Parents Response to Mentally Challenged Children

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ABSTRACT
The present study examined responses of parents to their mentally challenged child with emphasis on depression, anxiety and stressful life events.
The sample comprised 30 parents whose children had been diagnosed as mentally challenged. In addition to a socio-demographic and clinical data sheet, the tools used were Beck Depression Inventory (BDI), State Trait Anxiety Inventory (STAI) and Presumptive Stressful Life Events (PSLE). The samples were collected through Purposive sampling techniques.
The result showed that older parents of retarded children are found to have lower anxiety and stress. Parents reported more depressive symptoms and anxiety when the child's degree of retardation is higher. An interesting finding is that parents tend to be less anxious and stressed with first-born handicapped child than second-born handicapped child.
The study seems to have implication for better insight and understanding of parental reactions on their mentally-challenged children, where appropriate educational and residential services may be needed to provide them.

INTRODUCTION
Mental retardation is an idea, a condition, a syndrome, a symptom, and a source of pain and bewilderment to many families. The birth of a retarded child into a family may give negative feelings which can be found in parents of disabled children at early and later periods in the life cycle and they are the following: protectiveness of the helpless, revulsion at the abnormal, inadequacy of reproduction, inadequacy of rearing, anger, grief, shock, guilt, embarrassment (Mac Keith, 1973 and Dale, 1996). The effect of a disabled child on its parents, especially when the child lives at home, has been reported in many reviews and it has showed that parents and siblings of retarded children individually,
as well as the family as a whole, are at risk of numerous difficulties in comparison to families with non-retarded children (Crnic et al., 1983). Parents of children with mental retardation often experience feelings of stress and anxiety (Holroyd et al., 1975). It has also revealed that parents of disabled children had significantly higher levels of psychiatric symptoms and were more likely to meet criteria for depressive disorders, compared with controls. Between the parents of mentally-retarded children and neurologically impaired children there was no significant difference (Carpiniello et al., 1993). Most parents with a retarded child, even if they are well adjusted, are likely to experience major psychological stress. Reactions to this stress vary considerably from person to person, but there are some common patterns. The patterns are Loss of Self-esteem, Shame, Ambivalence, Depression, Self-sacrifice and Defensiveness (Roos, 1963).

It has been mentioned that unfortunately, the objectives of therapeutic approaches to parents of retarded children are often unrealistic and inappropriate. Two of the most popular but unrealistic objectives are getting parents to “accept” mental retardation and “lifting the depression”. Though parents may fully understand that their child is retarded, it is unrealistic to expect them to “accept” this fact with blandness and equanimity, since it affects very fundamental values and existential issues. “Chronic sorrow” has been described as the “normal” (in contrast to pathological) parental reaction to having a retarded child (Olshansky, 1966).

Reports have been found that Pediatricians are confronted with a number of difficult problems, while providing management services to mentally-retarded children and their families. Successful handling of these problems requires recognition that management is central to the care of the mentally-retarded child. The needs of mentally-retarded children and their families will not be met by interacting with families only around issues of acute physical illness. Attention must be directed toward psychosocial as well as medical variables and the emphasis must be on the total family system (Gayton, 1975). Understanding positive as well as negative impact of a child with Mental Retardation will lead to a more balanced view of families and disability (Blacher et al., 2007). Although a mentally-challenged child is problematic in every society and culture, the psychosocial reaction to a large extent is determined by culture. The society of Manipur is not yet ready both socially and economically to deal with the problems of mentally-challenged children and their families sufficiently. This is one of the reasons to study the problem in this society. The purpose of the study is to find out the psychosocial consequences among parents of mentally-challenged children in Manipur, which might help in early detection, intervention and psycho-educational support accordingly. The objective is to examine the level of depression, anxiety and stressful life events according to parents’ age group, child’s degree of MR and birth order of the child.

MATERIALS AND METHODS

The sample comprises 30 parents of mentally-challenged children. The children were diagnosed Mentally Retarded by Clinical Psychologists and had been certified as Mentally Retarded by the Medical Board of Disability (Govt. of Manipur). Parents of these children who are not diagnosed as mentally retarded and parents having past/current exposure to psychological testing/intervention were excluded. In addition to a sociodemographic and clinical data sheet, the following tools were used: Beck’s Depression Inventory (BDI, Beck et al., 1996), State Trait Anxiety Inventory (STAI, Spielberger et al., 1983) and Presumptive Stressful Life Events Scale (PSLE, Singh et al., 1983).
The required information was initially collected from different rehabilitation centre of mental retardation located at Imphal, Manipur, and detailed assessment was done by contacting the parents personally later on. The participants were assessed on the level of depression, anxiety and stressful life events. The assessments were done in the department of Clinical Psychology of Regional Institute of Medical Sciences RIMS, Imphal, Manipur and some few at the residence of the participants.

Statistical Analysis

The data was processed through SPSS version 13 and various statistics like mean, standard deviation were calculated and t-test was applied wherever found suitable and necessary and interpretation was made accordingly.

RESULTS

The BDI, STAI and PSLE were administered on the sample group. The gender distribution of the sample is 63 % female and 37 % male, 60 % of the retarded children belong to first parity and 40 % to second parity. And most of them (53 %) fall under the category of moderate mental retardation. The results are highlighted in the following tables.

Table 1: Age-Wise distribution of Mean ± S.D. of BDI, STAI, PSLE

<table>
<thead>
<tr>
<th>Age Group</th>
<th>BDI Mean ± S.D</th>
<th>STAI (state) Mean ± S.D</th>
<th>STAI (Trait) Mean ± S.D</th>
<th>PSLE Mean ± S.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-40</td>
<td>27.78 ±9.01</td>
<td>52.11 ±7.57</td>
<td>53.89 ±9.22</td>
<td>18.35 ±8.40</td>
</tr>
<tr>
<td>41-50</td>
<td>24.07 ± 9.78</td>
<td>52.50 ± 7.03</td>
<td>52.00 ± 5.88</td>
<td>18.00 ± 5.65</td>
</tr>
<tr>
<td>51-60</td>
<td>27.00 ± 3.60</td>
<td>41.33±10.06</td>
<td>48.67 ± 3.51</td>
<td>15.33 ± 6.65</td>
</tr>
<tr>
<td>61-70</td>
<td>20.75 ± 5.90</td>
<td>46.25±12.44</td>
<td>53.50 ± 1.29</td>
<td>19.75 ± 3.59</td>
</tr>
</tbody>
</table>

Table 2: Distribution of Mean ± S.D. of BDI, STAI and PSLE according to the child’s degree of MR

<table>
<thead>
<tr>
<th>Child’s degree of MR</th>
<th>BDI Mean ± S.D</th>
<th>STAI (state) Mean ± S.D</th>
<th>STAI(Trait) Mean ± S.D</th>
<th>PSLE Mean ± S.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>17.75 ± 9.46</td>
<td>53.25 ± 3.77</td>
<td>53.25 ± 7.89</td>
<td>18.00 ± 7.43</td>
</tr>
<tr>
<td>Moderate</td>
<td>26.94 ± 8.33</td>
<td>50.44 ± 9.66</td>
<td>52.94 ± 6.89</td>
<td>19.81 ± 7.19</td>
</tr>
<tr>
<td>Severe</td>
<td>24.44 ± 8.60</td>
<td>50.33 ± 8.58</td>
<td>50.89 ± 6.07</td>
<td>15.11 ± 5.77</td>
</tr>
<tr>
<td>Profound</td>
<td>29.00 ± 00</td>
<td>40.00 ± 00</td>
<td>55.00 ± 00</td>
<td>19.00 ± 00</td>
</tr>
</tbody>
</table>
Table 2 highlights that BDI has the highest score in profound degree of MR and lowest in mild degree. Both STAI (State) and STAI (Trait) has a negative correlation with the child’s degree of MR with highest score in Mild degree and lowest score in the profound degree. PSLE indicates highest score in Moderate degree and lowest in severe degree.

Table 3: Parity-Wise distribution of Mean ± S.D. of BDI, STAI and PSLE

<table>
<thead>
<tr>
<th>Parity</th>
<th>BDI Mean ± S.D</th>
<th>STAI (state) Mean ± S.D</th>
<th>STAI(Trait) Mean ± S.D</th>
<th>PSLE Mean ± S.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>25.17 ± 8.36</td>
<td>48.83 ± 9.09</td>
<td>51.39 ± 6.70</td>
<td>16.44 ± 5.33</td>
</tr>
<tr>
<td>2nd</td>
<td>24.83 ± 9.54</td>
<td>52.83 ± 7.69</td>
<td>54.00 ± 6.15</td>
<td>20.66 ± 8.11</td>
</tr>
<tr>
<td>t</td>
<td>t = 0.101</td>
<td>t = 1.252</td>
<td>t = 1.079</td>
<td>t = 1.724</td>
</tr>
<tr>
<td>df</td>
<td>df = 28</td>
<td>df = 28</td>
<td>df = 28</td>
<td>df = 28</td>
</tr>
<tr>
<td>p</td>
<td>p = 0.920</td>
<td>p = 0.221</td>
<td>p = 0.290</td>
<td>p = 0.096</td>
</tr>
</tbody>
</table>

Note: - S.D. – Standard Deviation, df – degree of freedom and IS – Insignificant

Table 3 shows that the Mean score of BDI was higher in first Parity than the second Parity. And the Mean scores of STAI (State), STAI (Trait) and PSLE were found to be higher in the second Parity compared to first Parity. However, no significant differences were observed in any of the combination.

DISCUSSION

The finding of the present study reveals that lower anxiety and stress were found in age group of 51-60 years. This finding indirectly supports earlier study in which older mothers were found to be more interactive and showed inventiveness and tolerance in child rearing thereby facilitating conducive environment for growth and development (Culp et al., 1991 and Persha et al., 2007). One reason for this could be because of increase of tolerance power in older parents and also the sample of the present study have been involved in special education, including training programs to facilitate child rearing and cope better with the situations.

Research on parents of retarded children reported more psychiatric symptomatology when the child showed high level of dysfunction (Khamis, 2007). The degree of the children’s mental retardation as well as conspicuous behaviour correlated positively with maternal stress (Gosch, 2001). The above findings are found to be consistent with the present finding regarding the depression level and trait anxiety which is found to be highest on parents of children with profound degree of mental retardation. This could be simply due to increase amount of efforts required to face the number of unavoidable difficulties on enhancing the development of the profoundly retarded child.

Earlier findings revealed that if the first child was handicapped, mothers coped more by “mastery” than mothers of a second born handicapped child (Rogner & Wessels, 1994). It is found to be consistent with the present study where anxiety (state and trait) and stressful life events were found to be greater in second born (MR) child than the first-born child. One reason could be having
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a child for the first time brings great changes in the role of the parents and they usually gives their best to manage it, with the thought that this is all about caring/rearing a child as they had no past experience to relate/compare (of rearing a normal child).

Some of the limitation of the present study are the small sample size that limits the generalise ability of findings. As the sample was heterogeneous, it consisted of either mother or father of different age without any uniformity; one could not control any extraneous factor. And to prove the specialty of the findings there should have been a control group.

CONCLUSION

The study seems to have implication for better insight and understanding of parental reactions on their mentally-challenged children, where appropriate educational and residential services may be needed to provide them. It might be helpful if parents, professional and handicapped themselves learn to join hands together for assistance and support, to bring their conditions immensely better than the past decades and look forward today’s hope will at last be translated into reality.

REFERENCES


