order to concentrate and cooperate with the new circumstances created by the mentally handicapped child. They expressed the need that disabled children should be kept in the hostel in order to avoid the bad effects upon the lives of other family members. Around seven parents expressed the need of hostels where their disabled children could live.
4. Most parents feel that except for themselves no other family members directly interact with the child and try to avoid such children. In some interviews mothers expressed that fathers of these children don't care much about this problem. They mentioned that fathers generally concentrate on other children's future and because they work for the whole day outside the home so they feel less stress . Because mothers usually stay at home with their children and they spend more time that's why they feel more stress which they had expressed during the interviews . But on the other hand around four mothers expressed that they were getting proper support and cooperation from their spouses . Some parents mentioned that after the birth of mentally handicapped child they did not prefer to have another child because of the

fear of possibility of having another child with mental retardation. Almost all the parents were satisfied by their decision of admitting the child in special school because it provided a kind of satisfaction that at least their child is also studying in some school like other normal children. Mothers were also quite satisfied because in this way by sending their disabled children to special school they feel that around six hours of stress were reduced because staying all the time with such children is probably more stressful.

5. Generally parents mentioned that their social and interpersonal relations are affected by this kind of problem in the family. They need to change their daily routine and other social activities in order to provide more time to the mentally handicapped child. On the other hand two fathers stated that they have increased their social circle so that they can get more interpersonal support from other members of the society. Almost all the parents mentioned that they get a lot of satisfaction when they come to special school and meet other parents. Sharing their feelings with one another was found to be a prominent coping strategy.

6. When parents were asked questions like " what are your future plans for this child after he / she will leave this school.? " or " what are your plans regarding future adjustment with this child .?" it was a general conclusion that they were little bit confused , because they were unable to decide properly that what might be the exact future plan for such child. By the way, few parents replied that they want that mentally handicapped children may get some kind of vocational training so that he/ she can at least spend some time in the society. Amongst the plans that parents had one parent stated that he wants that this child may go to the village where he will look after the agricultural farm and the labourers working there in the field.

7. Nine out of ten parents were satisfied that their mentally handicapped children are getting proper support and training in that special school and they described the different kinds of behavioural changes in the child that took place after admission. Some parents were quite content that their children

would become normal and a respectable average citizen after completion of the schooling there in that special school. When they were asked about what kinds coping strategies they use and what is the intensity of stress they feel , their responses were mixed. Some parents stated that support from spouse was a great source of satisfaction, meeting other parents who have children with mental disability was also a good coping strategy. Because scores of mothers on Questionnaire on Resources and Stress were acceptably high, so mothers were especially asked regarding causes of feeling more stress. Their general responses were that because they spend more time with the children, feel more emotional attachment and being a mother are important causes. Fathers also agreed that mothers feel more stress because most of them are housewives and also because of more anxiety about the future of the child.

8. Except one mother all parents accepted that they have developed more religious feelings after the birth of mentally handicapped child . They stated that these kinds of children are the result of some kinds of sin conducted by them (parents) in the previous birth. One mother exceptionally stated very stressful and frustrating feelings towards God and religion. She stated that diseases, whether mental or biological have some well known causes and not the God or sin. Almost all parents agreed that they had to change their life pattern and had to adjust according to the new demands created by the mentally handicapped child.

Chapter V

Discussion

CHAPTER - V
DISCUSSION

Different levels of stress in the parents of mentally handicapped children:

Overall scores of mothers and fathers indicate that age of the child is correlated negatively with parent and family problems and physical incapacitation factors of Questionnaire on Resources and Stress. It means that as the age of the child increases tension and stress experienced by the parents becomes less intense. It is indicated in some studies that parents develop an adaptation with the circumstances as their experience increases. Generally in the beginning because of not having such experience earlier parents become stressed. Time itself teaches them that how to cope and use different coping strategies.

Results indicate that all the stress factors are highly positively correlated with one another for both parents (Table 5). This is a clear indication that if parents have expressed stress on one factor then there is high possibility that they would express stress on other aspects also. There are a total of four stress factors in Questionnaire on Resources and Stress i.e., Parent and Family Problems, Pessimism, Child Characteristics and Physical Incapacitation. Table (5) indicates that these factors are highly correlated. For example if a parent has expressed more pessimistic view about life he has also expressed more problems in the physical abilities of the child.

If we look at t table for parents of younger children and the parents of older children (Table 19) we find significant differences between parent and family problems and physical incapacitation factors. These significant differences indicate that parents of younger children have expressed more stress and perceived more problem in themselves and in the whole family . Parents problems might be related to their personality, social and practical problem. In family problem there might be interpersonal problems, understanding and adjustment problems among different members. Physical incapacitation or parents perception of child's physical limitations

factor is perceived higher by the parents of younger children. It shows that in the beginning due to lack of resources, and adjustment parents might perceive child's problems greater.

As Peshwaria et.al. (1992) have mentioned in a study that age of the child affects the stress levels of parents. It is found that generally parents of younger children with mental retardation express more stress and impairment in their own abilities. This may be due to non-familiarity with this kind of problem earlier and due to lack of resources. But as the child grows they develop some adjustment capacities and adopt different kinds of coping strategies to deal with this problem.

Because parents in this study were quite satisfied with the learning performance of their children in the special school, so they were found to be quite content that as the child will grow his vocational and intellectual abilities would also develop. This probably might be one reason why the parents of older children have expressed less stress. This result is also supported by Orr et.al. (1993) who indicated that parents express variety of stressors and stress reactions regarding mental retardation of their children. Parents are known to get impacted in many ways because of having a child with mental retardation. These include, parents feeling sad, depressed at various stages of child's life and experiencing other emotional reactions. Their social life may get affected with recreational and leisure activities getting reduced. Interpersonal relationships with the family members, friends and others also get affected. Marital harmony gets disturbed owing to various child related reasons such as meeting extra child-care responsibilities and burden, affecting sexual relationship between parents due to less privacy, more fatigue and fear of producing another child with disability. Financial burdens may mount parents' own physical and mental health is reported to be at a greater risk. However, the quality and quantity of the impact experienced may be quite individualised for each of the parents depending upon the nature of support available to them such as emotional, physical or financial support. Other factors such as coping skills of parents themselves, child

characteristics such as age, level of mental retardation, presence and absence of associated conditions etc. may also constitute immensely how far parents are able to face the challenge of having a child with mental retardation. As they have further mentioned that as the time passes the effects of few stressors becomes less. They have mentioned that the passage of time will mitigate the effects of some stressors on parents and make their responses to stressful situations more routine. It is also possible that with the changing nature of the child's problems and increased expectations associated with growing older, the magnitude of stress that parents experience may increase.

Occupation of parents Is correlated positively with parent and family problems and pessimism indicating a positive relationship between economic status and perception of stress. Average educational qualification of the parents in this study was around undergraduate. Parents level of education is correlated positively with stress. This indicates that educated parents are better able to understand different problematic steps regarding mental retardation and their perception might be clearer.

One finding regarding this research question is that as the number of children increased perception of stress among the parents becomes less because they accept the realities and try to improve and adjust with the life of another child. This outcome is consistent with the findings of Turnbull and Turnbull (1990).

The study also revealed that size of family is significantly correlated with stress and resources. In this study mean scores of size of family is indicating that parents have generally 3-4 children and sometimes other family members also. This might be one reason behind the higher stress level because its certainly difficult to serve the demands of every family member. If there are other family members in the family and size is big then parents are distracted by other problems and they feel extra-burden and responsibility. This might be one reason why parents feel more stress when size of the family is big.

Result also indicate that inter-correlation among all the four factors is significantly positively correlated at .01 level of significance which shows inter-dependency among different stress factors. This result is quite similar to that where Friedrich, Greenberg and Crnic (1983) have found that different factors were inter correlated with each other. The four factors of Questionnaire on Resources and Stress are; parent and family problems, pessimism, child characteristics and physical incapacitation. Overall average is comparatively high on these factors. It shows that parents under stress experience all the stressful factors.

Occupation of the parents was found to be correlated negatively with the pessimism factor on QRS-F. This result can be clarified from the interview data where all those parents who were working outside the family expressed less stress and depression in their lives because of a busy routine and less involvement with the problems of the child. Both mothers and fathers had almost similar views when they were asked about their services and its relationship with the perception of stress.

If we look at the scores of fathers and mothers separately mothers have scored much higher than fathers at Questionnaire on Resources and Stress (Table 17). When mothers were questioned about the reasons during interviews, they stated that because fathers don't spend much time with the children and because mothers think that they are more emotionally attached with the problems of the children, so they feel more stress. In Indian context this result is quite acceptable because as Peshwaria etal. (1995) have mentioned - "As mothers are the usual caretakers of their children, they probably are more sensitive to the acceptance or rejection of their child by others. Also, it is the mothers who generally face the greater burden of child rearing, and thus require more help and support from others. When that is not forthcoming, rejection is experienced more by the mothers. Some mothers have reported greater rejection especially from the paternal grandmother and the father of

the child. In India, the mothers are often blamed by the paternal grandparents or the father for giving birth to a child with mental retardation".

During interviews many mothers expressed less knowledge about the exact nature and type of disability of the children. They stated the need of more information about mental retardation. As Auluck (2000) has also mentioned the need of guidance and support systems for parents so that they can help prevent their children from becoming victims of neglect and avoid creating burdens on society.

Parents of the younger children (5-10 years) have scored significantly higher on parent and family problems and physical incapacitation factors. This result can be explained on the basis of interviews where parents of elder children expressed slightly less stress because they stated that thinking much regarding this problem creates unnecessary tension. They also seemed to be reality oriented and accepted the situation as it is and tried to focus their attention on the future of other children. This result is consistent to some extent with a study conducted by Flynt et. al. (1992). Where they did not found significant difference in the scores of pre-schooler parents and young adult but mean of young adults stress score was comparatively less than the scores of parents of pre-school children on Questionnaire on Resources and Stress.

Coping strategies used by the parents at two age levels of children :

If we look at demographic variables and its relationship with coping strategies used by the parents then we find that there are many coping strategies which are correlated significantly.

As the age of the parents increased they have used restraint and acceptance coping strategies. It was found during interviews that parents of older children were more reality oriented and to a large extent they had accepted that life pattern of their disabled children could not be changed. They had expressed more denial kind of

feeling also where bitter realities are suppressed in order to make the life pattern normal. Not thinking about the harsh realities becomes one of the defence mechanisms.

Active coping is correlated negatively with age of parents. It means that active coping is more prominent in parents of younger children. In younger mentally handicapped children it is generally found that a sudden shock they face because of having this kind of child, they crave for different resources actively to cope. During interviews all parents stated that in the beginning they actively tried their best to treat the problem. But later on as they received information's from different sources they became passive and tried to think less and less. Compensation seems to be one of the defence mechanism used by the parents. Parents try their best to shape the future of their normal children. Its mainly because they try to compensate the loss created by the mentally handicapped child.

Bigger the family, there is less attention paid by the parents. It might be because there are other members in the family who can share responsibilities. Usually other persons try to avoid such children but if there are grandparents in the family then parents feel more relief because they to some extent share the responsibilities.

Parents use more planning coping strategies for the early born children than later ones. During interviews when parents were asked regarding future plans for their children they were not very sure. But it was noticed that parents of younger children had more plans. Parents usually seem very helpless because future plans for such children are different than normal children.

Mothers and fathers are not significantly different on using different coping strategies except where mothers have expressed that they use more coping strategy of focus on and venting of emotions. Actually during interviews it was noticed that mothers had expressed more needs than fathers and more emotionality also. This

result is consistent with a study conducted by Bailey, Blasco and Simeonsson (1992) indicates that mothers expressed significantly more needs than fathers, especially in family and social support, explaining to others and child care.

If we look at the t table for the parents of first age group and second age group children we see that parents of first age group children (5-10 years) have used significantly more active coping strategies than second age group parents. (Table 19).

Another thing that can be discussed here is that behavioural disengagement coping strategy is used by the parents of second age group children more than first age group. This result can be clarified by the results of the interviews where parents of older children expressed less stress and found to be more carefree than younger children. It is mainly because they try to adapt with the circumstances.

During interviews it was found that parents expressed religiosity as one of the comfortable coping strategy. And if we look at the intercorrelation table for coping strategies we find that turning to religion is correlated positively with acceptance and focus on and venting of emotions. This result indicates that more religious parents accept the problem of their children more readily and become more emotionally attached to religion and expression of emotions (Table 4).

Turning to religion coping strategy is correlated negatively with denial, behavioural disengagement and mental disengagement. This indicates that religious parents are more reality oriented and try to live and adjust properly with the circumstances created by the mentally handicapped children.

Differences in utilisation of resources by the parents of children across two child age groups :

If we look at t-values presented in table (19) we see that parent and family problems and physical incapacitation factors are significantly different at two age

group levels of the children. Other two factors of pessimism and child characteristics are not significantly different. Parents of younger children had perceived greater problems in their own behaviour and personality and in other family members also. It might be due to initial new problematic experiences with such child. Because rearing such children is certainly very problematic so it can lead to adjustment problems among different family members. Parents of younger children have perceived greater problems regarding physical disabilities in the child. As children grow, parents are found to search for positive aspects in the problems.

Parent and family problems consists of the items that indicate parents perception of problems for themselves, other family members and the family as a unit. Parents of the first age group children scored higher than second age group children.

It indicates that parents of younger children are more cautious and anxious about the problems. Might be due to a new experience of handling such situation their anxiety level and perception of problem would have increased.

One of the study that can be discussed here says that when mothers of autistic adolescents and mentally retarded adolescents were compared, mothers of artistic adolescents expressed more stress than mentally retarded adolescents. It is indicated in the study that due to lack of appropriate services this might occur (Donovan, 1988).

This finding is contrary to the finding of the research conducted by Farber (1975) where he has indicated that increasing demands can actually create more troubles for the parents of older children than younger children. On the other hand he has noted that stress associated with a child's level of cognitive impairment diminished with age.

On physical incapacitation factor also parents are significantly different. Parents of first age group children have scored higher than parents of second age group. Physical incapacitation factor involves the respondents perceptions of limitations in the child's physical abilities and activities.

As Orr et. al. (1993) have mentioned that as the time passes effects of some stressors on parents perceptions of physical incapacitation problem becomes less intense and routine. Because parents constantly try for proper adaptation with the problem.

When the responses of some parents of younger children and some elder children were compared on interview analysis, it was found that in Indian context due to lack of proper support programs and lack of information parents of younger children expressed more stress. Parents of older children were found to be adapted with the situation and they were trying to concentrate on the future of other children in the family.

In some studies researchers have indicated that transition periods are really a time of great stress. When a child reaches from age 13 to 16, there is general expectation of parents that he will behave like pre-adolescents. And if transition period is delayed or did not appear it becomes a really very stressful event for parents. Generally it is noticed in the case of mentally handicapped children that their transition periods are not very apparent. Like in Down Syndrome and artistic children there is a kind of continuity in their different developmental periods. (Neugarten 1976, Olson 1983).

Gender difference in stress levels, resource utilisation and coping strategies used by the parents :

t-values for mothers and fathers indicate that on coping strategy scale they are not significantly different although there is some variation in their scores. Only on

focus on and venting of emotions mothers have scored significantly higher than fathers. During interviews also when mothers were asked some questions regarding their children's problems they seemed to be providing many other extra information's. Whereas men's were replying generally to the point and brief also. It indicates that mothers are more emotional than fathers and they like to express their feelings before someone, so that intensity of stress could become less.

If we observe the results of Questionnaire on Resources and Stress factors t-value on all the four factors mothers have significantly higher scores than fathers. This result indicate that mothers perceive the problems related to them or their children as more stressful than fathers. This probably could be related to the role of a mother. In the Indian context mothers are facing more problems in comparison to fathers. Still a large percentage of womens are dependent upon their husbands for different resources. This might be one reason why mothers feel more stress in comparison to fathers.

Focus on the venting of emotions scores of mothers are significantly corrleated with turning to religion coping strategy which indicates that mothers are found to be more emotional and religious. It indicates that emotionality is one of the factors that can lead to religious feelings. Generally it is noticed that religious people are emotionally attached to their religions, God etc.

The above mentioned results can be discussed in the light of a study conducted by Peshwaria et. al. (1995). They have mentioned that mothers are found to be more under pressure to balance child care needs and household chores.

Further their results indicated that wives are able to emotionally support their husbands and infuse confidence in them. But on the other hand in their study very few mothers reported that fathers could also contribute in a similar way. In their study faith in God was reported as one of the important facilitators but mainly in the

case of moderately and mildly retarded children because they hope that their problem would find a solution.

According to a study conducted by Bailey, Blasco and Simeonsson (1992) mothers express more needs then fathers primarily in family and social support, explaining to others and child care.

This is substantiated in the interviews also where mothers expressed that they feel more burden and responsibility than their husbands. And in the cases where there are some other children mothers feel that they don't get sufficient time to concentrate on their own problems. Some mothers mentioned that they are loosing their own well being and are unable to cope with the situation. Fathers confirmed this and attributed it to the mothers greater emotional attachment and the fact of having greater responsibilities as far as the mentally disabled child is concerned.

Relationship between levels of stress and coping strategies used by the parents:

If we look at the scores of both parents on Questionnaire on Resources and Stress and its correlation with coping strategies then we find that parents and family problems, pessimism and child characteristics are correlated negatively with alcohol drug-disengagement. It means that when parents perceive the problems regarding their children's disability as more severe they incline less towards intoxicants. This result is quite contrary to common sense where we think that people incline towards alcohol more as their problems increase. The reason behind this result is that mothers scores are nil on alcohol and intoxicants dimension. On the other hand a negligible number of fathers accepted that they take alcohol. The reason behind not expressing might be that people generally don't like to express their personality and habit weaknesses before strangers. During interviews a very small number of mothers accepted that their husbands are really inclined towards alcohol.

Physical incapacitation (Parents perception of child's physical limitations) factor is correlated significantly with turning to religion and focus on and venting of emotions which indicates that as the problems of the children increased superstitious feelings in the parents also developed. Physical incapacitation factor is also correlated negatively with positive reinterpretation and growth. Coping strategy positive reinterpretation and growth can be explained as to look for something good in the situation, try to see in a different light, learning something from the experience etc. So, according to this relationship positive growth in the parents is inhibited because of the severity of the problem of the children.

As Cheng and Tang (1995) have mentioned in their study that children with Down Syndrome often have distinctive physical features and their parents thus reported the most frequent use of avoidance coping strategies to withdraw and avoid taking their children to public places to escape unfriendly stares, rejection or excessively sympathetic reactions by strangers.

Peshwaria et.al. (1995) have mentioned in their study that physical support from within and outside the family as the most important facilitator, next there was professional support, financial support, faith in God, self-determination and others. The parents reported external supports provided by others as a greater facilitator than their internal coping skills like faith in God, working out problems by their own effort, self determination and inspiration from spouse.

Chapter VI

Conclusions

CHAPTER - VI

Summary, Conclusions, Implications, Limitations and Suggestions for Further Research :

Summary : This study was designed to understand the ways in which parents of mentally handicapped children are affected and the kinds of stresses they face. If so then what kinds of coping strategies are used by them and what kinds of resources they utilise.

For the above purpose a correlational research design was employed. Samples were taken from a special school. Sample consisted of fifty sets of both mothers and fathers selected in two groups on the basis of the age of the handicapped child

Objectives of the study were as follows :

1. To investigate different coping strategies and different levels of stress among parents.
2. To see the effect of gender on coping responses, perception of stress and resource utilisation.

For the purpose of data collection four tools were used; Demographic Inventory, Questionnaire on Resources and Stress, COPE scale and Interviews with Parents.

Following were the results of the present study :

1. Scores of mothers on the Questionnaire on Resources and Stress were comparatively higher than fathers. It means that mothers had perceived the problems of their mentally handicapped children more stressful than fathers. During interviews also mothers expressed more stressful experiences than fathers and accepted that fathers feel more carefree than themselves.

2. Different factors of stress are closely interrelated to one another. For example; if parents have high scores on ' Physical Incapacitation ' factor (parents perception of child's physical limitations) they also have high scores on parent and family problems factor.
3. Parents of younger children have expressed more stress than parents of older children.
4. Parents who were working outside have expressed less stress than those parents who are living with the mentally handicapped child all the time.
5. Active coping was more prominent among the parents of younger children.
6. Mothers and fathers were not significantly different in their use of different coping strategies. Only on expression of emotion dimension mothers were significantly different to fathers.
7. Religiosity was one of the prominent coping strategies found in the parents of mentally retarded children.
8. Support from outside the family was found to be one of the great facilitator in coping and especially for mothers.

Findings : Following were the findings of the present study-

1. Different factors of stress (Parent and Family Problems, Pessimism, Child characteristics and Physical Incapacitation) were positively correlated to one another.
2. Parents of older children (14 to 21 years) feel less stress in comparison to parents of younger children (5 to 10 years).
3. In the families where there are many children parents express less stress regarding the problems of the mentally handicapped children because they try to concentrate on the well being and future of the other children.
4. In the joint families where there are other family members like Grandfather, Grandmother etc. parents feel less stress and responsibility.

5. Parents who were working outside the family expressed less stress. Almost all the parents (both mothers and fathers) expressed that working outside the family provides them a busy routine and less involvement with the problems of the child.
6. Mothers expressed more stress than fathers on all the factors of The Questionnaire on Resources and stress. This might be because mothers feel more emotional attachment and involvement with their children.
7. Coping strategies used by the mothers and fathers were not significantly different except on emotion expression dimension where mothers have shared more emotions with others than fathers.
8. Active coping strategy is more frequently used by the parents of younger children than parents of older children.
9. Turning to religion, active coping and behavioural disengagement are the prominent coping strategies used by the parents.
10. The parents who were around middle age more often use acceptance and restraint coping.
11. Parents of younger children were more stressful about the problems of their mentally handicapped children.
12. Mothers expressed more needs than fathers regarding family support and co-operation from others, and about how to rear the child properly.
13. Support from outside the family is one of the great facilitator to coping and especially for mothers.

Conclusions: Findings indicate following conclusions

1. Mothers expressed more needs and stress in comparison to fathers.
2. Different coping strategies were not significantly different for mothers and fathers.
3. Active coping , turning to religion and behavioural disengagement are prominent coping strategies.

4. Parents of younger children expressed more stress than parents of older children.

Implications:

1. This study is quite useful in the Indian context where parents are suffering from many troubles because of a mentally handicapped child in the family. Their problems can be understood in a better light if such studies are conducted thoroughly.
2. Interviews with parents provide them an opportunity to share their feelings and to express their problems thoroughly. Different needs of parents and children can be understood thoroughly in this way.
3. There is a lot of scope to do something for the betterment of the future of mentally handicapped children but also something can be done for their families which are under great pressure and helplessness. Some solutions may be sorted out if their problems and circumstances can be understood properly.
4. Parent's problems like interpersonal problems, family problems, economic problems, social problems can be understood with the help of such studies.
5. Knowing about different kinds of coping strategies is helpful in understanding the ways parents adopt to cope with the problems. Better understanding of different coping strategies provide an opportunity to help parents in a better way and to provide them some other strategies.

Limitations :

1. Both mothers and fathers of the same child could not be included in the study. If they were included it would have been a good idea to study both parents of the same child so that interpersonal problems and detailed knowledge of understanding among different family members can be understood. Reasons behind not including both parents in the study were that some of the students at Kasturba School were saying in the hostel. Usually at the time of vacation

only one parent comes to receive the child. Another problem was that some of the children had only one parent staying in the city and some had one parent expired earlier.

2. Age of the parents was not a major issue of the study but it could not be controlled. Some relationships are available regarding age of parents and use of different coping strategies.

3. Gender of children included in the study sample could not be controlled and distributed properly. So it's not possible to say anything about what coping strategies are used by the parents for a girl child and for a boy. This research could not study that what is the effect of gender of the child on parents coping strategies, perception of stress and utilisation of resources.

4. There were some children who were below five years of age and some were above twenty-one years. These children were included in the study sample but there number was quite negligible and it did not affect the overall composition of the sample because samples were taken from one school so options were limited regarding the age of the child.

5. Nature of disability (e.g.. Down Syndrome, Cretinism, Microcephaly, Cerebral Palsy etc.) could neither be controlled nor distributed properly in the study sample. It is mainly because nature of disability was not a major issue of the study. But it would have been a good idea to study nature of disability also but due to some practical problems it could not be studied.

6. Type of institution and different types of supports available to parents is one of the issues that could not be studied.

Suggestions For Further Research :

This study is mainly concerned to the parents of mentally handicapped children but some of the aspects have been left in this study. Actually it is very difficult to study all the issues and perspectives under one study. Followings are the suggestions for further research:

1. Gender of the mentally handicapped child is one of the issues that should be studied for example, a study should be designed to investigate the effect of mentally handicapped girl or boy child on family and society or whether parents feel more stress if the child is girl or a boy. There is a possibility that parents might be feeling more stress if the child is a girl.
2. Effectiveness of teaching to these children should be studied so that something can be done for the improvement in the teaching programmes. Also studies should be aimed at different programmes for the parents which are organised by the schools itself so that some modifications in these programmes be made.
3. Nature of disability is one of the important issues that should be studied thoroughly. There is a possibility that nature of disability might affect coping strategies and levels of stress among parents. Research should be focused on different categories of disabled children and a comparison on different perspectives.
4. Nature of disability and effectiveness of different vocational training's should be studied. An attempt should be made to see whether vocational learning is affected by the nature of disability. If so, then what kinds of training's are useful for children having different types of mental retardation. It should be examined that what kinds of vocational training's are necessary for these children and what kinds of improvements are needed.
5. There is a scope for the study that is related to different kinds of programmes for parents counselling and different kinds of supports available to them.

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Appendix

APPENDIX

PARENTS PERSONAL INFORMATION SHEET

NAME : ____________________

AGE : ____________________

OCCUPATION : ____________________

TYPE OF FAMILY : ____________________

QUALIFICATION : ____________________

TOTAL NUMBER OF CHILDREN : ____________________

SIZE OF THE FAMILY : ____________________

BIRTH ORDER AND AGE OF THE CHILD : ____________________

COPE SCALE

Instructions :

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

You have to respond in the following way :

"I usually don't do this at all" .	---------------------	1
"I usually do this a little bit".	---------------------	2
"I usually do this a medium amount".	---------------------	3
"I usually do this a lot".	---------------------	4

Please put a tick mark in the box you think appropriate and reply all 53 items.

Active Coping

I take additional action to try to get rid of the problem	1	2	3	4
I concentrate my efforts on doing something about it 1	2	3	4	
I do what has to be done, one step at a time	1	2	3	4
I take direct action to get around the problem	1	2	3	4

Planning

I try to come up with a strategy about what to do	1	2	3	4
I make a plan of action	1	2	3	4
I think hard about what steps to take	1	2	3	4
I think about how I might best handle the problem	1	2	3	4

Suppression of competing activities

I put aside other activities in order to concentrate on this	1	2	3	4
I focus on dealing with this problem, and if necessary let other things slide a little	1	2	3	4
I keep myself from getting distracted by others thoughts or activities	1	2	3	4
I try hard to prevent other things from interfering with my efforts at dealing with this	1	2	3	4

Restraint Coping

I force myself to wait for the right time to do something	1	2	3	4
I hold off doing anything about it until the situation permits	1	2	3	4
I make sure not to make matters worse by acting too soon	1	2	3	4
I restrain myself from doing anything too quickly	1	2	3	4

Seeking Social support for instrumental reasons

I ask people who have had similar experiences what they did	1	2	3	4
I try to get advice from someone about what to do	1	2	3	4
I talk to someone to find out more about the situation	1	2	3	4
I talk to someone who could do something concrete about the problem	1	2	3	4

Seeking social support for emotional reasons

I talk to someone about how I feel	1	2	3	4

I try to get emotional support from friends or relatives	1	2	3	4
I discuss my feelings with someone	1	2	3	4
I get sympathy and understanding from someone	1	2	3	4

Positive reinterpretation & growth

I look for something good in what is happening	1	2	3	4
I try to see it in a different light, to make it seem more positive	1	2	3	4
I learn something from the experience	1	2	3	4
I try to grow as a person as a result of the experience	1	2	3	4

Acceptance

I learn to live with it	1	2	3	4
I accept that this has happened and that it can't be changed	1	2	3	4
I get used to the idea that it happened	1	2	3	4
I accept the reality of the fact that it happened	1	2	3	4

Turning to religion

I seek God's help	1	2	3	4
I put my trust in God	1	2	3	4
I try to find comfort in my religion	1	2	3	4
I pray more than usual	1	2	3	4

Focus on & venting of emotions

I get upset and let my emotions out	1	2	3	4
I let my feelings out	1	2	3	4
I feel a lot of emotional distress and I find myself expressing those feelings a lot	1	2	3	4
I get upset, and am really aware of it	1	2	3	4

Denial

I refuse to believe that it has happened	1	2	3	4
I pretend that it hasn't really happened	1	2	3	4
I act as though it hasn't even happened	1	2	3	4
I say to myself "this isn't real"	1	2	3	4

Behavioural disengagement

I give us the attempt to get what I want	1	2	3	4
I just give up trying to reach my goal	1	2	3	4
I admit to myself that can't deal with it, and quit trying	1	2	3	4
I reduce the amount of effort I'm putting into solving the problem	1	2	3	4

Mental disengagement

I turn to work or other substitute activities to take my my mind off things	1	2	3	4
I go to movies or watch TV to think about it less	1	2	3	4
I daydream about things other than this	1	2	3	4
I sleep more than usual	1	2	3	4

Alcohol-drug disengagement

I drink alcohol or take drugs, in order to think about it less	1	2	3	4

A SHORT FORM OF THE QUESIONNAIRE ON RESOURCES AND STRESS

This questionnaire deals with your feelings about a child in your family. There are many blanks on the questionnaire. Imagine the child's name filled in on each blank. Give your honest feelings and opinion. Please answer all of the questions, even if they do not seem to apply. If it is difficult to decide True (T) or False (F), answer in terms of what you or your family feel or do most of the time. Sometimes the questions refers to problems your family does not have. Nevertheless, they can be answered True or False, even then. Please begin. Remember to answer all of the questions.

1. _______ doesn't communicate with others of his/her age group T/F
2. Other members of the family have to do without things because of _______ T/F
3. Our family agrees on important matters T/F
4. I worry about what will happen to ______ when I can no longer take care of him/her T/F
5. The constant demands for care for ______ limit growth and developed of someone else in our family T/F
6. _______ is limited in the kind of work he/she can do to make a living T/F
7. I have accepted the fact that ______ might have to live out his/her life in some special setting (e.g., institutions or group home). T/F
8. ________ can feed himself/herself T/F
9. I have given up things I have really wanted to do in order to care for ________ T/F
10. ________ is able to fit into the family social group T/F
11. Sometimes I avoid taking _________out in public T/F
12. In the future, our family's social life will suffer because of increased responsibilities and financial stress. T/F
13. It bothers me that ________ will always be this way T/F

14. I feel tense whenever I take _________ out in public T/F

15. I can go visit with friends whenever I want T/F

16. Taking _________ on a vacation spoils pleasure for the whole family T/F

17. _________ knows his/her own address T/F

18. The family does as many things together now as we ever did T/F

19. _________ is aware who he/she is T/F

20. I get upset with the way my life is going T/F

21. Sometimes I feel very embarassed because of __________ T/F

22. _________ doesn't do as much as he/she should be able to do T/F

23. It is difficult to communicate with _______ because he/she has difficulty understanding what is being said to him/her T/F

24. There are many places where we can enjoy ourselves as a family when _________ comes along. T/F

25. _________ is over-protected T/F

26. _________ is able to take part in games or sports T/F

27. _________ has too much time on his/her hands T/F

28. I am disappointed that _________ does not lead a normal life T/F

29. Time drags for __________, especially free time T/F

30. _________ can't pay attention very long T/F

31. It is easy for me to relax T/F

32. I worry about what will be done with __________ when he/she gets older T/F

33. I get almost too tired to enjoy myself T/F

34. One of the things I appreciate about ______ is his/her confidence T/F

35. There is a lot of anger and resentment in our family T/F

36. ________ is able to go to the bathroom alone T/F

37. ________ cannot remember what he/she says from one moment to the next T/F

38. ________ can ride a bus T/F

39. It is easy to communicate with __________ T/F

40. The constant demands to care for _________ limit my growth and development T/F

41. ________ accepts himself/herself as a person T/F

42. I feel sad when I think of __________ T/F

43. I often worry about what will happen to ________ when I no longer can take care of him/her T/F

44. People can't understand what ___________ tries to say T/F

45. Caring for _________ puts a strain on me T/F

46. Members of our family get to do the same kinds of things other families do T/F

47. _________ will always be a problem to us T/F

48. _________ is able to express his/her feelings to others T/F

49. _________ has to use a bedpan or a diaper T/F

50. I rarely feel blue T/F

51. I am worried much of time T/F

52. _________ can walk without help T/F

Specified areas for interviews

1. Nature of disability
2. Time of awareness with the problem of mental retardation
3. Cooperation from the family members
4. Effects of disability on other children / family members
5. Social and interpersonal relationships and mentally handicapped child
6. Future plans for the child
7. Effects of special schooling
8. Different coping strategies during stress
9. Changes in life pattern before and after the birth of disabled child
10. Expectations from society and special schools
11. Feelings of religiosity
12. Any other information?