STRESS AND COPING AMONG THE PARENTS OF MENTALLY HANDICAPPED

Thesis submitted in partial fulfilment of the requirements
for
the degree of Doctor of Philosophy of the University of Calicut.

By

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CERTIFICATE

This is to certify that the thesis entitled **"Stress and Coping Among the Parents of Mentally Handicapped"** is an authentic record of research carried out by **Mrs. Aniamma Mathew P.** under my guidance and supervision and that no part of it has been presented before for any other degree, diploma or title.

Thenhipalam
10th November, 1999

Dr. C.B. Asha
Research Guide

DECLARATION

I hereby declare that, the thesis entitled "**Stress and Coping Among the Parents of Mentally Handicapped**" is a bonafide record of research carried out by me under the supervision and guidance of **Dr. C.B. Asha**, Professor, Department of Psychology, University of Calicut and that no part of this thesis has been presented for any other degree or diploma or title earlier.

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Aniamma Mathew

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Chapter I

INTRODUCTION

One primary function of the family is providing a socially acceptable vehicle for producing and raising children. Most society share the view that parenthood is an expected and enviable state. While awaiting the birth of a child prospective parents experience a wide range of emotions. Often they feel fulfilment and usually some anxiety regarding the birth process and potential problems. They always have various expectations about the kind of persons the child will become (Susan and Rizzo, 1983).

The parents attitudes and resources determine to a great extent the kind and level of impact they feel at the birth of a child. Another important determinant is the child, especially the degree to which that child fulfils the expectations of the parents. (Shea and Bauer, 1985)

Although, birth of a baby may be a welcome one, the baby does constitute an intrusion to the life of the family unit. The centre of family's attention shifts. The addition of a child requires an adjustment in the family system. Stress may be placed on the marital relationship and on the family's economic and social status.

The birth of a child may draw a couple closer together as they share concerns, responsibilities, goals and pleasures. On the other hand the addition of a baby may cause discord and conflict. In many cases the birth of a baby means the loss of an income. Hospital costs, continued medical care, food and clothing for the baby create a financial structure that is staggering. The birth of a baby also brings about an immediate and dramatic change in the couple's life style.

The freedom to travel and to engage in an active social life will undoubtedly be curtailed.

Although the negative aspects of parenthood are numerous, they are usually overshadowed by the excitement of the baby's first smile, first words, and step. Most couple find that once the impact of birth is over the joys are well worth the changes.

In sharp contrast to the fulfilment experienced by most parents, couples who have abnormal babies may find few of the typical joys that compensate for the frustrations and inconveniences imposed by a child (Chin, Drew & Logan, 1979). The impact of the birth may be devastating and will require a life time adjustment.

Exceptional Child

The birth of an exceptional child places the family in a cultural dilemma. Society views parenthood positively, but it views parenthood of a handicapped child negatively (Zuk, 1959). Awareness of society's ambivalence adds to the stress the family feels within itself.

The stress factors accompanying the birth of a normal child are intensified when the child is not normal. The marital relationship may suffer unduly from the added stresses of blame, quilt and anxiety.

A child's handicap attacks the fabric of marriage in four ways. It excites powerful emotions in both parents. It acts as a desperating symbol of shared failure. It reshapes the organization of the family. It creates fertile ground for conflict (Featherstone 1980).

The economic stress may be multiplied by additional hospital and medical costs. The parents' social life may become non-existent. They may be fearful of rejection by their friends.

Additional stress is likely to occur in families of handicapped infants considering each family's uniqueness like number of members in the family, other chronic illness handicaps etc. However, the psychological impact experienced by these families are common-shock, denial and grief.

Mc Dowell (1976) suggested that parents progress through six emotional stages upon discovering their child's handicap: disbelief, guilt, rejection, shame, denial and a feeling of helplessness.

The following descriptions of a parent's reactions upon discovering her sons' handicaps, typically gives light to initial crisis reaction.

"I had spent many hours fighting panic-swinging upward when I got the details of a test result, and then down again when I made myself face the facts I had begun to face them the day I first called the paediatrician... But I will always remember my feelings of numb despair. I didn't cry or give much external sign of my inner hysteria but I felt that I would never be able to adjust to this situation.

The shock of the birth of a child like this doesn't come all at once. It is worse in some ways than the death of a child because you gradually realise that this child is never going to live in the fullest sense of the world....

It was difficult for us to absorb the first shock, which is truly physical as well as mental. We were numb, we could scarcely walk about and do our normal days work, or talk to other people.

The shock consisted of knowing that we have a child who would never grow up"... (Hosey, 1073).

Though reactions to the birth or diagnosis of an exceptional child vary from parent to parent or family to family, people seem to share common elements. Frequently, parent's initial feelings are shock and numbness; parents may experience periods of panic, anxiety and helplessness, as well as periods of indifference and anger, at which time parents face nearly overwhelming depression, apathy and bitterness (Shea & Baver, 1985, p.30).

Farber (1960) identified two types of crises that parents of mentally retarded children experienced. Grief is an initial crisis precipitated at the time, the child is diagnosed as handicapped. The second type of crisis is regarded as a crisis of role organization. This type of crisis suggests an inability to cope with the child over a long period of time. The reaction of parents to the diagnosis of mentally retarded has been compared to the trauma of a death in the family and have been called the "grief cycle" by Turnbull & Turnbull (1985).

As normal children progress from one developmental stage to the next; their parents observe them with pride, anxiety and alarm. Parents have expectations of them based on social, family and experiential standards. When children's behaviour deviate from the established standards, family crisis may develop.

Every child affect their family in the process of growing up based on the characteristic of the child and characteristics of family. Transitions from infancy to early childhood to late childhood and to adolescence affect the family and the child. Crises and triumphs present in every child's life affect the family too. In

addition to the pressures and demands all parents experience, parents of exceptional children must learn to deal with the exceptionality of various natures, sometimes for a lifetime.

Parents become aware of their child's exceptionality at birth or shortly thereafter during the pre-school years or after the child enters school. If they recognise the child's exceptionality before school entry they have time to adjust to the child's conditions and can accept the need for special education and related services. If they become aware upon or after school entry they may need time to adjust to the diagnosis, thereby delaying implementation of the needed services (Barsch, 1969).

Some evidence indicates that the child with a mild handicap has more severe adjustment problems arising from disturbed parent-child relationships than does the child with a severe handicap (Ross 1964). Parents may be tempted to overlook a mild handicap. The impact felt by the family of a mildly handicapped child and adolescent revolves around the discovery of the problems, nature of the problem, the cause of the problem and the treatment of the problem. One advantage inherent in later discovery of a problems is that families have in most instances formed a close tie with the child.

Parents of a severely handicapped child will have many adjustments to make as the baby grows into childhood, adolescence and adulthood. Because of their severe physical or mental handicap these children are not expected to become independent and to leave home. Parents experience stresses related to expectations of the child, family re-organization, prolonged and intensive care, provision of services and fear of the future.

Some handicapping conditions or illness may be more difficult for families than are others. Barsch (1964) asked professionals non-professionals and parents with and without handicapped child to rate the perceived severity of coping with 10 handicapping conditions of childhood. The 4 rated as most severe were cerebral palsy, brain injury, mental illness and mental retardation.

Mental Handicap

Definition : Mental handicap, mental retardation, mental deficiency, and mental subnormality are the terms used to describe the same condition. The term Mental Retardation and Mental Handicap are used interchangeably here. There are many definitions of Mental Handicap. American Association on Mental Retardation (1983) gave a comprehensive definition as follows.

"Mental Retardation refers to significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour, and manifested during the developmental period."

'General Intellectual functioning is defined as the results obtained by the administration of standardised general intelligence tests developed for the purpose and adapted to the conditions of the region/country. "Significant Subaverage" is defined as IQ of 70 or below on standardised measures of intelligence. The upper limit is intended as a guideline. It could be extended up to 75 or more, depending on the reliability of intelligence test used.

Adaptive Behaviour is defined as the degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. The expectation of adaptive behaviour may be reflected in sensory and motor skill development, communication skills, self

help skills and socialisation during infancy and early childhood. In the childhood and adolescence the deficits may be in application of basic, academic skills, in daily life activities, application of appropriate reasoning and judgement in the mastery of the environment or on social skills. In late adolescence and adulthood the vocational and social responsibilities and performance may be deficient.

Developmental period is defined as the period of time between conception and the 18th birthday.

In 1992 AAMR published its 9th version of the definition of mental retardation (Reiss, 1995). This definition is intended to support a paradigm shift from a deficiency to a support model of mental retardation. Under the old deficiency model, the locus of the mental retardation was seen as residing in the person or resulting from severe deficiencies in personal capabilities. Whenever a person with mental retardation did not learn in school, the deficiency model gives the teacher a quick excuse for not trying harder to educate the child, leading to education in a special environment. This type of segregation is known to have social and emotional effects on the child.

The new support model of mental retardation recognises that mental retardation is indicated by significant limitations, in personal capabilities. But diagnosticians are asked to assess more than just limitations in IQ and personal capabilities but to assess and identify the adequacy of supports in a given environment such as a school.

Under the new support model the process of diagnosing a person with mental retardation consists of three steps and a holistic evaluation of the person.

In the first step the individual must be formally evaluated within his cultural and educational context and found to function at approximately the IQ level of below 70 to 75. If this criteria is met, the individual's functioning in ten basic area is analysed for strength and need areas to improve the level of independence. A significant limitation must be present in two or more of these areas. Further the onset of the limits in adaptive functioning must have occurred before age 18.

In step two, the psychological and emotional state of the individual at the present time is considered, as well as the health status and present environment. The strength of these aspects as well as needed changes or supports is identified by a team of support persons. Next in step three, the needed supports in these dimensions is prescribed in level of intensity in order to develop an appropriate individualised service plan.

The new support model of Mental Retardation is given in table I and table II.

Table I

Support Model of Mental Retardation

Step I: Diagnosis of Mental Retardation.

> Intellectual functioning is approximately 70 to 75 (IQ) or below.

> There are significant related limitations in 2 or more adaptive skill areas.

> The age of onset is 18 or below.

Step II: Classification and Descriptions

> Describe strength/ need areas in relation to psychological/ emotional considerations.

> Describe physical health considerations

> Describe current environment and the optional environment to foster maximum growth and independence.

Step III: Profile and intensities of needed supports

> Identify needed supports for each of the 4 dimensions

Table II

Dimensions for clinical assessment of Mental Retardation.

Dimension I: Intellectual functioning and adaptive skills.

Communication
Self care
Social skills
Home Living
Community Use
Self Direction
Health and Safety
Functional Academics
Leisure
Work

Dimension II:

Psychological/Emotional consideration

Dimension III: Physical/ Health considerations

Dimension IV: Environmental considerations

There are medical, psychological and educational methods of classification of mental handicap. The medical classification is based on the cause, the psychological classification on the level of intelligence and the

educational classification on the current level of functioning of the mentally retarded person.

The characteristics of the mentally retarded persons vary depending upon the level of retardation. The terms used to describe the various degrees of retardation are given in Table III.

Table III

Degrees of Mental Retardation

Level of Retardation	IO
1. Mild	50-70
2. Moderate	35-49
3.Severe	20-34
4.Profound	Below -20

Characteristics of persons with various degrees of mental handicap by educational expectation are given in table IV.

Table IV

Classification of Mental Retardation by Educational Expectation

Terminology	Approximate IQ range*	Educational expectation
Dull normal	IQ 75 or 80 to 90	Capable of competing in school in most areas, except in the strictly academic areas in which performance is below average. Social adjustment that is not noticeably different from the larger population, although in the lower segment of

		adequate adjustment. Occupational performance satisfactory in non-technical areas, with total self-support highly probable.
Educable	IQ 50 to 75 or 80	Second to fifth-grade achievement in school academic areas. Social adjustment that will permit some degree of independence in the community. Occupational sufficiency that will permit partial or total self-support.
Trainable	IQ 20 to 49	Learning primarily in the areas of self-help skills, very limited achievement in areas considered academic. Social adjustment usually limited to home and closely surrounding area. Occupational performance primarily in sheltered workshop or an institutional setting.
Custodial	IQ below 20	Usually unable to achieve even sufficient skills to care for basic needs. Will usually require nearly total care and supervision for duration of lifetime.

*IQ ranges represent approximate ranges, which vary to some degree, depending on the source of data.

Source: Drew C.J., Logan D.R., Hardman M.L., Mental Retardation a life Cycle approach, 1984 Times Mirror/Mosby college publishing, 3rd ed., p.26.

When a mentally handicapped child is born all the hopes of the parents are shattered at the realisation of the handicap. This calls for a life long adjustment. The mentally retarded person will be seen as an internal source of stress until parents and the family as a whole can reach a measure of acceptance of the disabled individual. The discovery of mental retardation in one of the members in the family is initially a devastating blow for all parents. It produce an intense emotional shock wave in the family with a gamut of feelings ranging from disbelief to despairing anguish.

The responses of a family to a mentally retarded member will depend to a great extent on the severity of the condition. The presence of other physical disabilities and behavioural problems will place an additional stress on parents. While everyone's attention is focused on the infant the parents will have their own difficulties. The extra care demands, financial difficulties and health problems place additional stresses for them.

The presence of the retarded child will produce considerable changes in the family system. The perception of handicap changes the emotional tone, the attitudes and self images of parents and other members. Changes in the family relationship with relatives, friends and neighbours and the community at large are noticed. The family's social life become restricted and feelings of social rejection and isolation may follow.

When retardation is mild, the family will face other circumstances. The majority of mildly retarded children are not diagnosed until they enter school. By then the family will probably have adjusted to the child being slow or a little different from other children. However, by the time the retarded child is seven

or eight years old, most parents are forced to acknowledge that the child has an intellectual deficit. The pain for these parents is associated more to the diagnosis and labelling of MR than to the child's condition itself. For parents who value educational achievement, even mild retardation will be threatening the family's integrity. Families who are less oriented to educational high performance may resent the diagnosis because of embarrassment and loss of self-esteem.

In severe and profound mental retardation parents are promptly alerted to the evidence that the infants state is not completely normal. The fact that something is seriously wrong with their baby is presented to the parents suddenly. The news is received by most parents with total emotional shock.

One of the immediate parental reaction is a feeling of ignorance, about the condition of mental retardation. The grief reaction associated with the birth of a handicapped child is often a necessary bend of the road to acceptance. The tears, disappointment and sadness clean away the overwhelming feelings of parents at this stage.

With the child's diagnosis in hand, parents set out to find the cause of the intellectual impairments. Medical and Psychological consultations become frequent to find the cause and possible cure. They want to know how responsible they are for the child's condition. They may develop personal guilt or one parent may blame the other for the handicap. Moderate feelings of guilt are beneficial as it motivate parents to learn more about retardation and their child's condition. Eventually the parents realise that establishing a cause is less important than learning how to help the child. The phase of acceptance of the child begins and the parents start to find out practical solutions to every day problems. Parents

become aware that there are many other families who share similar circumstances. The feelings of being singled out gradually diminishes. This is a stage of problem solving for the parents regarding schooling, work potential and financial problems. Gradually a more positive parent-child relationship is evolved though the stresses may continue at each stage of development.

Family Stress

Concept of stress: Terms like stress, distress, crisis, difficulty are often used interchangeably. It has been used to refer to both a stimulus and a response (Rao, 1997).

The concept of family stress has been utilised with considerable frequency in literature including clinical and research literature. However, it has continued to remain elusive and is used without explicit definition. In many investigations at least one of three aspects of family stress is identified: (1) stressors (2) stress and (3) crisis.

(1) Stressors:- are defined as those life events or occurrences of sufficient magnitude to bring about change in the family system. (Hill, 1949)

(2) Stress:- is not seen as inherent in the event itself, but rather is conceptualised as a function of the response of the distressed family to the stressor and refers to the residue of tensions generated by the stressor which remain unmanaged (Hill, 1949,; Burr, 1973).

(3) Crisis:- refers to the amount of uncapacitatedness or disorganisation in the family where resources are inadequate (Hill, 1949; Burr, 1973)

In investigating social stress in families Hill (1958) presents a formula for crisis. A (the event) → interacting with B (the family crisis meeting

resources) → interacting with C (the definition of the family makes of the event) → produces x (the crisis) (Hill, 1958).

Definitions of the terms used in the above model will clarify this ABCX formula.

Stressor events (A) differ in their sources; some originate within the family, others from outside. Problems arising out of interpersonal relations within the family, birth of a handicapped child are stressor events, originating within the family. Economic depression or war are events originating from outside. In analysing stressful events Holmes and Rahe (1967) found one common theme, the occurrence of each event evolved or was associated with some adaptive or coping behaviour on the part of the individual involved.

Family resource (B) may include adaptability, coherence, financial stability, friends, religion, education and health. Persons with more skills, assets and resources, more versatile defences and broader experiences deal better with stress. The extent to which families define the event as a crisis (c)reflects the value system of the family and previous experience with crisis. A critical factor in evaluating impact of stressful events is the individuals perception of them (Rabkin & Struening, 1976). Perception, depends on the appraisal of potentially harmful, challenging, or threatening events.

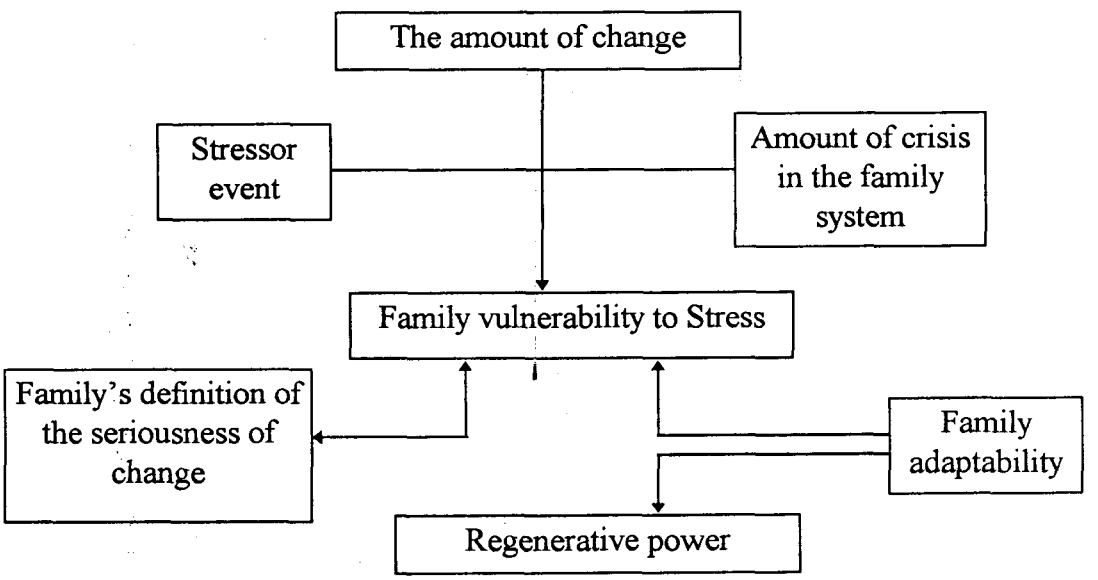
Crisis proneness (X) is the phenomenon of experiencing stressor events (A) with greater frequency and greater severity and defining these (c) more frequently as crisis.

Hill (1949) outlined a second part, a set of statements relating to:

The course of family adjustment which is said to involve (1) a period of disorganisation (2) an angle of recovery and (3) a new level of organisation.

Burr (1973) in particular has been involved in reworking the ABCX formulation into a bonafide part of deductive theory. From this work his central concepts of vulnerability and regenerative power emerged as major new addition to the Hill framwork (Fig.I) (Mc Cubbin et al 1980).

Figure I



Mc Cubbin and Patterson (1983) have added a new dimension to the ABCX model. Their "Double ABCX model" focuses on the family efforts over time to recover from a crisis situation. Using Hills original ABCX model as its foundation it adds post crisis variables in an effort to describe.

1. The additional life stresses and life strains that shape the course of family adaptation.

2. The critical psychological interfamilial and social resources, that families acquire and employ over time in managing crisis situation.
3. The changes in definition and meaning assigned by families to the process of adjustment as families develop a description of their efforts to overcome their predicament.
4. The coping strategies families employ and
5. The range of outcomes of these families efforts.

This elaboration of the ABCX model is an effort to describe additional concurrent stresses effecting recovery from the original crisis, both the new and previously existing resources, used by the families in the recovery process, their perceptions and evaluations of their post crisis situation and the family outcome or degree of adaptation.

The ABCX models may take on a greater potential utility in examining the process of stress in families of a child with mental retardation because mental retardation is such an extremely stigmatising feature of a person in this society. The family of the retarded person feels the brunt of their prejudices and it also may share them.

Family investigators have tried to study the patterns of normative stresses like transitions to child launching, post parenthood, retirement, widowhood, relocation and institutionalisation. Non-normative stresses like tornadoes, wars, loss of family members, occupational stress associated with changing roles of women also have been investigated.

A penetrating set of investigations on families of children with chronic and fatal illness also have been carried out. The greatest concentration of these

studies have focused on the emotional and psychological hardships of both the child and parents. The emphasis on the trying and often crippling impact of child related stressors has been helpful in sensitising the researcher and clinician to the traumas of chronic and demanding human experience. Four themes have emerged from this studies

(1) The importance of the decision making process in the management of stress (Summins et al; 1973),

(2) Systematic assessment of family hardships (Holroyd, 1974)and family resources (Mc Cubbin et al, 1979);

(3) Parental coping strategies and their impact on child health and family functioning (Mc Cubbin et al, 1979)

(4) Careful documentation of the course of adjustment overtime (Kubler- Ross, 1975).

The notion of clustering normative and non-normative life-events has also been offered by and Hill and Joy (1979) and Mc Cubbin et al (1980) as one possible explanation for why some families may be more vulnerable to stressor event or appear to lack regenerative power to recover from a crisis. The family which is already struggling with other life changes such as developmental transition and related role changes may lack the resources to cope with other changes. The concept of the pile up of family life events and stress has been studies by Vaughn et al (1979) and Pallerson and Mc Cubbin (1980).

Family Resources & Perception

The families crisis meeting resources (Hill's B factor) has received considerable attention as it has a central role in family stress framework. Four

factors that affect a family's adjustment to stressors were identified (1) Family members personal resources (2) The family systems internal resources (3) Social support and (4) Coping (Mc Cubbin et al, 1980).

Personal resources: It refers to the broad range of reserves and aids characteristic of individual family members which are available at times of need. These are financial (economic) well being, education (contributing to cognitive ability that facilitates realistic stress perception and problem solving skills), health (physical well being) and psychological resources or personality characteristics (George, 1980). Pearlin and Schooler (1978) have identified three personal psychological resources residing with self which can reduce the stressful consequence. (1) Self esteem (2) Self denigration and (3) Mastery - the extent to which one perceives control over one's life changes in contrast to fate.

Perception has been a central variable in both normative and non-normative stress investigations. The mediating role of perception in reducing the impact of stressful life events has been studied (Howard, 1974; Boss, et al, 1977). However in the study of family stress with the family system as the unit of analysis the variable of perception remains somewhat of an enigma (Mc Cubbin et al, 1980). Family system resources has gained prominence in stress research. Family adaptability and cohesiveness have received reasonable degree of attention. Families functioning moderately along the dimensions of cohesion and adaptability are likely to make a more successful adjustment to stress (Olson et al, 1979).

Family resources in the management of stress:

Pratt (1976) has described the "energised family" as being endowed with a fluid internal organisation characterised by flexible role relations and shared power which promote personal growth and member autonomy. The problem solving ability of the family is one of its fundamental resources in managing stress.

Families that are more economically advantaged are better able to handle the stress of retarded child than those who are less well off. (Farber, 1970). Two parent families cope better than one parent families (Beekman, 1983) . Mothers in successful marriages seem to cope better with caring for the retarded child (Friedrich, 1979).

The role of social network and the potential support it offers to reduce the immediate effect of stress have emerged as a major domain of family stress. Cobb (1976) has defined social support as information exchanged at the interpersonal level which provides (1) emotional support, leading the individual to believe that he or she is cared for and loved (2) esteem support, leading the individual to believe that he or she is esteemed and valued and (3) network support leading an individual to believe that he or she belongs to a network of communication involving mutual obligation and mutual understanding. The major social support networks studies were neighbourhoods, (Litwak, 1969) family and kinship (Caplan 1976; Sussman, 1976;Lopata, 1978) and mutual self help group (Mc Cubbin, 1979). The mediating influence of social support for specific stressor events has emphasised the role of social support in protecting against the effect of stressors and thereby contributing to a family's

invulnerability (Nuckorls, 1972; Kaplan et al, 1973; Gore, 1978). It has also emphasised the importance of social support in promoting recovery from stress experienced in the family thereby contributing to the families regenerative power. (Caplan, 1974; Colletta, 1979)

Coping: A dimension of family resources

The traditional approach to the study of the family stress has been to document the numerous psychological, interpersonal and social aberrations in the family's response to stressors and related hardships. This was a pathology-based model which does not allow for the possibility of positive outcome. It ignores the investigation of its mediators. A shifting away from this dysfunctional emphasis to competence or coping based frame work has been considered as an alternative to the pathology concept (Drotar, 1981). Coping is defined as the things people do both cognitive and behavioural to reduce or avoid the impact of stress (Rao, 1997). It has been referred to as (a) Coping style which is a stable predisposition to respond to stress in particular ways (b) Coping strategy: coping in relation to the special demands of specific situation. Coping behaviours are commonly categorised as (a) problem focused (b)emotion focused and (c) support seeking.

Central to the definition of coping is the assumption that stressful events have a differential impact as a result of their interaction with moderator variables. The concept of coping resources presented by Lazurus and Folkman (1984) provides a useful basis for understanding the coping process and subsequent familial out come. They delineated six types of coping resource, each

of which is assumed to moderate the adverse effects of stress as appraised within the individuals cognitive phenomenological framework.

They are:

1. Parental health and energy
2. Problem solving skills which involve both global and concrete abilities to search for and analyse information and generate various courses of action
3. Social support, involving potentially supportive relationships that may facilitate positive adaptations.
4. Material resources-including socio-economic status and income.
5. Positive beliefs-including feeling of self efficacy, greater internal level of control and belief in some higher purpose.
6. Social skills which refer to the ability to communicate with others in socially appropriate and effective ways. This variable facilitates in obtaining social support and is related to problem solving or coping strategies.

Thus the coping behaviours will 1) decrease the presence of vulnerability factors (Boss et al, 1979) 2) Strengthen or maintain those family resources (Adams, 1975) 3) reduce or eliminate stressor events and their specific hardships and 4) involve the process of actively influencing the environment by doing something to change the social circumstances (Mc Cubbin et al 1976)

The investigators have revealed that the family strategy of coping is not created in a single instant but is progressively modified over time. Because the family is a system coping behaviour involves the management of various dimensions of family life simultaneously;

1. Maintaining satisfactory internal conditions for communication and family organization
2. Promoting member independence and self esteem
3. Maintenance of family bonds of coherence and unity
4. Maintenance and development of social support in transactions with the community

5) Maintenance of some efforts to control the impact of the stresses and the amount of change in the family unit. Coping then becomes a process of achieving a balance in the family system which facilitates organization and unity and promotes individuals growth and development (Mc Cubbin et al 1980). Folkman and Lazarus (1984) classified coping into two broad types ; emotional and problem focused. Emotion focused coping involves efforts that regulate the emotional state associated with or resulting from the stressors. It includes efforts to avoid the situation, cognitively reframing the stressors, and selectively attending to positive aspects of the self or situation. On the other hand, problem focused coping includes direct coping and planned strategies for problem solving. Results of studies on coping in general, have supported the argument that a low level of distress is related to the use of problem focused type of coping. (Folkman et al 1986, Amirkham, 1990, Kvam & Lyons, 1991). Conversely emotion focused type of coping (Wishful thinking, avoidance, and self blame) is related to a high level of depressive symptoms (Amirkhan, 1990).

Marital Satisfaction

Research has indicated that the high level of marital satisfaction or support from husband expressed by mothers as an important facilitator in helping the family having a child with mental retardation to adjust better to life. (Belsky, 1984, Bristol, 1984; Gallagher, 1986). The elements of such support include encouragement, assistance and feedback (Gallagher et. al., 1981).

Family stress & coping in families of children with mental retardation

Interest in stress and coping in families of children with mental retardation has increased in recent years. This is a consequence of the normalisation movement. Normalisation begins with withdrawal from Institutionalisation. The best alternative to institution is the family. Yet the family environment will not serve as a reliable milieu for mentally retarded children if their presence is perceived as overly burdensome and stressful that adequate family functioning becomes impossible.

It is a saying that one of the institution's original function was to relieve the family of the perceived burden of caring for a child with mental retardation. The institutions may disappear but the families, needs do not. Yet the de-institutionalisation movement little did study about the families capacities, resources and limits in providing care. As a result the researchers are now trying to study the individual with mental retardation not in a social vacuum but in the immediate psycho-social context, the family.

Olshansky (1962) has speculated that almost all parents who have a mentally retarded child suffer from chronic sorrow throughout their lives. Parents having a child with mental retardation experience a variety of stressors

and stress reactions related to the child's disability (Orr et. al, 1993). However, the quality and quantity of the impact experienced, may be quite individualised for each of the parents depending upon the nature of the support available to them, their coping skills, child characteristics such as age, level of retardation and associated handicaps (Peshwaria et. al 1995). Although the passage of time will mitigate the effects of some stressors on parents and make their response to stressful situation more routine it is also possible that with the changing nature of child and increased expectations associated with growing older the magnitude of stress that parents experience may increase (Orr et al, 1993) .

The significance of the normative and non-normative distinction in mental retardation seems to be mediated by social classes. For middle class families mental handicap is a non-normative or unanticipated stressor regardless of the level of retardation. For the lower class family, the child's mental retardation is always a non-normative stressor if it is moderate or severe and mild retardation may be seen as normative (Farber, 1975).

The Present Study

In India it is estimated that 24 million people are mentally retarded (Mental Retardation : A manual for guidance counsellors). Majority of them reside in the rural areas with minimal facilities for their education and vocational rehabilitation. With the increasing emphasis on education, even the mildly mentally retarded are also identified causing stress to the family, in recent times. Earlier, the mildly mentally retarded were not identified in the rural areas at least, and they were well integrated in the agrarian society of our country.

With the advent of many awareness programmes at the state and national levels for mentally retarded, most of the parents are now sensitised regarding the condition. With the de-emphasise on institutionalisation these individuals continue to stay with family causing a lot of burden, and stress for parents and other members of family. It is important that strengthening these families would help them cope more effectively with the stressful situation of living with a mentally handicapped. To fulfil that aim the stress and coping pattern of parents of mentally retarded children in India is attempted to study in this research.

Statement of the Problem

This study is designed to explore the relative impact on family functioning on having a child with mental retardation. Previous researches and clinical information have highlighted that mental retardation in any member in the family is a chronic stress for other members and especially for parents. The mentally retarded child's age, sex degree of retardation and many other characteristics may have an impact on parent's and experience of stress and coping patterns. Hence the problem for the present investigation is stated as study of stress and coping , among the parents of the mentally handicapped .

Operational definitions of the concepts

Parental Stress: It is the parents response to the presence of a handicapped child in the family (stressor) consisting of a pattern of physiqlogical and psychological reactions. Responses such as parental worries, family problems, pessimism, characteristics of the child, among others, have been considered as indicators of high levels of stress of the parents and are assessed here.

Coping: It is defined as a personal or collective effort to manage and to reduce the stress on having a mentally retarded child in the family. In the present study coping behaviours like maintaining family integration, co-operation, social support, self esteem, communication with other parents and consultation with medical staff etc. are explored.

Marital satisfaction : It is the degree of satisfaction the parents report about their married life considering all aspects of their marital relationship.

Mental Retardation: Mental retardation is defined as the significantly sub-average intellectual functioning (IQ<70) resulting in or associated with deficits in adaptive behaviour and manifested during the development period.

Parent: The biological parents of the mentally handicapped individuals are included in the present study.

REVIEW OF LITERATURE

Aniamma Mathew Puthupakambil "Stress and coping among the parents of mentally handicapped" Thesis. Department of Psychology, University of Calicut, 1999

Chapter II

REVIEW OF LITERATURE

Since the dawn of history the stress of illness has been recognised as a universal experience. There is much overlap in the kinds of problems faced by individuals and family with so called chronic illness and those with chronic handicap (Pragh and Thomson, 1990). The individual's handicap may bring about a family crisis. Families with generally healthy adaptive patterns usually though not always respond with temporary restriction in function followed by a return to a pre-illness level of functioning. A few families may stabilise at a higher level of functioning representing a type of family development (Koos, 1946).

Parents of children with handicaps experience both normative and unusual stresses. They encounter commonplace stressors like any family such as illness, financial difficulties and daily hassles (Delongis, 1985). In addition, they may experience sources of stresses that are due to living with a child who is handicapped such as extra care demands, difficulties in obtaining child care, child behaviour problems and conflicts with professional service providers (Gallagher et al, 1983; Quine and Pahl, 1985).

In a growing number of recent studies investigators have advocated a paradigm shift from a pathological approach that emphasis the family's problems and strains to a family's competence approach that places an emphasis on the understanding of the family adjustment (Dyson, 1991).

The concept of coping has been widely accepted as a moderating factor between stressful events and adaptational outcomes. Folkman, Lazarus, Gruen

and, Delongis (1986) defined coping as the persons cognitive and behavioural efforts to manage (reduce, minimise, master, or tolerate) the internal and external demands of the person environment transaction that is appraised as taxing or exceeding the person's resources. Here coping is not limited to successful efforts but includes all purposeful attempts to manage stress regardless of their effectiveness. Interest in stress in families of children with mental retardation has increased dramatically in recent years. The best alternative to institutions for children with mental retardation is the family. But if their presence is perceived as overly burdensome and stressful for the family the family environment will not serve as a reliable milieu for the mentally retarded child, and adequate family functioning becomes impossible. Consequently a number of studies, were concentrating on the mentally retarded child's immediate psychological context, the family.

This section reviews the work done in the area of stress and coping on families of children with mental retardation.

Gath (1977) studied the impact of an abnormal child upon the parents. Thirty families with a new born Mongol baby were matched with thirty families with a normal baby. Both groups were followed for 18 months to two years and interviewed six times. Few differences could be found in the mental or physical health of the two groups of parents but marital break down or severe marital disharmony was found in nine of the Mongol families and in none of the controls. However, the parents of almost half the Mongol children in this study felt drawn closer together and their marriage rather strengthened than weakened by their shared tragedy.

Wilton and Renaut (1980) studied the stress levels in families with intellectually handicapped pre-school children and families with non-handicapped pre-school children. The sample included 42 mothers of moderately and severely retarded children and 42 mother of non-handicapped pre-school children. The mothers were further subdivided into two subgroups. Younger mothers (below 30 yrs) and older mother (above 30 years of age). The education levels and socio-economic status were also taken into consideration. The questionnaire on resources and stress (Holroyd, 1974) was used to get the stress score. The results showed that the mothers with handicapped children experienced significantly higher levels of stress than non-handicapped children, in relation to parent problems, family problems and child problems. Age of the mother did not appear to be a pertinent factor.

Chetwynd (1985) examined the factors contributing to stress on mothers caring for an intellectually handicapped child in the family. 91 mothers took part in the study. Mean age of mothers was 38.4 years and children was 9.6 years. The stress in mothers was assessed by maternal malaise inventory. Stress levels were higher amongst mothers whose children had a management problem, overactive or underactive and unable to play with others. Stress was more for mothers whose social life was restricted and had health problems. Stress among mothers of intellectually handicapped children is significantly higher than amongst mothers of non-handicapped children. Marital breakdown was also more among them.

Wikler, (1986) examined the relationship of transitions and stress in 60 families of older mentally retarded children. Families, whose offsprings were

entering adolescence (11 to 15 years old) and young adulthood (20 to 21 years old) were identified as being in transition. They were contrasted with families whose offspring were not of those ages. Families were assessed once and then again 2 years later. Results at both points in time suggested that the families experienced increased levels of stress at transitions in developmental stage of the retarded person.

Minnes (1988) investigated family resources and stress associated with having a mentally retarded child. Subjects were 60 mothers of mentally retarded children living at home. All levels of retardation were considered and the children were under the age of 12 years. Parental stress, internal family resources, external family resources, child and parent characteristics were assessed. Results indicated that characteristics of the child and the families crisis meeting resources were significant predictors of various forms of stress.

Mother's perception of family stress and ways of coping with adolescents who were autistic or had mental retardation were compared by Donovan in 1988. There were 36 children in each group comparable in terms of age, sex, IQ, maternal age and number of siblings. Questionnaire on resources and stress-revised; Locke Wallace Marital adjustment scale-Shortform and Coping health Inventory for parents-form D were used assess the variable. 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. Further more maternal coping styles were consistent across group, indicating that mothers

with adolescents who had a handicap relied heavily on community resources and professional help for coping.

Flynt and Wood (1989) assessed perceptions of family stress and coping behaviour of 90 mothers (aged 22-60 years) with a moderately mentally retarded child at the age of school entry (6-9 years) early adolescence (12-15 year) and young adulthood (18-21 year) 60 per cent of subjects were black and 58per cent were married. Subjects' socio-economic status was also measured. Measures of family stress and coping were administrated to subjects with a retarded child in one of these normative transition periods. There were no significant differences in family stress scores across the three child age groups. Significant difference were found for race and maternal age with regard to perceived stress. Significant difference in coping behaviours were also found for race, marital status and socio-economic status.

Problematic situations experienced by mothers of mentally retarded children and those characteristics of retarded children that may influence family life problems were examined by Harris and Mettale (1989). They studied mothers of 30 retarded children and mothers of 30 non-retarded children. Comparisons revealed group differences in children's characteristics and duration of maternal involvement in child oriented activities. No overall group differences in maternal well-being emerged. Child welfare issues and restrictive time demands were the most intense family problems, reported by mothers with retarded children. Ratings of more intense family problems were associated with more time spent with the child and more symptoms of maternal depression.

Frey et al., (1989) used a multidimensional approach to study the stress and coping among parents of mentally handicapped children. The relations of child characteristics, family social network, parent belief systems and coping styles to parent outcome variables of parenting stress, family adjustment and psychological distress of fathers and mothers were examined with parents of 48 young handicapped children. Child characteristics predicted mothers and fathers parenting stress and fathers' psychological distress. Parental belief systems predicted all three parent outcomes for mothers and fathers. Coping styles predicted psychological distress. Psychological distress was low in mothers who had either a positive belief system or a non-critical family network.

Baxter (1989) investigated stigma as stress in social interactions of parents, of mentally retarded children in three age cohorts. Interviews were conducted with 131 mothers and fathers of mentally retarded children. Parent perceived stress attributed to social attitudes was measured on 5 point Likert-type scale. Three deviating characteristics of the child were identified as stressors. "Noticeability" of the childs speech and behaviour and also behaviour management problems were found to be significantly associated with parental stress. No association was found between noticeability of child's appearance and parental stress. Distressing reactions of others such as staring, displaying discomfort, inappropriately ignoring and drawing attention to the child were also identified as stressors.

Rimmerman (1991)studied 86 parents of adolescents with severe intellectual disability. The parents responded to a questionnaire on their locus of control and perceived social support as moderators of stress and the likelihood of

applying for out of home placement. Findings indicated that applying parents of whom the higher percentage was single parent families tended to have an external locus of control, less social support and high levels of stress. Parental internal locus of control and positive appraisal of social support were the only resources that moderated child related stress and increased the likelihood of keeping the adolescent child at home.

Dyson (1991) examined the association of the presence of a child with handicaps and parental stress and family dysfunctioning. Fifty five families with young children with development handicap (mental retardation, physical and sensory handicap, speech disorder, learning disabilities and developmental delay were compared with a matched group of families of children without handicaps on the variables of parental stress and family functioning. The result provided strong evidence that family stress is related to the care of a child with special needs in middle class families. However the results further suggested that family group do not differ on the general family functioning excepting that these families emphasised achievement and moral religious beliefs and valued set rules and procedures for operating family life.

Flynt et al., (1992) examined the social support of mothers of children with mental retardation. Subjects were 80 mothers of children who were developmentally delayed or diagnosed with moderate mental retardation. The age range of children was from 6 months to 20 years. The age range of the mothers was 21 to 60 years with a mean of 35.8 year. The questionnaire on resources and stress-F and the questionnaire on social support were used for the study. Results indicated that the stress was higher for the subjects with the

children in the pre-school age group. On the social support variable, the intimate support differed significantly across age group. Mother of pre-schoolers utilised social support to a greater extent than did other mothers and there mothers relied more on intimate support (spouse) than other supports.

Rousey, et al., (1992) studied mothers and fathers perceptions of stress and coping with children who have severe disabilities. 147 parents participated in the study. Parents independently completed the questionnaire on resources and stress. The results indicated that mother reported more pessimism regarding their child's future than did fathers. There was no significant difference on total QRS-F Score. Greater perceived parent and family problems related to lower marital adjustment for fathers and depression for both father and mothers reported.

Floyd and Saitzyk (1992) evaluated the importance of socio-economic status as a determinant of parenting attitudes and behaviours and as a moderator of problems associated with raising children with handicaps, in 171 families raising a child with mild or moderate mental retardation. Self report measures assessed parents attitude regarding control, independence, and closeness within the family and parental and family problems. Supportive, aversive, and controlling, parent child interactions were observed in the home. Higher socio-economic status was associated with parental attitudes and behaviours related to fostering independent initiative in the family and lower socio-economic status with more controlling and negative behaviour. However, regardless of socio-economic status, controlling parental behaviours, were responsive to the level of functioning of the child. Negative and controlling interactions with the child

were more highly correlated with the parents reports of parental and family problems of upper socio-economic status parents.

Schultz et al., (1992) evaluated a study that was undertaken to obtain information pertinent to the formative stages of psycho-educational programme, "caring for parent caregivers" for 24 fathers and 33 mothers of children with disabilities. Perception of family functioning and subjective distress were assessed using a pre-test post-test control group design. Results suggested that mothers are more likely to acknowledge realistic concerns. All 39 subjects indicated a positive experience with 34 subjects noting positive changes in attitude and behaviour.

Taang and Tsang (1992) compared the level of stress experienced by 205 parents with pre-school special children and 51 parents of normal children using the Parenting Stress Index and the General Health Questionnaire. The groups were grossly comparable in age, sex and socio-economic status. The pre-school special parents scored significantly higher in the sub-scales of parent domain, child domain and total scores of PSI and GHQ. Results confirm the hypothesis that these parents experience more parenting stress and are mentally more vulnerable.

Baxter (1992) studied the appraised significance of intellectual disability for parents of children in three age cohort. An interview schedule was administered to 61 mother-father dyads and 9 mothers of 3-19 years old moderately- severely intellectually disabled children. Results indicated that appraised significance perceptions of parents were potentially exacerbating mediators of parental stress. Findings are consistent with the proposition that the

parent appraised significance of the child's disability for their parental role becomes increasingly salient as an exacerbating mediator of parental stress during the later childhood to early adolescent years.

Chomicki and Wilgosh (1992) compared the concerns of parents of 27 children with Moderate Mental Retardation (MMR) and those of the parents of 25 children with Severe Mental Retardation (SMR). Parents of children with SMR and those with school age children had significantly more concerns about hospitalization of their children than did parents to children with MMR or those with pre-school children. Similarly parents of SMR children have more concerns on the parent-professional relationship variable than did parents of children with MMR. A high level of concern on the professional competence variable was expressed by all parents. Results suggest that severity of impairment is an important factor of the number and nature of concern that are experienced by parents when seeking health care services for their children with mental retardation.

Koller et al., (1992) reported the data covering a 15 year period on the health, behaviour and functioning of a representative population of 157 Families of Children with Mental Retardation (FCMR) and 165 families of comparison children were used in Cluster Analysis to obtain selectively homogenous grouping of families. Only a small minority of FCMR did not cluster together with comparison families. More than a third functioned poorly. A few clusters had ambiguous configuration, but most were easily understood and conformed generally to expectation in validation analysis. The highest rates of behaviour

disturbance in children with mental retardation occurred in clusters where rates of psychiatric disturbance were high for mother or for both parents.

Patterns of stress in families of children with paediatric conditions that varied on two dimension - fatal Vs non-fatal outcome and presence Vs absence of cognitive impairment were studied by Walter Van-Slyke and Newbrough in 1992. Families of 23 children with cystic fibrosis, 24 with diabetes and 24 with moderate mental retardation were compared to families of 24 healthy children. Subjects were aged 11-19 years. Maternal responses of Questionnaire on Resource and stress-short form indicated that families of children with chronic conditions did not differ from families of healthy children on scales assessing general aspects of family stress such as family conflict. However the diagnostic groups differed on QRS-Scales assessing stressors specific to the child's disability.

Dossetor et al., (1994) examined the value of Expressed Emotions (EE) as a measure of the relationship between adolescents with intellectual impairment and their Parental Primary Carers (PPC). PPC's of 92 intellectual impaired adolescents (ages 14-19 years) completed an interview that included the Handicap Behaviour Skills Schedule the Social Support Questionnaire and the General Health Questionnaire. 32 PPCs showed high EE. High EE was significantly related to PPC's psychological ill health, poor practical social support, poor quality of marriage, greater professional support and an insecure style of respire care usage. High EE criticism was associated with PPC's having an adolescent of less severe intellectual impairment, more behavioural disturbance, but less professional support.

Dyson's investigation on parental stress and family functioning over time in 38 families of children with disabilities was reported in 1993, Comparisons were made between 2 time periods and with 36 families of children who did not have disabilities. Predictors of parental stress were identified. Results showed a high level of stability in parental stress and a modest degree of consistency overtime in family functioning in both groups. There was also stability in the best predictors of parental stress. (Presence or absence of disabilities and the quality of family relationships) Families of children with disabilities were distinguished by the exceedingly greater amount of stress at both periods of study.

Floyd and Philippe (1993) compared the in time interactions of parents with their school age children in 53 families of children with mild or moderate mental retardation and with 51 families of children without mental retardation. The children were 6-16 years of age. The parents of children with mental retardation were relatively more controlling and less playful with their children. However they also employed effective behaviour management practices without resorting to coercive control strategies. Further 24-51% of the variance in interaction processes were predicted by a set of risk factors common to both groups with the status of the child as having or not having mental retardation accounting for relatively little unique variance.

Kraus's (1993) investigation on child related and parenting stress showed the similarities and differences between mothers and fathers of children with disabilities. The sample consisted of married mothers and fathers of 121 toddlers; 39 with Down Syndrome, 44 with motor impairment and 38 with

developmental delay of uncertain aetiology. No significant differences were found by the diagnostic group with respect to child's gender, family income, parental age, parental education or parental employment status. The Parenting Stress Index, Child Improvement, Locus of Control Scales, Parent Support Scale and Family Adaptability and Cohesion Evaluation Scales were used as parent measures. The results indicated that fathers had more stress related to their child's temperament and their relationship to their child. Mothers reported more stress from the personal consequences of parenting. Fathers were more sensitive to the effects of the family environment whereas mothers were more affected by their personal support network.

Shek and Tsang (1993) studied the coping response of Chinese parents with pre-school mentally handicapped children. Chinese Coping Scale along with other instruments assessing the parents stress, mental health, marital satisfaction and care giving patterns were given to 381 parents of pre-school mentally handicapped children. The analysis revealed that a significant proportion of the parents seldom sought help from others when dealing with the stress arising from taking care of their handicapped children.

Kravetz and Nitivitz (1993) examined how mothers and fathers cope with the tensions involved in the day to day struggle of raising a child with mental retardation. It was investigated whether the ways in which mothers and fathers cope with these tensions are related to the school adjustment of the child. 57 parent pairs with a child with mental retardation participated in the study. The Ways of Coping Scale and AAMD. Adaptive Behaviour Scales were used.

The problem focused coping Scale and emotion focused coping styles were investigated. The results indicated that mothers use emotion focused coping more than do fathers. Father's emotion focused coping was found to be positively and significantly related to their children's school adjustment. Mother's problem focused coping correlated positively with their children's constructive behaviour and negatively with their children's behaviour disturbance. Emotion focused coping was associated with school achievement for fathers regardless of the extent to which they used problem focused coping.

Bruce and Schultz (1994) examined the developmental component of parenting children with intellectual disability using 51 mother father dyads. The perceptions that the parents held of their children, their parenting experience and their level of physical and emotional well-being were compared among 3 age cohorts of children. Cohort I consisted of 12 children (Ages 1-4 years) Cohort 2 consisted of 22 children (aged 5-10 years) and Cohort 3 consisted of 17 children (aged 11-21 years). There was a lack of significant difference among cohorts and among fathers and mothers in terms of parental perception and well being, indicating similar perceptions of the impact of child's condition on the parents. Significant differences were found among cohorts in child-related handicapped and acknowledgement of special progress of the child. An inverse relationship between age of cohort and level of happiness in parenting was apparent.

Bruce et al., (1994) employed a development framework to compare 3 age Cohorts comprised of 58 mother-father dyads of children or young adults with intellectual disabilities. Cohort I comprised parents with children aged 1-4 years. Cohort 2 comprised parents with children aged 5-10 year and Cohort 3

comprised parents with children aged 11-21 year. Measures of intusive thoughts, avoidance behaviour current emotional distress over reminders of time of diagnosis of disability and intensity of wishing for what might have been, were used to reflect the parents grief reaction. Result indicated no significant age related differences in parents responses but significant gender related differences in parent response. Mothers scored higher than father on all measures. However on the wishing Scale there were no significant differences between fathers and mothers. It is concluded that grieving is an ongoing feature of rearing a child with intellectual disability and is more intense for mothers than fathers.

Ali et al., (1994) assessed the personality characteristics and psychological problems of parents of 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 Questionnaire was used to measure the pscychoticism neuroticism and extraversion introversion responses of the parents. Parents of mentally retarded children had significantly higher score on neuroticism scale, indicating that they were more emotionally unstable than the parents of normal children. Fathers and mothers in each group did not differ significantly except for parents of normal children in the Extraversion- Intro-version Scale where fathers were more extraverted than mothers.

Rogner and Wesels (1994) compared mothers and fathers strategies for coping with a Ist born or 2nd born child with mental retardation. Subjects were 25 mentally retarded children (mean age 10 years) and their mothers (mean age

39 years) and fathers (mean age 41 years). The parents completed interviews and questionnaires assessing their levels of emotional stress and their strategies for coping with their MR child. The responses of mothers and fathers were compared and the effects of child's birth order (1st or 2nd) were analyzed. Mothers reported more stress than fathers in both group.

Cheng and Tang (1995), studied coping with psychological distress of Chinese parents of children with Down Syndrome and compared it with parents of children with language delays or no disabilities. The Chinese Parental Coping Style, the Chinese version of the General Health Questionnaire, Life Orientation Test, Self Mastery Scale and Demographic data were used to assess stress and coping compared to parents of no disabilities groups. The parents of disabled children reported a higher level of psychological distress, were less optimistic, felt less self-efficacious and engaged in more frequent use of self-reliance coping style. Main effects for parent gender revealed that mothers 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. Inter correlations among variables showed that avoidance coping style and self mastery emerged as the two importance correlates of parental distress.

Trute (1995) investigating the gender differences in the psychological adjustment of parents of young developmentally disabled children. Psychological distress, as expressed through symptoms of depression was studied in a cross sectional sample of parents providing home care to develop mentally disabled children. Mothers and fathers were interviewed separately in 73 house holds.

The intent of the study was to explore predictors of Symptoms of depression to better understand what child family and life circumstances might be differentially related to psychological stress in the cohorts of men and women. The results indicated that the degree to which child disability was appraised as a family stressor with negative consequence on family functioning was found to be significantly related to age of the disabled child, level of child disability, family income the types of diagnosis and child's temperament, sex of the child, family size and age and education of the mother or father. Mothers reported significantly higher levels of depression than did fathers. Mothers with younger children and fathers with male children appeared to be at higher risk for depression. Personal or intrapsychic coping resources (Self esteem) and strongtie social resources (Spousal relationship) were found to significant predictors of depression in both mothers and fathers. Informal respite resources were related to mothers well being.

Ainge (1995) compared the impact of having a child with an intellectual disability on parenting views of both fathers and mothers. Fathers and mothers(ages 27-70 years) of 19 children (aged 4-31 years) with intellectual disabilities rated their feelings about each issue. On over 75 per cent of items couples either rated identically or disagreed only marginally, supporting the view that children with intellectual disability have a deterministic influence on both their parents.

Carpiniello et al., (1995) investigated levels of psychiatric symptoms and of subjective and objective, burden associated with care for their disabled child with 20 parents of mentally retarded children. 20 parents of children with

neurological impairments and 20 parents of children without disabilities. Subjects completed State-trait Anxiety Inventory, Beck Depression Inventory and the Self-Reporting Questionnaire Subjects with disabled children had significantly higher levels of psychiatric symptoms and depressive symptoms compared with controls.. The two groups of subjects with disabled children reported considerable subjective and objective Burden although there were no difference between those groups in the level of burden.

Cohil & Gliddin (1996) studied the influence of child diagnosis on family and parental functioning. They compared families of children with Downs Syndrome with families raising children with other types of developmental disabilities. They employed three methodological strategies; (1) between families of children with Downs Syndrome to other disabilities (2) case by case matching and (3) regression techniques were performed to predict family functioning outcomes for entire sample. Results showed no difference between matched groups on various measures of functioning, which was replicated with multiple regression techniques. However in unmatched samples, families of children with Down Syndrome showed better functioning.

Research in India

In Indian context research on mental retardation has laid much emphasis on epidemiological work, biopsychological factor, cognitive functioning and personality, ecological factors in causation and malnutrition in the past (Sen,

1988). Studies on stress and coping in the field of handicaps in general and mental handicap specifically are very scarce in our country.

Narayan (1979) studied the impact of mentally retarded children on their families and reported that parents of mentally retarded children lacked opportunity for social contacts, had sense of rejection and social isolation and had marital disharmony.

Rastogi (1981) studied the attitude of parents towards their mentally retarded children. Parents of 50 mentally retarded children were investigated using an attitude questionnaire prepared for this purpose. Results indicated that majority of the fathers have a favourable attitude on the scale of acceptance irrespective of the degree of retardation of their child. However the fathers reported a greater degree of hostility in the severe group. The mothers of the severely retarded reported an unfavourable attitude towards their children. The parents attitude was accompanied by feelings of guilt, pessimism and sometimes even hostility and aggression.

Sheshadri et al., (1983) examined the impact of mentally handicapped child on the family. The sample consisted of 30 mothers of mentally handicapped children of all age and all degrees of retardation. Social Burden Scale (Pai and Kapur, 1981) and Marital Adjustment Questionnaire (Bhat and Gauba, 1978) were used. The results showed that there was no significant marital disharmony in the sample. Most mothers reported a favourable attitude towards the child. It was also noted that the greater the degree of retardation in the child the greater was the felt burden. Child's degree of retardation was not seen to be correlated to the attitude or marital adjustment.

Chaturvedi and Malhotra (1984) conducted a follow up study of the parental attitudes and perception towards their retarded children. 30 families were included in the study. Parents of higher education had a more scientific perception. Rejecting attitude was the commonest.

Moudgil et al., (1985) investigated the buffering effect of social emotional support on the stress experienced by parents of mentally retarded children A semi-structured Interview Schedule and the measure of emotional support were administered to the 18 pairs of parents of mentally retarded children. Results showed that the parents, are depressed, they worry about the children's schooling and giving more attention to children. They reported marital disharmony and disturbed relationships and social image. The parents who got maximum social emotional support from spouses, family, members, friends, relatives etc. experienced less stress and problems. Also the female child created more social emotional problems for parents.

Veena (1985) conducted a study to find out the management problems and practices of home makers with a disabled member in the family. The sample consisted 80 families. The results indicated that the nature and extent of the disabled member affected the problems faced by the family and the family had to make more efforts to solve the problems as the extend of handicap increased. The home makers had a positive attitudes towards the disabled.

Peshawaria et al., (1990) conducted the study to find out the parents needs regarding behaviour problems in mentally handicapped persons. The results indicated that parents predominately seeks help for managing problems of 'disobedience' in their retarded children.

Thressiakutty and Narayan (1990) studied the parental perceptions of problems and expectations regarding their adolescent and adult mentally retarded children. The data revealed that inappropriate social behaviours rank highest with regard to complaints followed by poor communication abilities and dependence in self-care. Parental expectations with regard to their mentally retarded wards showed that majority of the parents expected vocational training and personal independence than any other types of help. Their study also revealed that only a very low number asked for residential facility and they wanted to keep the child with them whatever might be their deficiency.

Srivastava (1990) in his study on frustration aggression patterns of mothers of retarded children and normal children found that mothers differed significantly in two groups in their frustration reactions. 50 mothers each were examined in two groups. Indian adaptation of Resenzwing, Picture-Frustration (PF) study (Adult form) as adapted by Pareek (1968) was used for the study. The results indicated that the mothers of mentally retarded children scored significantly higher on extrapunitive (E) factors and inpunitve factors (M). They were found to be more ego extrapunitive, less inpunitive, had more obstacles dominance, more ego-defensive, and more aggressively denied any offence levied upon them.

Peshawaria et al.,(1990) conducted a survey on teachers perception of problem behaviours among mentally handicapped persons in special school settings. The survey covered 288 institutions. The results indicated that teachers reported problem behaviours predominantly in the form of 'restlessness' 'physically overactive' and inattentive behaviours.

Scqueria, Madhu Rao, Subbakrishna and Prabhu (1990) investigated the perceived burden and coping status of 55 mothers (aged 21-55 years) of 30 male and 25 female mentally handicapped children (age 5-12 years) in relation to gender and degree of retardation. There were no differences in the perceived burden with regard to the sex of the child. Subjects, reports more extensive disruption of routine family activities when the children had a large number of associated problems. Mothers of severely retarded children had a greater perceived burden than did mothers of moderately retarded children. 70.9 percent of the subjects showed severe strain on their psychological health. Denial, rehearsal of alternative outcomes finding a purpose and seeking support were the most common coping styles used by the subjects.

Tangri and Verma (1992) carried out a study of social burden felt by mothers of handicapped children. The impact of handicapped child on the family was assessed. Two groups of mothers, ie. those of (1) 50 physically handicapped children and (2) 50 mentally handicapped children participated in the study. Mothers were interviewed on the social burden scale. Results revealed that the mothers of mentally retarded children reported higher social burden than those of the physically handicapped children. \Also, the mothers of handicapped girls reported more burden than those of handicapped boys.

Ramagopal and Rao (1994) attempted to assess the behaviour disorders in moderately mentally retarded and their relation to parental attitude. The sample consisted of 60 parents of moderately mentally retarded children of both sexes in the age range of 8 to 12 years. Parents reported negative attitude towards their moderately retarded children. There was a non significant

negative correlation between behaviour disorder and parental attitude of the moderately mentally retarded children.

Annapurna (1997) conducted a study on 60 families having mentally handicapped children belonging to 3 age groups of childhood, late childhood and adolescence. The tools used for the study were socio economic status scale, family resource scale, family coping scale, family functioning scale, family integration scale, family burden scale family satisfaction scale and problem behaviour checklist. The study involved fathers, mothers and significant other persons as family members. Results indicated significant difference between three groups of family members on marital issues, extended family support. Mothers scored high on both. Fathers perceived more financial burden. Significant other persons scored high on coping skills than fathers and mothers. Positive correlation was reported between socio-economic status, family satisfaction, behaviour problems and stress for fathers. Negative correlation was reported between social resources and stress for fathers. Socio conomic status and family satisfaction positively correlated with mothers stress, whereas social resources and family resources had negative correlation for mothers.

The above review of literature shows the paucity of research work done in the area of stress and coping in the area of mental handicap in India. In the field of mental retardation there are hardly any systematic comprehensive studies, reported from India in the past. For any programme to be successful for the mentally handicapped involving family members, the understanding of the family is a basic necessity. The stress experienced by them due to the presence of handicapped child, the coping patterns they use to successfully adjust with

that home atmosphere and various socio-economic, and other familial parameters which have an influence on family-all have to be systematically investigated before planning out the programme for mentally handicapped. Hence this is an effort to study those factors in Indian set up so that the individual handicapped and his family are better understood.

METHODOLOGY

Aniamma Mathew Puthupakambil “Stress and coping among the parents of mentally handicapped” Thesis. Department of Psychology, University of Calicut, 1999

Chapter III

METHODOLOGY

Interest in stress in families of children with mental retardation has increased dramatically in recent years. The birth of an impaired child is an unexpected event that occurs at a time of already heightened physical and emotional awareness on the part of parents. At this vulnerable time parents are faced with the loss of a normal child in addition to the overwhelming demands of coping with the presence of a handicapped child. Such an event is a crisis for the family, precipitating stress and forcing parents to adapt and cope. Research into stress and its effects on having a handicapped can make a strong contribution to our understanding of the process of adaptation and coping in the family.

Lazarus and Folkman (1984) have argued that the stress, an individual experience is not a simple function of the number of demands placed on that individual. If personal resources are adequate to meet those demands, the individual can successfully adapt, even if environmental demands are considerable. Lazurus and Folkman conceptualised individuals as having five categories of coping resources; social networks, problem solving skills, general and specific skills, utilitarian resources, and health/energy/morale.

The present work is undertaken to study the stress and coping among parents of mentally retarded individuals. This is a multidimensional approach to the study of stress and coping in the specific cultural context of Indian set up and especially in the State of Kerala. Such a study is greatly relevant when majority of the handicapped individuals live with parents causing added stresses and

concerns regarding their education, vocation and future life to the family. This study is expected to throw light on the parent's nature of stress and their coping patterns in relation to various psycho-social variables so that the parents can be better understood and helped in living with a handicapped person.

Objectives of the Present Study:

Primary Objectives :-

I. To examine the patterns of stress experienced by the parents of mentally retarded individuals in the following four categories.
    1. Parents of children with IQ below 50 and age between 12-18 yr
    2. Parents of children with IQ above 50 and age between 12-18 yr
    3. Parents of children with IQ below 50 and age between 5-11 yr
    4. Parents of children with IQ above 50 and age between 5-11 yr

II. To study the coping patterns used by the parents when a mentally retarded child is present in the family in the following four categories:
    1. Parents of children with IQ below 50 and age between 12-18 yr
    2. Parents of children with IQ above 50 and age between 12-18 yr
    3. Parents of children with IQ below 50 and age between 5-11 yr
    4. Parents of children with IQ above 50 and age between 5-11 yr

III. To understand the marital satisfaction experienced by parents of mentally retarded individuals in the following four groups:
    1. Parents of children with IQ below 50 and age between 12-18 yr
    2. Parents of children with IQ above50 and age between 12-18 yr

3. Parents of children with IQ below 50 and age between 5-11 yr
4. Parents of children with IQ above 50 and age between 5-11 yr

Secondary Objectives:

To understand the major objectives in a better way, the following secondary objectives are also included in the present study.

I. The inter-relationship between stress, coping patterns and marital satisfaction.

II. The effect of the mentally retarded child's (1) sex (2) other handicaps and (3) behaviour problems on parental stress, coping pattern and marital satisfaction.

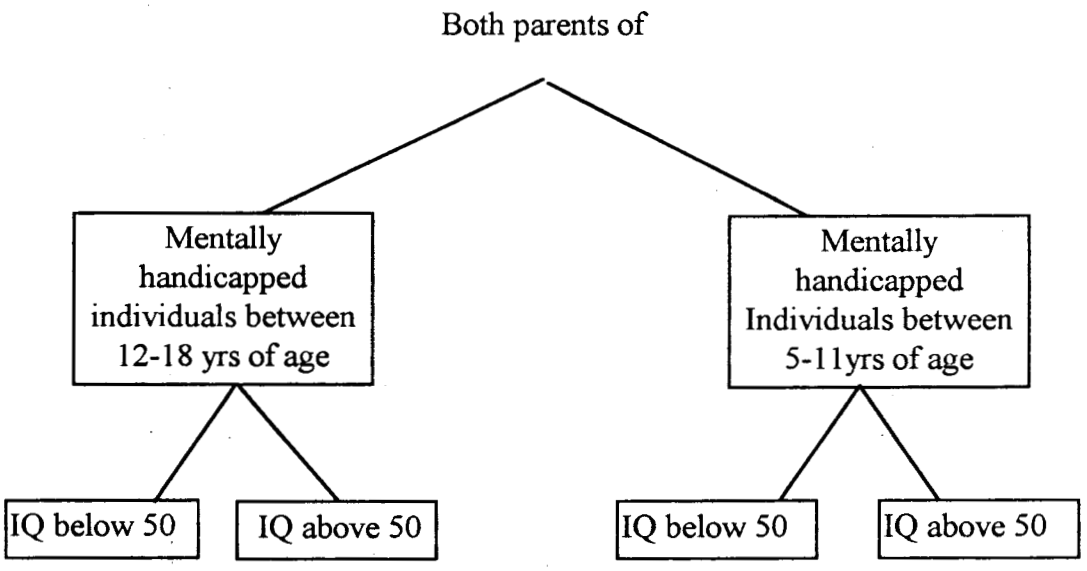
Sample:

1. Both parents (father and mother) of mentally retarded individuals of age group between 5 to 18 yrs. Further classification is made as follows:

a. Parents of children between 5 to 11 yrs of age

b. Parents of children between 12 to 18 yrs of age

In the above two age groups further grouping is done, based on two levels of retardation i.e. IQ above 50 and IQ below 50. So the total sample categorization is as follows:



Only biological parents are considered for this study .The sample is collected form paediatric and psychiatric departments of government and private hospitals, special schools for mentally handicapped, community clinics and vocational rehabilitation centres. The parents of children, who are permanently residing in mental hospitals or homes for retarded individuals are not considered for the study. The IQ of the children are assessed individually using standardised tests of intelligence whenever it is not available from the concerned institutions case records.

Tools used for the Study

1. Socio Demographic Data Sheet: This is used to obtain the basic background information about the handicapped individual and their parents which serve as the independent variables for the present study. The information included are

I The Parent's

1. Age

2. Education
3. Occupation
4. Family income
5. Family's social supports and
6. Total number of children in the family

II The mentally handicapped individual's

1. Age
2. Sex
3. IQ
4. Behavioural problems and
5. Other handicaps in the individual

Socio-demographic data sheet is given in appendix 1.

2. The short form of the Questionnaire on Resources and Stress- (QRS-F) Friedrich Edition (Friedrich, Greenberg and Crnic, 1983).

This is a 52 item questionnaire, developed from the Questionnaire on Resources and Stress originally developed by Holroyd in 1974. It measures the impact of a developmentally delayed, handicapped or chronically ill child on other family members. The QRS-F is factor analysed and four independent factors have emerged. The tool thus measures the four broad categories of (1) parent and family problems, (2) pessimism (3) Child characteristics and (4) Physical incapacitation. The instrument requires respondents to provide 'true' or 'false' answers concerning their children and family. QRS-F gives a total stress score and separate scores on four, independent factors of stress.

Description of Factors :

Factor I: Parent and family problems, consists of 20 items that assess the respondents perception of problems for themselves, other family member or the family as a whole.

Factor II: Pessimism, consists of 11 items. The central characteristic of this factor is an immediate and future pessimism about the child's prospects of achieving self sufficiency.

Factor III : Child characteristics, consists of 15 items. This factor involves the respondent's perception of the specific behavioural or attitudinal difficulties presented by the index child.

Factor IV: Physical incapacitation, consists of 6 items. This factor involve the respondent's perceptions of limitations in the child's physical abilities and self help skills.

This particular factor structure suggests that the problems facing the families of handicapped are clearly multidimensional and that the score on a given dimension can not predict or be predicted from knowledge of the scores of the remaining dimensional factors. The KR-20 reliability co-efficient for this short form is determined to be 0.95. Validation study of QRS -F is determined to be 0.93 by its authors. Also the correlations between four QRS-F factors and other independent measures of depression, problem checklist and social desirability are indicative of the concurrent validity of the QRS-F.

Vernacular translation

Since this tool was originally developed in English a vernacular translation of it was carried out for the purpose of present investigation. The following procedure was adopted for this purpose.

The tool was first translated from English to Malayalam by an expert in both languages. The translated Malayalam version was retranslated to English by another person equally proficient in both languages. The equivalence of the original and the retranslated version was checked. Items on which difference appeared were reworded in the vernacular version until the original and the retranslations attained acceptable uniformity. The vernacular version was tried out on a small sample of five normal people in order to check any possible difficulty in comprehending items and was found to be comprehensible.

Reliability

Reliability of the vernacular translation of QRS-F was found by test retest reliability method. The questionnaire was given to 30 parents of mentally retarded individuals between the ages of 30-45 yrs. A retest was conducted after two weeks. The test retest reliability was 0.92 (Spearman- Brown Prophecy Formula).

Validity

The scores obtained from the above sample was correlated with those obtained from them using the English version. The correlation obtained was 0.78.

The reliability and validity coefficients indicate that the vernacular version of QRS-F used in this study is reasonably dependable and can be used

to assess the 'stress' of parents of mentally retarded children. The original QRS-F and the translated version are given in Appendix II.

3. Coping Health Inventory for Parents- CHIP (Mc Cubbin et al., 1983).

This was used as an assessment schedule to assess parental coping patterns in the care of the chronically ill children initially. Later, many investigators have reported its efficacy in studying the coping patterns of parents of handicapped individuals (Dimovan, 1988; Flynt and Wood, 1989). The CHIP was developed to record what parents find helpful or not helpful to them in the management of family life when one or more of its members is ill for a brief period or has a medical condition which calls for continued medical care. Coping is defined as personal or collective (with other individuals, programs) efforts to manage the hardships associated with health problems or handicaps in the family. This is a Likert type questionnaire consisting of 45 items. Coping scale scores were computed for each of the three patterns by means of an unweighted summing of a parent's "helpfulness" ratings (0 = not helpful, 1= minimally helpful, 2 = moderately helpful, 3 = extremely helpful) across behaviour items within each pattern. The items were factor analysed and three coping patterns emerged.

Description of Factors

Coping Pattern I: Maintaining family integration, co-operation and an optimistic definition of the situation, is composed of 19 behaviours that centre around family life and relationships and the parents outlook of life and the ill/handicapped child. The first coping pattern is labelled maintaining family integration, co-operation and optimistic definition of the situation.

Coping Pattern II : Maintaining social support self esteem and psychological stability, consists of 18 behaviour items that focus upon the parents efforts to maintain a sense of their own "Well-being" through social relationships, involvement in activities that have the potential of enhancing ones self-esteem, and doing things to manage psychological tensions and strains. This coping pattern therefore, is labelled maintaining social support, self esteem and psychological stability.

Coping Pattern III: Understanding the medical situation through communication with other parents and consultation with medical staff, involves eight coping behaviours that focus on the relationships between other parents with an ill child and the medical staff and its programme. It includes behaviours directed at understanding and mastering the medical information needed to care for the ill child. This coping pattern is labelled understanding the medical situation through communication with other parents and consultation with the medical staff.

Coping scale scores were computed for each of the three patterns by means of an unweighted summing of a parents "helpfulness".

Reliability and Validity (CHIP)

The instrument has a reliability of 0.71. Cronbach's alphas, computed for the items on each coping pattern, indicate respectable reliabilities of 0.79, 0.79 and 0.71 for the respective coping patterns to be described.

The three parental coping scores for each parent were correlated with the validation measures of family environment and changes in child's health and

reported to be of good validity ratings across behaviour items within each pattern by the authors.

CHIP was also originally developed in English and so a vernacular translation was prepared in Malayalam for the present study. The procedure for this was exactly the same reported for QRS-F earlier.

Reliability: Reliability of CHIP is ascertained on the basis of response of 30 parents between the age of 30-45 yrs. The test-retest reliability coefficient obtained for CHIP is 0.95 indicating high reliability for CHIP- vernacular version.

Validity: Validity is estimated by correlating the scores obtained on vernacular translation from 30 parents and their scores on English version of CHIP. The validity coefficient is 0.86. The high reliability and validity coefficients authenticates the tests suitability for measuring coping patterns of parents in this cultural set-up. CHIP- original, and vernacular translation are given in Appendix III.

Marital Satisfaction Scale

To assess the marital satisfaction of parents one single summary question regarding their married life was asked. They were requested to rate their marital satisfaction considering all aspects of their married life on a Visual Analogue Scale. This type of a Visual Analogue Scale was originally devised by Atiken (1955) to assess the depressed mood. Later it was found to be useful in assessing the subjective report of pain or any other feelings and hence was used to assess the marital satisfaction. It is a straight line either horizontal or vertical, the ends of which are fixed by a statement of the extreme limit of the variable to be

measured; eg: extremely unsatisfactory married life and extremely satisfactory married life.

In the present study the Marital Satisfaction Scale is a horizontal graphic rating scale in which in addition to the defined fixed end points there are descriptive terms placed at specified intervals along its length.

The subject is asked to mark where he would like to place himself along the line as far as their married life is concerned. The scale is said to be highly sensitive to the subjective reports of the specified variable and hence is known to give reliable results. The present scale has 7 ratings from 0 to 6 indicating the marital satisfaction experienced by both parents. The Marital Satisfaction Scale is given in Appendix IV.

Pilot Study

First trials were conducted with 10 parent pairs to experiment the interview schedule to collect the socio-demographic data and other tools for study. Based on this study necessary modifications were made in the schedule and the tools were finalised for collection of data.

After interviewing both parents together to collect all information on demographic data sheet, they were asked to fill in the questionnaire independently and return it within 2-3 days. Parents were explained about the purpose of study and doubts were clarified regarding the questionnaires. The parents who reported difficulty in reading and writing due to low educational status, the researcher read out the inventories and the responses of the parents were marked.

Statistical Analysis

The computer facility was utilised for the analysis of data which was systematically processed. The major statistical tests used are Analysis of Variance, t-tests and correlations. Simple percentages are calculated for other socio-demographical variables related to parents and children and on dependent variables.

RESULTS AND DISCUSSION

Aniamma Mathew Puthupakambil “Stress and coping among the parents of mentally handicapped” Thesis. Department of Psychology, University of Calicut, 1999

Chapter IV

RESULTS AND DISCUSSION

The present study is discussed under the following headings:

1. An overview of the characteristics of the respondents
2. Pattern of stress experienced by the respondents
3. Nature of coping patterns employed by the respondents
4. Nature of marital satisfaction experienced by the respondents
5. Inter relationship between the above three major variables among the respondents
6. Nature of relationship between Dependent variables and some of the child characteristics

1. An Overview of the characteristics of respondents:

1.1 Sample of the study: Parents characteristics

The biological parents of mentally handicapped individuals constitute the sample for the present study.

The parents belong to the following four groups

Group I Parents of Mentally Handicapped individuals of 12-18 yrs. of age and IQ below 50

Group II Parents of Mentally Handicapped Individuals of 12-18 yrs. of age and IQ above 50

Group III Parents of Mentally Handicapped Children of 5-11 yrs. of age and IQ below 50

Group IV Parents of Mentally Handicapped Children of 5-11 yrs. of age and IQ above 50

The description of the Sample is given in Table 1.11

Table 1.11

Frequency distribution of Sample of the Study: Parents

Group	Frequency/ Father	Percentage	Frequency/ Mother	Percentage
I	32	23.5	32	23.5
II	33	24.3	33	24.3
III	38	27.9	38	27.9
IV	33	24.3	33	24.3
Total	**136**	**100**	**136**	**100**

Table 1.11 shows the number of respondents taken up for the study. It can be noted that both parents are almost equally represented in all groups.

1.12 Age

Since the age of the mentally handicapped children are controlled the age of the parents in general comes within a particular range. The details of which are given in Table 1.12.

Table 1. 12
Age Description of Parents

		Age range	Mean age in years
Group I	Father	38yrs – 52 yrs	45.2
	Mother	35yrs – 50yrs	42.4
Group II	Father	38yrs – 54 yrs	46.1
	Mother	32yrs – 48yrs	43.2
Group III	Father	28yrs – 40 yrs	35.0
	Mother	24yrs – 38yrs	32.2
Group IV	Father	30yrs – 45yrs	34.0
	Mother	28yrs – 40 yrs	31.0

In Group I father's mean age is 45.2 yrs and mother's mean age is 42.4 yrs. In Group II father's mean age is 46.1 yrs and mother's mean age is 43.2

yrs. Group III father's mean age is 35 yrs and mother's mean age is 32. 2 yrs. Group IV fathers have a mean age of 34 yrs and mothers have a mean age of 31 yrs.

1.13 Education

Parental education is divided into four categories. The frequency and percentage in each educational category for the entire group is given in table 1.13.

Table 1. 13
Description of Educational background of parents

Educational Category	**Frequency & Percentage**			
	Father		Mother	
	Frequency	Percentage	Frequency	Percentage
Below 7 yrs of Edn.	27	19.9	36	26.5
8-10 yr	53	39.0	68	50.0
11-15 yr	43	31.6	29	21.3
Above 15yr	7	5.1	3	2.2
Total	130*	100	136	100

- Education is not mentioned by 6 fathers.

It can be seen from Table 1.13 that 70.6 percent fathers and 71.3 percent mothers have more than 8 years of education.

1.14 Occupation

Father's occupation is classified into 4 categories, the details of which are given in Table 1.14.

Table 1.14
Occupation of Father

Category	Frequency	Percentage
Unskilled	46	33.8
Semiskilled	33	24.3
Skilled	49	36.0
Others	2	4.4
Total	**130 ***	**100**

*Occupation is not mentioned by 6 fathers

While conducting the study it was found that majority of the mothers were housewives and not having any other specific occupation. So the mother's occupation is classified into two categories only. The details are given in table 1.15.

Table 1.15
Occupation - Mother

Category	Frequency	Percentage
Working	21	15.4
House wife	115	84.6
Total	**136**	**100**

Table 1.15 shows that only 15.4 percent mothers are working and 84.6 percent house wives.

1.16 Family Income

The income is taken for family as a unit and not for father and mother separately. This is mainly due to the fact that father continued to be the breadwinner for most of the families taken up for the present study.

Table 1. 16

Family Income per Month

Income	Frequency	Percentage
Upto Rs. 1500/-	34	25.0
Rs. 1501- Rs. 3500	38	27.9
Above Rs. 3500/-	64	47.1
Total	**136**	**100**

Table 1.16 shows that 47.1percent of the sample has a family income of more than Rs.3500/- per months.

1.17 Family Social Support

Four types of social supports are identified for the present investigation. The nature of family social support is assessed by interviewing the parents. Table 1.17 shows the types of family support available to the parents in the present study.

Table 1. 17
Family Social Support

Type of Social Support	Frequency	Percentage
Other members in the family	48	35.3
Relatives	62	45.6
Friends	5	3.7
Community	7	5.1
No Support	14	10.3
Total	**136**	**100**

45.6 percent and 35.3 percent of parents in the present group receive support from relatives and other members respectively in the care of their

mentally handicapped child. 10.3 percent reports that they have no social supports available in the care of the child. Friends and community serve as supports for 3.7 percent and 5.1 percent of the total sample only.

1.18 Total Number of Children in the Family

The details of number of children in the family are given in Table 1.18.

Table 1.18
Total number of Children in the family

No. of Children	Frequency	Percentage
One child	5	3.7
Two children	85	62.5
Three Children	40	29.4
Four or more Children	6	4.4
Total	**136**	**100**

It can be seen that 62.5 percent of the families have only 2 children. 3.7 percent of families have only one child who is mentally handicapped. 29.4 percent have three children and 4.4 percent have four or more children.

1.2 Sample of the Study: Child Characteristics

Various characteristics of handicapped children are taken into consideration for the purpose of studying parent's stress, coping and marital satisfaction. The details are discussed in the following tables.

1.21 Age and IQ of the children

Age and IQ of the handicapped children are the major controlled variables in the present investigation. The frequency distribution of children based on age and IQ is given in table 1. 21.

Table 1. 21
Age & IQ of the Child

Group		Frequency	Percentage
I	12-18yr IQ < 50	32	23.5
II	12- 18yr IQ >50	33	24.3
III	5-11yr IQ < 50	38	27.9
IV	5-11yr IQ > 50	33	24.3
Total		**136**	**100**

Table 2.21 indicates that almost an equal representation is ensured in all four groups (23. 5 % 24.3 %, 24.3 % & 24.3 %).

1.22 Sex of the Child

Table 1.22 shows the frequency distribution with regards to sex for the total sample in this investigation.

Table 1. 22

Sex of the Child

Sex	Frequency	Percentage
Male	71	52.2
Female	65	47.8
Total	**136**	**100**

Tables 1.22 shows that 52.2 percent of children are males and 47.8 percent are females in the present study.

1. 23 Behavioural Problems of Child

Behavioural problems in the mentally handicapped tend to increase the stress of parents. The coping behaviours, may differ accordingly and the marital satisfaction may vary.

Table 1.23 shows the frequency of presence or absence of behavioural problems in the total sample.

Table 1. 23

Behavioural Problems

Behavioural Problems	Frequency	Percentage
Present	52	38.2
Absent	84	61.8
Total	**136**	**100**

It can be seen that 61.8 percent of the present sample of children has no behavioural problems and 31.2 percent has behavioural problems.

1.24 Presence of other handicaps in the mentally handicapped

Multiple handicaps cause more care giving problems for parents usually. If the mentally handicapped individual has some other handicaps along with it, the stress experienced by the parents may differ. Table 1. 24 shows the frequency of other handicaps present in the sample.

Table 1.24
Other Handicaps

Other handicaps	Frequency	Percentage
Present	26	19.1
Absent	110	80.9
Total	**136**	**100**

Table 1.24 indicates that 80.9percent of children have no other handicaps along with mental retardation. The other handicaps include, auditory-visual-physical problems, seizure disorders etc.

2. Pattern of Stress experienced by the Respondents

One of the major objectives of the present investigation is to find out the pattern of stress experienced by the parents in the four major groups and the difference in that pattern across the groups. Questionnaire on Resources and Stress is used for this purpose. Total stress score and four separate factor scores are computed and percentage, 't' values and ANOVA are calculated.

2.1 Total stress

Table 2.11 shows the frequency and percentage of fathers who report low stress, moderate stress or extreme stress on having a mentally handicapped individual in the family.

In table 2.11 it can be seen that moderate stress is reported by 63.3percent fathers in the total sample. It is interesting to note that 40percent fathers of Group III (5-11 yr. & IQ <50) report severe stress and 54.3 percent moderate stress. This may be due to the fact that these children demand more physical care from parents. This observation supports the finding of Barsch (1969) that if the parents become aware of their child's exceptionality upon or after school entry they may need time to adjust to the diagnosis. There is evidence that the early years in the life of a disabled child are a profound parenting time that can be stressful for both parents (Bryne and Cunningham, 1985).

Table 2.11
The total stress of fathers

Count Row pct. Col pct. Total pct.	Low stress	Moderate stress	Extreme stress	Row Total
Group I	6 18.8 35.3 4.7	20 62.5 24.7 15.6	6 18.8 20.0 4.7	32 25
Group II	7 23.3 41.2 5.5	20 66.7 24.7 15.6	3 10.0 10.0 2.3	30 23.4
Group III	2 5.7 11.8 1.6	19 54.3 23.5 14.8	14 40.0 46.7 10.9	35 27.3
Group IV	2 6.5 11.8 1.6	22 71.0 27.2 17.2	7 22.6 23.3 5.5	31 24.2
Column Total	17 13.3	81 63.3	30 23.4	128 100.0

Table 2.12 shows the frequency in each group against total stress of mother.

Table 2.12 shows that mothers also experience moderate stress when they have a mentally handicapped child (62.2 %). Like fathers, they too experience extreme stress (56.7 %) in case of children in the category of 5-11 yr. and IQ <50 supporting Barsch's (1969) view points.

Table 2.12

Total Stress of Mothers

Count Row Pct Col. Pct Total Pct	Low stress	Moderate stress	Extreme stress	Row Total
Group I	4 12.5 22.2 3.1	23 71.9 29.1 18.1	5 15.6 16.7 3.9	32 25.2
Group II	9 31.0 50.0 7.1	18 62.1 22.8 14.2	2 6.9 6.7 1.6	29 22.8
Group III	-	16 48.5 20.3 12.6	17 51.5 56.7 13.4	33 26.0
Group IV	5 15.2 27.8 3.9	22 66.7 27.8 17.3	6 18.2 20.0 4.7	33 26.0
Column Total	18 14.2	79 62.2	30 23.6	127 100.0

Flynt et al., (1992) reports that stress is higher for the mothers with mentally retarded children in the pre-school age and with moderate retardation. In this investigation too mothers report more stress when their children belong to younger age group with IQ below 50. Similar finding is reported by Minnes (1988) that stress associated with mental retardation diminish with age. As retarded child grows older parents may come to terms with their child's cognitive impairment. Cameron and Orr (1987) support this finding that half of the families of children with delayed development has moderate level of stress

2.2 Stress Factor I : Parent and Family Problems

Stress Factor I is analysed separately in all four groups for fathers and mothers. Table 2.21 shows the frequency and percentage of fathers who report Stress Factor I as mildly, moderately or extremely stressful.

Table 2. 21

Stress Factor I for Fathers

Count Row pct. Col. pct. Total pct.	Low stress	Moderate stress	Extreme stress	Row Total
Group I	10 33.3 32.3 7.9	14 46.7 24.6 11.1	6 20.0 15.8 4.8	30 23.8
Group II	9 30.0 29.0 7.1	14 46.7 24.6 11.1	7 23.3 18.4 5.6	30 23.8
Group III	4 11.4 12.9 3.2	16 45.7 28.1 12.7	15 42.9 39.5 11.9	35 27.8
Group IV	8 25.8 25.8 6.3	13 41.9 22.8 10.3	10 32.3 26.3 7.9	31 24.6
Column Total	31 24.6	57 45.2	38 30.2	126 100

Table 2.21 shows that parent and family problems are moderate to extremely stressful for 45.2 and 30.2 percent fathers in the total sample. Again in Group III 35.7 percent father's report Stress Factor I as moderately stressful and 42.9 percent as extremely stressful.

Table 2.22 shows mothers perception of stress on Stress Factor I.

Table 2.22

Stress Factor I for Mothers

Count Row pct. Col. pct. Total pct.	Low stress	Moderate stress	Extreme stress	Row Total
Group I	7 24.1 25.9 5.7	19 65.9 29.2 15.4	3 10.3 9.7 2.4	29 23.6
Group II	11 37.9 40.7 8.9	15 51.7 23.1 12.2	3 10.3 9.7 2.4	29 23.6
Group III	2 6.3 7.4 1.6	13 40.6 20.0 10.6	17 53.1 54.8 13.8	32 26.0
Group IV	7 21.2 25.9 5.7	18 54.5 27.7 14.6	8 24.2 25.8 6.5	33 26.8
Column Total	27 22.0	65 52.8	31 25.2	123 100

Table 2.22 shows that Stress Factor I is moderately stressful for 65 percent mothers of the total sample. It is extreme for 53.1 percent mothers in Group III. This may be due to the reason that mothers continue to be the primary care givers of children in the younger age groups and the parent and family problems may be affecting the mothers more than fathers. It is reported that the major burden for daily domestic care of young disabled is largely carried out by mothers. (Carey, 1982). It seems that in situations involving the home care of young developmentally disabled children, the child's primary care taker will

experience more emotional distress if they carry the bulk of parenting duties in family (Romans- Clarkson, etal., 1986).

2.3 Stress factor II: Pessimism

Pessimism as a factor of total stress is analysed for both parents. Table 2.31 shows the frequency and percentage of fathers in each group on stress factor II

Table.2.31

Stress Factor II of Father

Count Row pct. Col pct. Total pct.	**Low stress**	**Moderate stress**	**Extreme stress**	**Row Total**
Group I	2 6.7 22.2 1.6	2 6.7 7.7 1.6	26 86.7 28.6 20.6	30 23.8
Group II	5 16.7 55.6 4.0	8 26.7 30.8 6.3	17 56.7 18.7 13.5	30 23.8
Group III	2 5.7 22.2 1.6	10 28.6 38.5 7.9	23 65.7 25.3 18.3	35 27.8
Group IV	.. .. ..	6 19.4 23.1 4.8	25 8.6 27.5 19.8	31 24.6
Column Total	9 7.1	26 20.6	91 72.2	126 100

Table 2.31 shows that 72.2 percent of fathers report extreme pessimism with regard to their children with mental retardation as a group. Group wise

analysis also shows a high percentage of fathers in all groups reporting extreme pessimism .

Table 2.32 shows the frequency distribution and percentage of mothers on Stress Factor II.

Table 2.32

Stress Factor II of Mothers

Count Row pct. Col pct. Total pct.	**Low stress**	**Moderate stress**	**Extreme stress**	**Row Total**
Group I	. .	8 26.7 22.2 6.5	22 73.3 25.6 17.7	30 24.2
Group II	1 3.4 50.0 0.8	13 44.8 36.1 10.5	15 51.7 17.4 12.1	29 23.4
Group III	1 3.4 50.0 0.8	10 30.3 27.8 8.1	22 66.7 25.6 17.7	33 26.6
Group IV	..	5 15.6 13.9 4.0	27 84.4 31.4 21.8	32 25.8
Column Total	2 1.6	36 29.0	86 69.4	124 100

Table.2.32 shows that 69.4 percent of mothers have extreme pessimism on having a retarded child. Group wise analysis shows that 84.4 percent mothers of young mentally retarded children with IQ above 50 report extreme pessimism. This may be due to the reason that the identification of handicapped in this group may be of recent origin and mothers may be going

through the initial phase of adjustment. Only 51.7 per cent mothers of older mentally retarded children with IQ above 50 report extreme pessimism may be because their mothers are aware of their potentials and have adjusted to it.

The findings suggest that a high percentage of parents of mentally handicapped individuals experience extreme pessimism regarding their children. This has great clinical significance, as the pessimism in parents may influence the implementation of needed services for their children. It is suggested that parents as a group require professional help in dealing with their pessimistic outlook so that better care may be provided for their children. Moudgil et al (1985) in their study on parents report that parents of mentally handicapped are depressed and they worry about the handicapped children's schooling and future supporting the present findings.

2.4 Stress Factor III : Child Characteristics

The characteristics of the retarded child influence the parental stress, coping behaviours and marital satisfaction. Stress Factor III is separately analysed for father and mother. Table 2.41 shows the frequency distribution and percentage of fathers on Factor III of stress.

Table .2.41 shows that 49.2 percent fathers of total sample report moderate stress on Factor III. However in Group III 48.6 percent has reported extreme stress on Factor III and in Group II 53.3 percent fathers report only mild stress with regard to child characteristics. In Group III the characteristics of the handicapped child are more prominent in terms of their physical appearance and dependency needs as they belong to the group with IQ below 50. On the other hand Group II children have much lesser dependency on parents usually as

they have only mild retardation. This may be the reason for experiencing varied stress in these two groups on factor III stress, child characteristics.

Table.2.41

Stress Factor III of Father

Count Row pct. Col pct. Total pct.	Low Stress	Moderate Stress	Extreme Stress	Row Total
Group I	5 16.7 15.6 4.6	19 63.3 30.6 15.1	6 20.0 18.8 4.8	30 23.8
Group II	16 53.3 50.0 12.7	12 40.0 19.4 9.5	2 6.7 6.3 1.6	30 23.8
Group III	5 14.3 15.6 4.0	13 37.1 21.0 10.3	17 48.6 53.1 13.5	35 27.8
Group IV	6 19.4 18.8 4.8	18 58.1 29.0 14.3	7 22.6 21.9 5.6	31 24.6
Column Total	32 25.4	62 49.2	32 25.4	126 100

Table 2.42 indicates mothers reports on Stress Factor III

Table 2.42

Stress Factor III of Mother

Count Row pct. Col. pct. Total pct.	Low Stress	Moderate Stress	Extreme Stress	Row Total
Group I	5 16.7 17.2 4.0	16 53.3 25.4 12.8	9 30.0 27.3 7.2	30 24.0
Group II	10 34.5 34.5 8.0	18 62.1 28.6 14.4	1 3.4 3.0 0.8	29 23.2
Group III	5 15.2 17.2 4.0	12 36.4 19.0 9.6	16 48.5 48.5 12.8	33 26.4
Group IV	9 27.3 31.0 7.2	17 51.5 27.0 13.6	7 21.2 21.2 5.6	33 26.4
Column Total	29 23.2	63 50.4	33 26.4	125 100

Stress Factor III is reported to be a moderate stressor for mothers in the total sample (50.4%). 48.5percent mothers in Group III report it as an extreme stressor. Here again the mothers have to give more attention to this group on self care skills as most of these children are more incapacitated due to low IQ and in the younger age group. This may be the reason for mothers experiencing more stress in this group.

2.5 Stress Factor IV : Physical Incapacitation

Physical incapacitation of the children is reported to be a significant stress factor in handicaps for the care givers. Stress Factor IV is analysed separately for fathers and mothers.

Table 2.51 shows the frequency distribution and percentage for father on Stress Factor IV.

Table 2.51

Stress Factor IV of Father

Count **Row pct.** **Col pct.** **Total pct.**	**Low Stress**	**Moderate Stress**	**Extreme Stress**	**Row Total**
Group I	2.2 73.3 22.4 17.5	7 23.3 43.8 5.6	1 3.3 8.3 0.8	30 23.8
Group II	25 83.3 25.5 19.8	3 10.0 18.8 2.4	2 6.7 16.7 1.6	31 23.8
Group III	23 65.7 23.5 18.3	3 8.6 18.8 2.4	9 25.7 75.0 7.1	35 27.8
Group IV	28 90.3 28.6 22.2	3 9.7 18.8 2.4	--	31 24.6
Column Total	98 77.8	16 12.7	12 9.5	126 100

It can be seen in table 2.51 that physical incapacitation of the child is only a low stress in 77.8 percent of fathers. This can be expected as physical incapacitation is not very common with mentally retarded children excepting in

very severe or profound cases. Group wise analysis also shows similar findings on Factor III of Stress.

Table2.52 indicates frequency and percentage for Stress Factor IV of mothers.

Table 2.52

Stress Factor IV of Mother

Count Row pct. Col pct. Total pct.	Low Stress	Moderate Stress	Extreme Stress	Row Total
Group I	24 80.0 25.8 19.2	6 20.6 20.0 4.8	-	30 24.0
Group II	23 79.3 24.7 18.4	5 17.2 16.7 4.0	1 3.4 50.0 0.8	29 23.2
Group III	18 54.5 19.4 14.4	14 42.4 46.7 11.2	1 3.0 50.0 0.8	33 26.4
Group IV	28 84.8 30.1 22.4	5 15.2 16.7 4.0	-	33 26.4
Column Total	93 74.4	30.0 24.0	2 1.6	125 100.0

On Stress Factor IV mothers (74.4%) report only low stress. However, 42.4percent mothers in Group III report moderate stress on Factor IV. This may be due to the reason that mothers are more involved in the caring of children in this age group and the children are more dependent on mothers for their self care

needs due to low IQ and younger age. This supports the findings of Carry (1982) and Romans and Clarksons et al. (1985).

2.6 Group Differences on Stress

To find out whether there is any significant group difference between four group on stress, 't' values are computed.

Table 2.61 shows the 't' values for fathers on total stress score.

Table 2.61

Total Stress - 't' values for Father

Between Groups	Frequency N		Mean M		SD		't' value
I&II	30	30	29.1	24.2	90.06	8.56	2.50*
I &III	30	35	29.1	32.5	9.06	9.68	2.24*
I & IV	30	31	29.1	29.4	9.06	7.10	0.15
II & III	30	35	24.2	32.5	8.56	9.68	3.63**
II & IV	30	31	24.2	29.4	8.56	7.10	2.60*
III & IV	35	31	32.5	29.4	9.68	7.10	1.45

(*P<0.05; ** P<0.01)

Table 2.61 shows that Groups II & III differ significantly on total stress (t=3.63; P< 0.01). Fathers of Group III report more stress than fathers of Group II (M= 32.5 & 24.2 respectively). Low IQ and younger age of mentally handicapped children turn out to be significant stress factor for fathers. This can be expected as the Group II handicapped individuals are older & have IQ above 50 and they are usually independent on all their skills causing less stress to their parents. Significant difference in stress is observed for fathers in Groups I & II (t= 2.15; P<0.05) where Group I parents report more stress (M= 29.1 & 24.2

respectively) indicating that low IQ is a significant factor in predicting stress. Significant difference is noticed between Groups I & III (t= 2.24 P<0.05) where Group III fathers experience more stress than Group I (M=32.5 & 29.1 respectively). This indicates that low IQ in younger age group is more stressful for parents than low IQ in older age group. Groups II & IV fathers also differ significantly on total stress (t=2.60; P<0.05). This indicates that handicapped children in lower age group is more stressful for fathers than older age groups even when they are of mild mental retardation. This may be due to the increased care giving demands the younger age group places on fathers.

Table 2.62 indicates the 't' values on total stress score for mothers.

Table 2.62

Total stress - 't' values for mother

Between Groups	Frequency N		Mean M		SD		't' value
I&II	30	29	28.3	24.2	8.09	8.27	-
I &III	30	33	9.5	13.0	4.29	4.37	3.17**
I & IV	30	33	28.3	28.5	8.09	8.16	0.09
II & III	29	33	24.2	33.3	8.27	8.61	4.22**
II & IV	29	33	24.2	28.5	8.27	8.16	2.05*
III & IV	33	33	33.2	28.5	8.61	8.16	2.31

(*P<0.05; ** P<0.01)

Table 2.62 shows that Groups I & III mothers differ significantly (t= 3.17; P<0.01) on total stress score where Group III mothers report more stress than Group I. (M= 13.0 & 9.5 respectively) The younger age group of handicapped children places more stress on mothers than older children possibly

due to increased care giving demands. Mothers of Groups II & III also differ significantly (t= 4.22; P<0.01) where Group III mothers report more stress (M=24.2 & 33.2 respectively) indicating that younger age group and low IQ increase the perception of stress of mothers. Groups II and IV differ significantly (t= 2.05: P<0.05) where Group IV mothers report more stress suggesting that younger children place more stress for mothers than older children even when they have only mild mental handicap.

To ascertain the results of t-value and to compare the variation in stress of parents in four groups One Way Analysis of Variance test is conducted for both parents. The results are given in table 2.63.

Table 2.63

ANOVA

Total stress of parents

	Source	DF	SS	MS	F Value
Father	Bet. Gr.	3	1121-92	373.97	4.96**
	Within Gr.	122	9205.79	75.46	
	Total	125	10327.71		
Mother	Bet. Gr.	3	1282.96	427.65	6.22**
	Within Gr.	121	8314.24	68.7	
	Total	124	9527.20		

(**P< 0.01)

The results of table 2.63 show that there is a significant variation between four groups on the total stress score of both parents (F=4.96 and F= 6.22 for father and mother respectively; P<0.01) From table 2.61and table 2.62 it can be seen that Groups II & III show considerable variation, the mean values

being M= 24.2 and M= 32.5 for fathers and M= 24.2 and M= 33.2 for mothers. This suggests that low IQ in younger age group is a significant predicator of stress for both parents. From table 2.62 it can also be seen that when IQ is kept constant the younger age group places more stress for mothers as there is a significant variation between Groups I & III (M= 9.5 & M= 13.0 respectively.)

The results of 't' values and ANOVA indicate that both IQ and age are significant factors in causing stress to the parents. A younger child with severe retardation causes more stress than an older child with mild or severe retardation. This may be due to the fact that the younger child has more personal care demands and when severity of handicap increases the care demands too increase. Similar findings are reported by Rogner and Wells (1994) that fathers experience increased stress on having mentally retarded child below 12 yrs. Tsang and Tsang (1992) in their study on pre-school normal comparable children with special children reported that parents of special children experience more parenting stress. Trute (1995) report that the degree to which child's disability is appraised as a family stressor is related to the age of the child and level of child's disability. The younger the child and severe the retardation, the stress appraised will be more. Similar results are reported by, Wilton and Renaut (1980) Wickler (1986) Chomicki and Wilgosh (1992) , Dyson (1993) and Cheng and Tang (1995). However contradictory findings are reported by Flint and Wood (1989) that there is no significant difference between groups in family stress scores across three child age groups.

To find out whether there is any significant difference between groups on four stress factors taken separately 't' values and ANOVA are computed for both fathers and mothers separately.

Table 2.64 shows t-values for fathers on Stress Factor I.

Table 2.64

Stress Factor I - 't' values for father

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	29	9.4	9.5	5.14	4.83	0.06
I &III	30	35	9.4	12.0	5.14	4.21	2.24*
I & IV	30	31	9.4	10.5	5.14	4.60	0.84
II & III	29	35	9.5	12.0	4.83	4.21	2.23*
II & IV	29	31	9.5	10.5	4.83	4.60	0.80
III & IV	35	31	12.0	10.5	4.21	4.60	1.43

(* P<0.05)

Table 2.64 shows that Groups I & III fathers differ significantly on stress factor I (t= 2.24; P<0.05), the Group III fathers reporting more factor I stress than Group I (M= 12.0 & 9.4 respectively). Groups II and III also differ significantly (t= 2.23, P<0.05), where again Group III reporting more stress related to parent and family problems.

Table 2.65 shows the t-values for mothers of Stress Factor I.

Table 2.65

Stress Factor I - 't' values for mother

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	28	9.5	9.1	4.29	4.25	0.41
I &III	30	33	9.5	13.0	4.29	4.37	3.17**
I & IV	30	33	9.5	10.0	4.29	4.10	0.41
II & III	28	33	9.1	13.0	4.25	4.30	3.54**
II & IV	29	31	9.5	10.0	4.83	4.60	0.80
III & IV	33	33	13.0	10.0	4.37	4.10	2.90**

(** $P < 0.01$)

It can be seen from table 2.65 that Groups I and III, Groups II and III and Groups III and IV differ significantly on stress factor I of mothers, ($t = 3.17, 3.54$ and 2.90 respectively; $p<0.01$). The Group III mothers report more stress than all other groups related to parent and family problems the mean value being 13.0

ANOVA is computed to ascertain the results of 't' values for the parents on stress factor I.

Table 2.66 shows ANOVA for parents on Stress Factor I.

Table 2.66 shows that significant variation between group is not evident for fathers on stress factor I. However for mothers significant variation is evident. Further looking at Table 2.65 the variation is present mainly for Groups I and III, the means being 9.5 and 13.0 and Groups II and III, the means being 9.1 and 13.0. Parent and family problems constitute a major stress for mothers of young mentally handicapped children with severe retardation.

Table 2.66

ANOVA

Stress Factor I of Parents

Group	Source	DF	SS	MS	F Values
Father	Bet.Gr.	3	144.07	48.02	2.19
	Within Gr.	121	2654.12	21.93	
	Total	124	2798.19		
Mother	Bet.Gr	3	300.58	100.19	5.53**
	Within Gr.	120	2172.29		
	Total	123	2472.97	18.10	

(** P<0.01)

Table 2.67 shows 't' values on Factor II stress for fathers.

Table 2.67

Stress Factor II - 't' values for father

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	30	9.1	7.8	2.18	2.66	2.02+
I &III	30	35	91.1	8.0	2.18	2.53	1.80
I & IV	30	31	9.1	9.0	2.18	1.70	0.07
II & III	30	35	7.8	8.0	2.66	2.53	0.31
II & IV	30	31	7.8	9.0	2.66	1.70	2.16*
III & IV	30	31	8.0	9.0	2.53	1.70	1.92

(* P<0.05)

Table 2.67 shows that Groups I and II differ significantly on Stress Factor II of fathers (t=2.02; P<0.05). Group I fathers report more stress related to pessimism than Group II. Groups II and IV also differ significantly (t=2.16;

P<0.05), the Group IV reporting more pessimism than Group II. In Group I the severity of mental handicap may be making fathers to feel more pessimistic, whereas in Group IV it may be that parents are getting adjusted to the presence of a young handicapped child in the family.

Table 2.68 shows the Stress Factor II of mothers and t values

Table 2.68

Stress Factor II - 't' values for Mothers

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	29	8.6	7.7	2.24	2.37	1.40
I &III	30	33	8.6	8.3	2.24	2.34	0.46
I & IV	30	32	8.6	9.0	2.24	2.25	0.81
II & III	29	33	7.7	8.3	2.37	2.34	0.97
II & IV	29	32	7.7	9.0	2.37	2.25	2.21*
III & IV	35	31	8.0	9.0	2.53	1.70	1.90

(*P<0.05)

Table 2.68 shows that only Groups II and IV differ significantly on Stress Factor II of mothers (t=2,21; P<0.05). Group IV mothers report more pessimism than Group II, probably because the children are of younger age groups and mothers are involved more with their care giving needs and are in the initial stages of adjusting to the identification of a handicapped child in the family.

To further ascertain the results ANOVA is computed for both parents.

Table 2.69 shows the ANOVA for Stress Factor II of both parents.

Table 2.69

ANOVA

Stress Factor II of both Parents

	Source	DF	SS	MS	F-Value
Father	Bet.Gr.	3	41.67	13.89	2.62
	Within Gr.	122	647.63	5.31	
	Total	125	689.30		
Mother	Bet.Gr.	30	27.10	9.03	1.77
	Within Gr.	120	635.10	5.29	
	Total	123	662.19		

Table 2.69 shows that there is no significant variation between groups on Stress Factor II for both parents.

Table 2.70 shows 't' values on Stress Factor III of father

Table 2.70

Stress Factor III - 't' values for Father

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	30	8.7	5.4	3.06	2.84	4.28**
I &III	30	35	8.7	9.7	3.06	3.66	1.20
I & IV	30	31	8.7	8.5	3.06	2.67	0.25
II & III	30	35	5.4	9.7	2.84	3.66	5.20**
II & IV	30	31	5.4	8.5	2.84	2.67	4.37**
III & IV	35	31	9.7	8.5	3.66	2.67	1.50

(**P<0.01)

Table 2.70 shows that Groups I & II differ significantly (t=4.28, P<0.01) on Stress Factor III of fathers. In Group I, where the handicapped children belong to severe retardation category, the fathers report more stress associated with child characteristics. This can be expected as the severely retarded children usually will have more dependency and more personal care needs from parents. Groups II and III also differ significantly (t=5.20, P<0.01) where Group III has more stress associated with child characteristics. This also can be expected as these children are of younger age groups and with severe mental handicap. Groups II and IV fathers also differ significantly (t=4.37, P<0.01) where Group IV fathers, experience more factor III stress. This may be due to the fact that the Group IV fathers have younger mentally retarded children though both groups have only mild degree of retardation. Younger children always require more help from parents in taking care of their personal needs.

Table 2.71 shows 't' values for Stress Factor III of mother

Table 2.71

Stress Factor III - 't' values for Mother

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	29	8.5	5.8	3.03	2.60	3.64**
I &III	30	33	8.5	9.4	3.03	3.01	1.26
I & IV	30	33	8.5	8.1	3.03	3.04	0.53
II & III	29	33	5.8	9.4	2.60	3.01	5.05**
II & IV	29	33	5.8	8.1	2.60	3.04	3.13**
III & IV	33	33	9.4	8.1	3.03	3.04	1.83

(** P<0.01)

Table 2.71 shows that Groups I and II mothers differ significantly on Factor III stress (t=3.64; P<0.01). Group I mothers report high stress related to child characteristics compared to Group II and the reason may be that Group I children have severe mental retardation and prominent physical features and incapacitation compared to Group II children. Groups II and III mothers also differ significantly (t=5.05, P<0.01) on Factor III stress, the Group III experiencing more stress than Group I. This can be explained, by the lower age and severe mental retardation of Group III children. Groups II and IV also differ significantly (t=3.13, P<0.01) on Factor III, the Group IV mothers experiencing more stress. This may be explained in terms of the younger age of the children and the initial phase of adjustment of parents to the presence of handicap.

To further ensure the results obtained on t-test, ANOVA is calculated. Table 2.72 shows the F-values for both parents on Stress Factor III.

Table 2.72

ANOVA

Stress Factor III of parents

	Source	**DF**	**SS**	**MS**	**F- Value**
Father	Bet.Gr.	3	320.27	106.78	11.09**
	Within Gr.	122	1174.55	9.63	
	Total	125	1494.83		
Mother	Bet.Gr.	3	214.83	71.61	8.33**
	Within Gr.	121	1040.16	8.60	
	Total	124	1254.99		

(**P< 0.07)

Table 2.72 shows that when Stress Factor III is subjected to ANOVA significant variation between groups are noticed for both parents. Further looking at Table 2.70 the variation is mainly for Groups II and III, the means being 5.4 and 9.7 for the fathers. From Table 2.71, it can be seen that the variation is mainly for Groups II and III for mothers also. It can be inferred that younger age and severe retardation place tremendous stress on parents in terms of child characteristics.

Stress Factor IV is analysed separately for both parents. Table 2.73 shows the 't' values for fathers on Stress Factor IV.

Table 2. 73

Stress Factor IV -'t' values for Father

Between Groups	Frequency N		Mean M		SD		Total
I&II	29	29	2.0	1.9	1.10	1.22	0.52
I &III	29	35	2.0	2.8	1.10	1.91	1.92
I & IV	29	30	2.0	1.5	1.10	0.68	2.24*
II & III	29	35	1.9	2.8	1.22	1.91	2.22*
II & IV	29	35	1.9	2.8	1.22	1.91	1.55
III & IV	35	30	2.8	1.5	1.9	0.68	3.55**

(*P<0.05 ; ** P<0.01)

Table 2.73 shows that fathers of Groups III and IV differ significantly (t=3.55, P<0.01) on Stress Factor IV where Group III fathers experience more stress related to physical incapacitation. This finding is not surprising as this group of children belongs to the younger age group and severe mental retardation category. Children in this group generally have poor motor skills, self

care skills and communication skills placing more stress on parents. Groups I and IV and Group II and III also show significant difference at 0.05 level indicating that lower age places more stress on parents compared to older age than severity of retardation in terms of physical incapacitation.

Table 2.74 shows the 't' values for mothers on Stress Factor IV

Table 2.74

Stress Factor IV - 't' values for Mother

Between Groups	Frequency N		Mean M		SD		Total
I&II	29	29	1.8	1.9	0.95	1.08	0.52
I &III	29	33	1.8	2.5	0.05	1.20	2.72*
I & IV	29	31	1.8	1.8	0.95	0.72	0.07
II & III	29	33	1.9	2.5	1.08	1.20	2.12*
II & IV	29	31	1.9	1.8	1.08	0.72	0.52
III & IV	33	31	2.5	1.8	1.20	0.72	2.97**

(* $p<0.05$; ** $p< 0.01$)

Table 2.74 shows that Groups III and IV differ significantly ($t=2.97$, $P<0.01$) on Stress Factor IV of mothers. Group III, where the children have severe mental retardation places more stress on mothers than mild mental retardation possibly due to their physical incapacitation and personal care needs. Groups I and III also differ significantly suggesting that younger age group gives more stress to mother than older age group even when both have severe mental retardation. Mothers of Groups II and III also differ significantly on Stress Factor IV indicating that younger age group with severe retardation places more stress on parents than older age group and mild mental retardation.

To further ascertain the results ANOVA is computed for Stress Factor II for both parents. Table 2.75 shows the F values for stress factor IV.

Table 2.75

ANOVA

Stress Factor IV of Parents

Group	Source	DF	SS	MS	F -Value
Father	Bet.Gr.	3	29.52	9.84	5.49**
	Within Gr.	199	213.09	1.79	
	Total	122	242.60		
Mother	Bet.Gr.	3	12.34	4.11	4.06
	Within Gr.	118	119.66	1.01	
	Total	121	132.00		

(**P<0.01)

Table 2.75 suggests that Stress Factor IV of father shows considerable variation between all four groups. Group III and IV show maximum variation, the mean values being 2.8 and 1.5 (Table 2.73). This suggests that severe retardation in younger age group is a considerable stress factor for fathers in terms of the physical incapacitation of children. However no significant variation is observed for mother on Stress Factor IV.

These results are in line with the findings of Frey et al., (1989) who report that child characteristics is a significant predictor of parenting stress. Kraus (1993) and Trute (1995) also report similar findings. Baxter (1989) and Minnes (1988) report that the deviating characteristics of the mentally retarded child are significantly associated with parental stress. Chetwynd's (1985) study on factors contributing to stress on mothers caring for an intellectually

handicapped child reports that child characteristics is a significant predictor for stress for mothers. From India Sequeira et al (1990) report that mothers of severely retarded children perceive greater burden than moderately retarded children in the age group of 5-12 yrs.

Minnes (1988) suggests that stress associated with mental retardation diminish with age. As retarded child grows older parents may come to terms with their child's cognitive impairment. There is evidence that the early years in the life of a disabled child are a profound parenting time that can be stressful for both mothers and fathers (Bryne and Cunningham, 1985). Severity of the child's disability has a dramatic impact on the experience of the stress of parents (Beckman , 1983; Blacher, Nihira and Mayers, 1987). The present study reveals that mentally retarded children in the older age group are less stressful than mentally retarded children in the younger age group for parents. As Flynt and Wood (1989) report it may be that older mothers perceive lower family stress than younger mothers due to their maturity or the experience that age brings. However, Wilton and Renault (1986) report that maternal age does not affect family stress levels.

In brief the analysis of the pattern of stress for parents suggests that:

1. Both parents experience moderate to severe stress on having a mentally retarded child in the family.
2. Difference in the experience of stress exists between groups based on level of retardation and age of the children. Younger child with severe retardation places more stress than an older child, with mild or severe mental retardation for both parents.

3. On analysing the four factors of stress it is found that the stress factor II (Pessimism) is an extreme factor of stress for majority of parents in all four groups and there is no significant difference between groups on this factor. Stress Factor IV (Physical incapacitation) is reportedly a low stress for parents in the total sample. However significant differences in groups are noticed on this factor for both fathers and mothers. Younger child with severe retardation is significantly different from others and places more stress on parents on this factor of physical incapacitation. The Stress Factor III (Child characteristics) differentiates the groups from one another for fathers and the Stress Factor I (Parent and family problems) discriminates the mothers between each group. Group difference is more prominent between Groups II and III suggesting that both age and severity of retardation influence the perceived stress of parents. Younger child with severe mental retardation places more stress on parents compared to other groups on different factors of stress.

3. Nature of Coping Patterns Employed by the Respondents:

The coping patterns used by parents are studied using Coping Health Inventory for Parents (CHIP). Three coping patterns obtained on CHIP are analysed separately for the four groups - Frequency, Percentage, 't' values and ANOVA are computed.

3.1 Coping Factor I: Maintaining family integration, co-operation and an optimistic definitions of the situation.

Table 3.11 shows the frequency and percentage of father's response on Coping Factor I.

Table 3.11

Coping Factor I of Father

Count Row Pct. Col. Pct. Total Pct.	Little helpful	Moderately Helpful	Extremely helpful	Row Total
Group I	2 6.7 66.7 1.6	6 20.6 19.4 4.9	22 73.3 25.0 18.0	30 24.5
Group II	-	7 25.0 22.6 5.7	21 75.0 23.9 17.2	28 23.0
Group III	1 3.0 33.3 0.8	13 39.4 41.9 10.7	19 57.6 21.6 15.6	33 27.0
Group IV	-	5 16.1 16.1 4.1	26 83.9 29.5 21.3	31 25.4
Column Total	3 2.5	31 25.4	88 72.1	122 100

Table 3.11 shows that 72.1 per cent of the fathers of total sample report that Coping Factor I is extremely helpful when they have a mentally handicapped child and only very few (2.5%) report that it is little helpful. However among Group III father's only 57.6 per cent report that this coping factor is extremely helpful. This may be because of the fact that these parents have young mentally handicapped children with IQ below 50 demanding more care and attention of parents. They may be still in the process of getting adjusted to the presence of the handicapped child in the family.

Table 3.12 shows the mothers response on Coping Factor I.

Table 3.12

Coping Factor I of Mother

Count **Row Pct.** **Col Pct.** **Total Pct.**	**Little Helpful**	**Moderately Helpful**	**Extremely Helpful**	**Row Total**
Group I	-	9 30.0 31.0 7.4	21 70.0 22.6 17.2	30 24.6
Group II	-	4 14.3 13.8 3.3	24 85.7 25.8 19.7	28 23.0
Group III	-	10 32.3 34.5 8.2	21 67.7 22.6 17.2	31 25.4
Group IV	-	6 18.2 20.7 4.9	27 81.8 29.0 22.1	33 27
Column Total		29 23.8	93 76.2	122 100

Table 3.12 shows that 76.2 per cent mothers report extreme help in using Coping Factor I when they have a mentally handicapped child and none of them report that it is of little help. Group analysis shows that when the child is severely mentally retarded the percentage of mothers reporting that this coping factor is extremely helpful reduced slightly compared to the other groups.

3.2 Coping Factor II : Maintaining social support, self esteem and psychological stability.

Table 3.21 shows the frequency and percentage of father's response on Coping Factor II.

Table 3.21

Coping Factor II of Father

Count Row Pct. Col Pct. Total Pct.	Little Helpful	Moderately Helpful	Extremely Helpful	Row Total
Group I	3 10.0 17.6 2.5	16 53.3 25.0 13.1	11 36.7 26.8 9.0	30 24.6
Group II	5 17.9 29.4 4.1	6 21.4 9.4 4.9	17 60.7 41.5 13.9	28 23.0
Group III	6 18.2 35.3 4.9	21 63.6 32.8 17.2	6 18.2 14.6 4.9	33 27
Group IV	3 9.7 17.6 2.5	21 67.7 32.8 17.2	7 22.6 17.1 5.7	31 25.4
Column Total	17 13.9	64 52.5	41 33.6	122 100

Table 3.21 shows that 52.5 percent of fathers in the total sample report the effectiveness of Coping Factor II as moderately helpful and 41 percent as extremely helpful. Group analysis shows that 60.7percent of Group III father's report it to be extremely helpful where the child is of mild mental retardation

and belongs to older age. Parents of younger mentally retarded children use this coping factor less frequently than others.

Table 3.22 shows the mother's response on Coping Factor II.

Table 3.22

Coping Factor II of Mother

Count **Row Pct.** **Col Pct.** **Total Pct.**	**Little Helpful**	**Moderately Helpful**	**Extremely Helpful**	**Row Total**
Group I	1 3.3 5.3 0.8	16 53.3 26.7 12.9	13 43.3 28.9 10.5	30 24.2
Group II	3 10.3 15.8 2.4	6 20.7 10.0 4.8	20 69.0 44.4 16.1	29 23.4
Group III	11 34.4 57.9 8.9	18 56.3 30.0 14.5	3 9.4 6.7 7.4	32 25.8
Group IV	4 12.1 21.1 3.2	20 60.6 33.3 16.1	9 27.3 20.0 7.3	33 26.6
Column Total	19 15.3	60 48.4	45 36.3	124 100

Table 3.22 shows that 48.4 percent of total mothers report moderate helpfulness and 36.3percent report extreme helpfulness in using Coping Factor II. When Group II is taken separately, 69 percent report extreme helpfulness in using Coping Factor II. However, in Group III 34.4 percent mothers report little

helpfulness only in using Coping Factor II where the children have severe mental retardation and they are of younger age group.

3.3 Coping Factor III: Understanding the medical situation through communication with other parents and consultation with medical staff.

Table 3.31 shows the response of fathers on Coping Factor III.

Table 3.31

Coping Factor III of Father

Count **Row Pct.** **Col Pct.** **Total Pct.**	**Little Helpful**	**Moderately Helpful**	**Extremely Helpful**	**Row Total**
Group I	2 6.7 40.0 1.7	1 10.0 18.8 2.5	25 83.3 25.3 20.8	28 25.0
Group II	1 3.8 20.0 0.8	4 15.4 25.0 3.3	21 80.8 21.2 17.5	26 21.7
Group III	2 6.1 40.0 1.7	4 12.1 25.0 3.3	27 81.8 27.3 22.5	33 27.5
Group IV	-	5 16.1 31.3 4.2	26 83.9 26.3 21.7	31 25.8
Column Total	5 4.2	16 13.3	99 82.5	120 100

Table 3.31 shows that 82.5percent of fathers find Coping Factor III as extremely helpful when they have a retarded child in the family. Group wise analysis also shows a similar trend.

Table 3.32 shows mother's responses on Coping Factor III

Table 3.32

Coping Factor III of Mother

Count Row Pct. Col Pct. Total Pct.	Little Helpful	Moderately Helpful	Extremely Helpful	Row Total
Group I	-	7 23.3 29.2 5.7	23 76.7 24.0 18.7	30 24.4
Group II	1 3.6 33.3 0.8	9 32.1 37.5 7.3	18 64.3 18.8 14.6	28 22.8
Group III	2 6.3 66.7 1.6	5 15.6 20.0 4.1	25 78.1 26.0 20.3	32 26.0
Group IV	-	3 9.1 12.5 2.4	30 90.9 31.3 24.4	33 26.8
Column Total	3 2.4	24 19.5	96 78.0	123 100

Table 3.32 shows that 78percent of mothers find Coping Factor III as extremely helpful in the presence of a mentally handicapped child in the family.90.9 per cent of mothers of Group III uses this coping factor very frequently. This may be due to the reason that the identification of mental handicap in the this group may be of recent origin and mothers are trying to find out more about this condition from other parents and professionals.

Coping Factors I and III turn out be extremely helpful for majority of parents in all groups. Coping Factor II is only moderately helpful for them.

3.40 Group Difference on coping factors

To find out whether there is any significant difference between groups on 3 factors of coping, t-tests and ANOVA are computed.

Table 3.41 shows the results of t-test for Coping Factor I of fathers.

Table 3.41

Coping Factors I - 't' values for fathers

Between Groups	Frequency N		Means M		SD		't' values
I&II	30	28	42.3	43.6	9.42	9.18	0.54
I &III	30	33	42.3	42.2	9.42	8.84	0.04
I & IV	30	31	42.3	44.6	9.42	7.94	1.04
II & III	28	33	43.6	42.2	9.18	8.84	0.64
II & IV	28	31	43.6	44.6	9.18	7.94	0.45
III & IV	33	31	42.2	44.6	8.84	7.94	1.14

Table 3.41 shows that there is no significant difference between groups on Coping Factor I for fathers.

Table 3.42 shows the 't' values for mothers on Coping Factor I.

Table 3.42

Coping Factor I - 't' values for Mothers

Between Groups	Frequency N		Means M		SD		't' values
I&II	30	28	43.3	45.8	8.04	8.78	1.14
I &III	30	32	43.3	42.5	8.04	8.73	0.36
I & IV	30	33	43.3	45.7	8.04	5.97	1.35
II & III	28	32	45.8	42.5	8.78	8.73	1.45
II & IV	28	33	45.8	45.7	8.78	5.97	0.06
III & IV	32	33	42.5	45.7	8.73	5.97	1.71

Table 3.42 shows that there is no significant difference between groups on Coping Factor I for mothers.

ANOVA is computed to further ascertain the results on Coping Factor I Table 3.42 indicates the F- values for both parents on Coping Factor I.

Table 3.43

ANOVA

Coping Factor I

	Source	DF	SS	MS	F value
Father	Bet. Gr.	3	123.03	41.01	0.52
	Within Gr.	118	9240.25	78.31	
	Total	121	9363.28		
Mother	Bet. Gr.	3	259.13	86.38	1.38
	Within Gr.	119	7461.91	62.71	
	Total	122	7721.03		

Table 3.43 shows that there is no significant variation between groups on Coping Factor I, for fathers and mothers.

Table 3.44 shows 't' values for Coping Factor II of fathers.

Table 3.44 shows that fathers of Group II and Group III differ significantly ($t=2.20$; $p<0.05$) on Coping Factor II. Group II fathers use Coping Factor II i.e. maintaining, social support, self-esteem and psychological stability more frequently than Group III fathers. This may be because of the fact that Group II children have only mild mental retardation and they belong to the older age group and the parents have psychologically adjusted to the presence of the child in the family.

Table 3.44

Coping Factor II - 't' values for Fathers

Between Groups	Frequency N		Means M		SD		't' values
I&II	30	28	33	35.3	10.30	11.18	0.81
I &III	30	33	33	29.4	10.3	9.77	1.43
I & IV	30	31	33	32.2	10.2	8.32	0.34
II & III	28	33	35.3	29.4	11.18	9.77	2.20*
II & IV	28	31	35.3	32.2	11.18	8.32	1.21
III & IV	33	31	29.3	32.2	9.77	8.32	1.23

(*P<0.05)

Table 3.45 shows the 't' values for Coping Factor II of mother.

Table 3.45

Coping Factor II- 't' values for Mothers

Between Groups	Frequency N		Means M		SD		't' values
I&II	30	29	34.9	28.0	7.22	11.10	1.26
I &III	30	32	34.9	27.3	7.22	10.92	3.22**
I & IV	30	33	34.9	31.5	7.22	7.91	1.78
II & III	29	32	38.0	27.3	11.10	10.92	3.79**
II & IV	29	33	38.0	31.5	11.0	7.91	2.67**
III & IV	32	33	27.3	31.5	10.92	7.91	1.76

(*P<0.05; **P<0.01)

Table 3.45 shows that there is a significant difference between mothers of Groups I and III (t= 3.22; P<0.01) on coping factor II where mothers of Group I use Coping Factor II more frequently than Group III. This may be due to the fact that children of Group I are of older age group and mothers have better adjusted to their presence than Group III. Group II and III also differ significantly (t= 3.79; P<0.01) where Group II mothers use Coping Factor II more frequently. It can be seen that in general Group II mothers use Coping Factor II more frequently than other groups. This may be because of the reason that the children in this group have mild mental retardation and belong to the older age group. Their dependency needs may be much less than other children and mothers may have adjusted to their presence in the family. Groups II and IV mothers also differ significantly on Coping Factor II (t= 2.67; P<0.01) where again Group II parents use Coping Factor II more frequently.

To further ensure the results ANOVA is carried out for Coping Factor II. Table 3.46 shows the result of ANOVA.

Table 3.46

ANOVA

Coping Factor II

	Source	DF	SS	MS	F value
Father	Bet. Gr.	3	543.12	181.04	1.84
	Within Gr.	118	11582.43	98.16	
	Total	121	12125.55		
Mother	Bet. Gr.	3	1938.69	646.23	7.27**
	With Gr.	120	10662.98	88.86	
	Total	123	12601.67		

(** P<0.01)

Table 3.46 shows that there is no significant variation between groups for fathers on Coping Factor II. However significant variation between groups is evident for mothers on Coping Factor II. (F=7.27; P<0.01) Group II shows maximum variation with Group III the means being 38.0 and 27.3 respectively (Table 3.45). The results indicate that mothers of children with mild mental retardation and between 12-18 yrs of age use Coping Factor II more frequently than all other groups.

Table 3.47 shows the t-values for fathers on Coping Factor III

Table 3.47
Coping Factors III- 't' values for Fathers

Between Groups	Frequency N		Mean M		SD		't' values
I&II	29	27	18.5	17.5	3.97	4.51	0.85
I &III	29	33	18.5	19.4	3.97	4.41	0.82
I & IV	29	31	18.5	19.1	3.97	2.88	0.69
II & III	27	33	17.5	19.4	4.51	4.41	1.60
II & IV	27	31	17.5	19.1	4.51	2.88	1.61
III & IV	33	31	19.4	19.1	4.41	2.88	0.28

Table 3.47 shows that there is no significant difference between groups on Coping Factor III of fathers.

Table 3.48 shows 't' values for mothers on Coping Factor III.

Table 3.48

Coping Factor III- t values for Mothers

Between Groups	Frequency N		Mean M		SD		't' values
I&II	30	28	21.0	26.9	13.92	3.96	1.51
I &III	30	32	21.0	18.3	13.92	4.21	1.04
I & IV	30	33	21.0	20.1	13.92	2.36	0.34
II & III	28	32	16.9	18.3	3.96	4.21	1.34
II & IV	28	33	16.9	20.1	3.96	2.36	3.98**
III & IV	32	33	18.3	20.1	4.21	2.36	2.18*

(*P<0.05; **P<0.01)

Table 3.48 indicates that mothers of Group II and IV differ significantly (t=3.98; P<0.01) on Coping Factor III i.e. understanding the medical situation through communication with other parents and consultation with medical staff. Group IV mothers use this coping factor more frequently than others. This can be expected as the children in this group are younger and mothers tend to shop around with an aim of finding out a solution for their child's problem. They would consult doctors and other parents for this purpose mostly as they are the primary care givers. Similarly Group III and Group IV mothers also differ significantly (t=2.18; P<0.05) where Group IV mothers use this coping behaviour more frequently. This may due to the reason that the perception of handicap is of recent origin in this group as the children are of mild mental

retardation and the parents tend to meet doctors and parents with an aim to know more about the condition and to find a solution for their child's problems.

To further ensure the results, ANOVA is computed for Coping Factor III for both parents. Table 3.49 gives result on ANOVA.

Table 3.49

ANOVA

Coping Factor III

	Source	**DF**	**SS**	**MS**	**F-value**
Father	Bet. Gr.	3	58.34	19.45	1.22
	Within Gr.	116	1842.33	15.88	
	Total	119	1900.67		
Mother	Bet. Gr.	3	301.25	100.42	1.76
	With Gr.	119	6772.38	56.91	
	Total	122	7073.63		

Table 3.49 shows that there is no significant variation between 4 groups on Coping Factor III for both parents.

The overall analysis of the coping behaviours of parents in terms of frequency and percentages for the total sample indicates that Coping Factor I and Coping Factor III are extremely helpful for majority of parents in all groups in coping with the stresses of having a mentally handicapped child at home - no matter the age or severity of mental retardation. Coping Factor II is moderately helpful for 52.5percent of fathers and 60percent of mothers. Donovan (1988) report similar findings that the child's age, sex or family socio-economic status has no significant impact on mothers coping behaviour. He reports that mothers

rely heavily on community resources and professional help for coping with a mentally handicapped child at home. In the present study Coping Factors I and III can be considered as problem focused coping and Coping Factor II as emotion focused coping. In Indian culture people are more dependent on others basically when they face a problem. This may be a reason why the present sample of parents used Coping Factor I and Coping Factor III frequently which are related to family, professional and community supports.

Coping Factor-II i.e. maintaining social support, psychological stability and self esteem is frequently used by parents of Group II where the children have mild retardation and above 12yrs. of age. Having lived with these children for a longer time, the parents may be aware of their problems and potentials and, may have psychologically adjusted to it. Parents of younger age group often rely on Coping Factors I and III, which are related to family, professional, and community helps. It is known that soon after identification of a handicap in their child, parents go around looking out for a solution by consulting professionals and other parents.

The literature on coping behaviours of parents supports the above findings in some studies. Cheng and Tang (1995) report that Chinese mothers use more social support coping style on having a mentally handicapped child. On the other hand Shek and Tsang (1993) report that significant proportion of parents seldom sought the help from others in taking care of their pre-school mentally handicapped child.

Kravetz and Nitivitz (1993) report that mothers use emotion focused coping more than fathers when a mentally retarded child is present in the family.

Flynt et. al., (1992) examine social support of mothers and report that mothers of pre-schoolers use social support to a greater extent than other mothers and these mothers rely more on intimate support. Donovan (1988) reports that maternal coping styles are constant across groups. Similar findings are obtained in the present investigation also.

4. Marital Satisfaction

Marital satisfaction of parents are studied in the present investigation to learn more about its relationship to stress and coping of parents.

Table 4.11 shows Marital Satisfaction of fathers in the total sample and four groups taken separately.

Table 4.11
Marital Satisfaction of Father

Count Row Pct. Col. Pct. Total Pct.	Low Satisfaction	Moderate Satisfaction	Extreme Satisfaction	Row Total
Group I	3 10.0 12.0 2.3	24 80.0 25.8 18.2	3 10.0 21.4 2.3	30 22.7
Group II	7 21.2 28.0 5.3	25 75.8 26.9 18.9	1 3.0 7.1 0.8	33 25.0
Group III	13 34.2 52.0 9.8	20 52.6 21.5 15.2	5 3.2 35.7 3.8	38 28.8
Group IV	2 6.5 8.0 1.5	24 77.4 25.8 18.2	5 16.1 35.7 3.8	31 23 .5
Column Total	25 18.9	93 70.5	14 10.6	133 100

Table 4.11 shows that 70.5percent of fathers of the total sample report moderate marital satisfaction. A detailed analysis of the groups show that 52percent fathers in Group III report only low satisfaction. That is when the children are of younger age group and with severe mental retardation the fathers report low marital satisfaction possibly because they have more stress associated with the presence of these children in the family.

Table 4.12 shows the Marital Satisfaction of mother in the total sample and in the groups taken separately.

Table 4.12

Marital Satisfaction of Mother

Count **Row Pct.** **Col. Pct.** **Total Pct.**	**Low Satisfaction**	**Moderate Satisfaction**	**Extreme Satisfaction**	**Row Total**
Group I	3 10.0 14.3 2.3	25 83.3 26.9 19.4	2 6.7 13.3 1.6	30 23.3
Group II	9 27.3 42.9 7.0	22 66.7 23.7 17.1	2 6.1 13.3	33 25.6
Group III	6 18.2 28.6 4.7	21 63.6 22.6 16.3	6 18.2 40.0 4.7	33 25.6
Group IV	3 9.1 14.3 2.3	25 75.8 26.9 19.4	5 15.2 33.3 3.9	33 25.6
Column Total	21 16.3	93 72.1	15 11.6	129 100

Table 4.12 shows that 72.1percent of mothers of the total sample report moderate marital satisfaction, 16.3percent low satisfaction and 11.6percent extreme marital satisfaction. Group analysis shows that 83.3percent of mothers of Group I report moderate marital satisfaction whereas only 63.6percent of Group III report moderate satisfaction. This may be again due to the reason that mothers have to attend to various care giving needs of these children. Both parents report lesser satisfaction when the children belong to severe handicap and younger age group compared to other groups.

4.2 Difference between Groups

To find out whether there is any significant difference between groups on marital satisfaction 't' values and ANOVA are computed.

Table 4.21 shows the 't' values for fathers on marital satisfaction.

Table 4.21

Marital Satisfaction-'t' values for Fathers

Between Groups	Frequency N		Mean M		SD		Total
I&II	30	29	3.1	2.8	1.27	0.87	1.33
I &III	30	33	3.1	3.0	1.25	1.55	0.29
I & IV	30	31	3.1	3.4	1.25	1.29	0.28
II & III	29	33	2.8	3.0	0.87	1.55	0.83
II & IV	29	31	2.8	3.4	0.87	1.29	2.37*
III & IV	33	31	3.0	3.4	1.55	1.20	1.09

(*P<0.05)

It can be seen in Table 4.21 that the fathers of Groups II and IV differ significantly on marital satisfaction (t=2.31; P<0.05), the Group IV fathers reporting more marital satisfaction than Group II. Bruce and Schultz (1994)

report similar findings that level of happiness of parents increase when the age of handicapped child decreases.

Table 4.22 shows 't' values for mother's on Marital Satisfaction Scale.

Table 4.22

Martial Satisfaction- 't' values for Mothers

Between Groups	Frequency N		Mean M		SD		Total
I&II	30	29	3.0	2.7	1.05	1.17	1.07
I &III	30	31	2.0	3.2	1.05	1.28	0.75
I & IV	30	33	3.0	3.2	1.05	1.28	0.82
II & III	20	31	2.7	3.2	1.17	1.28	1.69
II & IV	29	33	2.7	3.2	1.17	1.28	1.77
III & IV	31	33	3.2	3.2	1.28	1.28	0.05

Table 4.22 shows that there is no significant difference between any groups on marital satisfaction of mothers

To further ensure the results ANOVA is computed for both parents on marital satisfaction.

Table 2.23 shows ANOVA on martial satisfaction for both parents.

Table 2.23 indicates that there is no significant variation between groups on marital satisfaction for both parents.

Table 2.23

ANOVA

Marital Satisfaction

	Source	DF	SS	MS	F -Value
Father	Bet. Gr.	3	6.72	2.24	1.38
	Within Gr.	119	193.30	1.62	
	Total	122	200.02		
Mother	Bet. Gr.	3	6.02	2.01	1.39
	Within Gr.	119	171.69	1.44	
	Total	122	177.71		

The above shown tables indicate that both parents in all groups report moderate satisfaction with regard to marital relationship. Significant difference is noticed only between fathers of mildly mentally retarded in two age groups where fathers of younger handicapped children reporting more martial satisfaction. No significant difference is present for mothers in different groups. When the child has only mild mental retardation, the age of the child influence fathers marital satisfaction. The older age group children leads to decreased marital satisfaction for fathers compared to younger age group. For mothers, neither age of the child, nor level of retardation affect the marital satisfaction considerably. The findings of the present study is contrary to those report by Moudgil et al (1985) and Shek and Tsang (1993). Moudgil et al., report marital disharmony among parents of mentally retarded children from India. Sheck and Tsang report decreased marital satisfaction among parents of pre-school mentally handicapped children. Korn, Chess and Fernandez (1978) have

observed that among 75 percent of their sample of families with exceptional children the child does not impair marital quality or family patterns. Dunlop and Hollingsworth (1977) have reported that a large number of parents consider that the exceptional child has little effect on their family life. Donovan (1988) reports that the impact of handicaps on marital adjustment is only negligible and marital relationship appears to be insulated from the detrimental effects of stresses related to rearing a child with handicap. Sheshadri et al., (1983) report no significant marital disharmony among parents of mentally retarded children in India.

However it remains unclear what specific effects of handicapped child are on the marital relationship of their parents. In some cases the experience of jointly rearing a handicapped child can pull the couple together (Zigler and Hodapp, 1991) and in some cases marital break down or severe marital disharmony (Gath, 1977) may result. The present study suggests that parents of mentally handicapped children as a group experience moderate marital satisfaction.

5. Inter relationship between the Dependent variables - Stress, Coping and Marital satisfaction.

To find out the nature and extent of relationship between the major dependent variables, correlations are computed. Correlation is found out for the total sample and for the 4 groups separately, for both fathers and mothers.

On the variable of 'stress' the total stress score only is taken into consideration for computing correlation.

Table 5.1 shows the inter correlation between dependent variables for both parents for the total sample.

Table 5.1
Inter Correlation between Dependent variables for the total sample
N=136

Sl.No.	1	2	3	4	5	6	7	8	9	10
Dependant† variables	TSS (F)	TSS (M)	CF-I (F)	CF-I (M)	CF-II (F)	CF-II (M)	CF-III (F)	CF-III (M)	MSS (F)	MSS (M)
1	1									
2	0.40**	1								
3	-0.47**	0.11	1							
4	-0.06	0.38**	0.45**	1						
5	-0.37**	0.13	0.88**	0.47**	1					
6	-0.11	0.12	0.46**	0.83**	0.57**	1				
7	0.48**	0.12	0.79**	0.31**	0.74**	0.29**	1			
8	-0.06	0.30**	0.18**	0.62**	0.12	0.52**	0.02	1		
9	0.12	0.14	0.47**	0.15	0.41**	0.15	0.32**	0.01	1	
10	-0.07	0.10	0.12	0.47**	0.02	0.38**	0.08	0.80**	0.55**	1

(** P<0.01)

† TSS (F) : Total Stress Score - (Father)
TSS (M) : Total Stress Score - (Mother)
CF-I (F) : Coping Factor I - (Father)
CF-I (M) : Coping Factor I - (Mother)
CF-II (F) : Coping Factor II - (Father)
CF-II (M) : Coping Factor II - (Mother)
CF-III (F) : Coping Factor III - (Father)
CF-III(M) : Coping Factor II (Mother)
MSS (F) : Marital Satisfaction Score - (Father)
MSS (M) : Marital Satisfaction Score - (Mother)

Table 5.1 indicates that the total stress of fathers and mothers shows a significant positive correlation between each other for the total sample (r= 0.40; P<0.01) Marital satisfaction of father and mother also shows significant positive correlation (r= 0.55; P<0.01).

Coping Factors I and II of fathers negatively correlate with their stress (r= - 0.47, r=- 0.37; P<0.01). However Coping Factor III of fathers has a positive correlation with their stress perception (r=0.48; P<0.01) indicating that understanding their child's condition through consultation with medical staff and communicating with other parents tend to increase their stress. Table 5.1 also shows that use of one coping factor is associated with use of other coping factors too for fathers (r=0.88 for CF-I & CF-II, 0.79 for CF-I & CF-III and 0.74 for CF-II & CF-III; P= 0.01). Marital satisfaction of father is also positively correlated with their three coping factors (r=0.47; 0.41 & 0.32 resp. for CF-I, CF-II & CF-III, P<0.01). It is also seen that CF-I of fathers positively correlates with CF-I of mother (r=0.45; P<0.01) & CF-II of mother (r=0.46; P<0.01). CF-II of fathers also shows a positive correlation with CF-II of mothers (r=0.57; P<0.01).

On the other hand all three coping factors of mother show a negative correlation with perception of stress for them, as shown in Table 5.1 though not significant. All the coping factors tend to help mothers in reducing their stress on having a mentally retarded child in the family. All three coping factors show a positive correlation with each other for mothers too. (r=.83, 0.62 & 0.52 resp. for CF & CF-II, CF-I & CF-III & CF-II & CF-III; P<0.01).

Table 5.2
Inter correlation of Dependent Variables for Group I
n=32

Sl.No.	1	2	3	4	5	6	7	8	9	10
Dependant variable†	TSS (F)	TSS (M)	CF-I (F)	CF-1 (M)	CF-II (F)	CF-II (M)	CF-III (F)	CF-III (M)	MSS (F)	MSS (M)
1	1									
2	0.56**	1								
3	-0.55**	0.02	1							
4	-0.03	-0.04	0.30*	1						
5	-0.45**	0.18	0.90**	0.34*	1					
6	0.02	-0.44**	0.35*	0.86**	0.48**	1				
7	0.54**	-0.02	0.88**	0.31*	0.84**	0.33*	1			
8	0.03	0.05	0.34*	0.43*	0.26	0.37*	0.26	1		
9	0.12	-0.12	0.54**	0.03	0.44**	-0.04	0.47**	0.12	1	
10	-0.06	0.13	0.37*	0.40*	0.35*	0.37*	0.33*	0.22	0.62**	1

(* $p<0.05$; ** $p<0.01$)

† (Same as that of Table 5.1)

Table 5.2 is the correlation matrix for Group I. It can be seen that the total stress of fathers positively correlate with stress of mothers ($r= 0.56$; $P<0.01$) and marital satisfaction also shows a similar trend ($r= 0.62$; $P<0.01$).

Coping Factors I and II of fathers negatively correlate with their stress perception ($r= -0.55$ & -0.45 resp: $P<0.01$). However Coping Factor III increases their perception of stress ($r= 0.54$; $P<0.1$). Again use of one coping factor is associated with use of other two coping factors for fathers as their correlations are 0.90, 0.88 and 0.84 respectively for CF-I & CF-II, CF-I & CF-II and CF-II & CF-III ($P<0.01$). Marital satisfaction of fathers also shows a significant positive correlation with three coping factors of them.

For mothers frequent use of Coping Factors I and II reduce their perception of stress ($r= - 0.40$ NS & $r = - 0.44$; $P<0.01$). All three coping factors of mothers show significant positive correlation with each other ($r=0.86$ for CF-I & CF-II $P<0.01$; 0.43 for CF-I & CF-III and 0.37 for CF-II& CF-III' $P<0.05$). Marital satisfaction of mother's is also positively correlated with three coping factors of them. It can also be noted that mothers increased marital satisfaction is associated with frequent use of all three coping factors for fathers ($r= 0.37$, for CF-I, 0.35 for CF-II & 0.33 for CF-III $P<0.05$).

Table 5.3 shows the correlation matrix for Group II.

Table 5.3

Inter correlation between Dependent Variables for Group II

n=33

Sl.No.	1	2	3	4	5	6	7	8	9	10
Dependant † variables	TSS (F)	TSS (M)	CF-I (F)	CF-I (M)	CF-II (F)	CF-II (M)	CF-III (F)	CF-III (M)	MSS (F)	MSS (M)
1	1									
2	0.22	1								
3	-0.42**	0.08	1							
4	-0.08	-0.48**	0.54**	1						
5	-0.35*	0.12	0.92**	0.61**	1					
6	-0.11	0.39**	0.57**	0.90**	0.69*	1				
7	0.08	0.06	0.67**	0.38*	0.67**	0.40*	1			
8	0.15	0.14	0.46**	0.91**	0.54**	0.83**	0.35*	1		
9	-0.13	0.10	0.62**	0.32*	0.59**	0.32*	0.45**	0.23	1	
10	-0.23	-0.22	0.06	0.54**	0.10	0.45**	-0.08	0.43*	0.27	1

(* P<0.05; ** P<0.01 ;

† Same as that of Table 5.1)

Table 5.3 shows a positive correlation between stress of fathers and mothers though not significant (r=0.22) and marital satisfaction of fathers and mothers (r=0.27, P<0.05). All Coping factors of fathers are correlated to all coping factors of mothers in the positive direction. It indicates that Group II fathers and mothers use all three coping factors at the same time in the same way.

Coping Factors I & II of fathers show a negative correlation with their stress (r= -0.42; P<0.01 r= –0.35 P<0.015).

All three coping factors of fathers are positively correlated to each other (r=0.92, 0.67, 0.67 respectively for CF-I & CF-II, CF-I & CF-III and CF-II & CF-III; P<0.01). Marital satisfaction of father is also associated with frequent use of all three coping factors. (r=0.62, 0.59, 0.45 respectively for CF-I, CF-II & CF-III; P<0.01).

For mothers Coping Factors I and II show a negative correlation with their stress (r= -0.48; P<0.01; r= -0.39; P<0.01 for CF-I and CF-II respectively). All three coping factors of mothers are positively correlated to each other (r=0.90, 0.91, 0.83 resp. for CF-I & CF-II; and CF-I & CF-III respectively). Marital satisfaction of mothers is also positively correlated to the frequent use of all coping factors (r=0.54, 0.45, 0.43 respectively for CF-I, CF-II & CF-III; P<0.01). It can also be seen that the marital satisfaction in mother negatively correlates with their stress (r= -0.22) though not significant.

Table 5.4 shows the correlation matrix for Group III

Table 5.4
Inter correlation between Dependent Variables for Group III
n= 38

Sl.No.	1	2	3	4	5	6	7	8	9	10
† Dependent variables	TSS (F)	TSS (M)	CF-I (F)	CF-I (M)	CF-II (F)	CF-II (M)	CF-III (F)	CF-III (M)	MSS (F)	MSS (M)
1	1									
2	0.19	1								
3	-0.44**	-0.02	1							
4	-0.11	-0.12	0.44**	1						
5	-0.36*	0.05	0.88**	0.45**	1					
6	-0.12	-0.23	0.51**	0.85**	0.55**	1				
7	0.62**	0.01	0.87**	0.28*	0.82**	0.32*	1			
8	0.12	-0.56**	0.66**	0.80**	0.65**	0.75**	0.59**	1		
9	-0.04	0.13	0.30*	0.03	0.20	0.23	0.02	0.05	1	
10	-0.07	0.14	0.14	0.51**	0.10	0.49**	-0.04	0.37*	0.52**	1

(* P<0.05 ** P<0.01) † same as that of table 5.1

Table 5.4 indicates that stress of fathers and mothers are positively correlated (r=0.19) though not significant. Marital satisfaction between fathers and mothers also shows a positive correlation (r=0.52; P<0.01). All coping factors of fathers are also positively interrelated to all coping factors of mothers. All three coping factors of father are positively correlated to each other in Group III also. (r=0.88, 0.87 and 0.82 resp. for CF-I & CF.II, CF-I & CF-III, CF-II & CF-III; P<0.01) Marital satisfaction of fathers shows a positive correlation with Coping Factor I (r=.30; P<0.05). Coping Factors I and II of fathers negatively correlate with stress (r = -0.44 and r= -0.36 resp. for CF-I, CF-II; P<0.01). However Coping Factor III shows a positive correlation with fathers stress (r=0.62; P<0.01). This may be due to the fact that children in Group III belong to the younger age group and fathers are still in the process of getting adjusted to it and trying to get more information about the handicap.

For mothers all three coping factors help them to reduce their stress perception when a handicapped child is present in the family (r=-0.12, NS -0.23 NS for CF-I & CF-II and-0.56 for CF-III; P<0.01). All three coping factors of mother are positively correlated to each other (0.85, 0.80 & 0.75 resp. for CF-I & CF-II, CF-I & CF-III and CFII & CF-III resp; P<0.01). Increased marital satisfaction in mother is associated with frequent use of all three coping factors of them (r= 0.51, 0.49, 0.37 resp; for CF-I, CF-II & CF-III; P<0.01).

Table 5.5
Inter correlation between Dependent Variables for Group IV
n=33

Sl.No.	1	2	3	4	5	6	7	8	9	10
† Dependent variables	TSS (F)	TSS (M)	CF-I (F)	CF-I (M)	CF-II (F)	CF-II (M)	CF-III (F)	CF-III (M)	MSS (F)	MSS (M)
1	1									
2	0.72**	1								
3	-0.62**	0.02	1							
4	0.19	0.01	0.46**	1						
5	-0.58**	0.02	0.79**	0.28*	1					
6	0.12	0.01	0.24	0.60**	0.32*	1				
7	0.68**	0.03	0.76**	0.20	0.75**	0.15	1			
8	0.10	0.23	-0.10	0.15	0.13	0.26	0.15	1		
9	0.12	-0.10	0.54**	0.16	0.59**	-0.04	0.53**	0.03	1	
10	-0.09	-0.14	0.15	0.16	0.30*	0.19	0.09	0.03	0.71**	1

(*P<0.05 ** P<0.01)

† same as that of table 5.1.

Table 5.5 shows that stress of fathers and mothers is positively correlated (r=0.72; P<0.01) for Group IV too. Marital satisfaction between father and mother also shows a positive correlation (r=0.71; P<0.01). Significant positive correlation is obtained between fathers coping factors and mothers coping factors.

Coping Factors I and II of fathers show a negative correlation with their stress (r=-0.62, -0.58; P<0.01). Again Coping Factor III increases their stress perception (r=0.68; P<0.01) possibly due to the reason that the handicapped child is of younger age group and fathers are still in the stage of understanding more about the handicap and getting adjusted to it. Father's use of one coping factor is associated with the use of other coping factors too (r=0.79, 0.76, 0.75 resp. for CF-I & CF-II, CF-I & CF-III and CF-II & CF-III; P<0.01). Fathers marital satisfaction is also positively correlated with the use of Coping Factors I, II & III (r= 0.54, 0.59 & 0.53 resp. for Coping Factor I, II & III ; P<0.01).

Coping Factor III of mothers is observed to be having a positive correlation with their stress perception (r=0.23; NS) in Group IV. This may be attributed to the handicapped child's younger age as the mothers may be going through the process of adjusting to the handicap and trying to get all information about child's condition.

The results of the inter correlation computed for the total sample and for the groups separately indicate positive correlation between stress of fathers and mothers, marital satisfaction of fathers and mothers and coping factors of fathers and mothers. Similar finding is reported by Rousey and Blacher (1992) that

fathers and mothers of children with disabilities differ little in their perception of stress and coping.

When stress is correlated against Coping Factors for fathers and mothers it is noticed that the use of Coping Factors I and II in general are negatively correlated with stress for both parents. The emergence of this inverse relationship between Coping Factors I and II and stress adds support to the importance of family cohesion in the maintenance and restoration of family equilibrium in times of potential crisis. External environment can affect the impact of a retarded child on family. Suelzle and Keenan (1981) report that a family's support net work (other parents of retarded children, extended family, friends) can help families cope with stress associated with having a retarded child. However Coping Factor III shows a positive correlation with stress for fathers in general. In the younger age group mothers also show a similar trend. Although professional and other support are usually expected to reduce parental stress, the present study indicates the opposite. Similar finding is reported by Minnes in 1988.

Communication problems between doctors and parents of handicapped children are well documented (Quine and Pahl, 1986). Murdock (1984) reports continuing dissatisfaction of parents with the amount of knowledge and advice offered and unhelpfulness of home visits by professionals. Jacobs (1977) reports that 45 out of 120 parents report receiving no satisfactory information about their child's handicaps or the service available to them. Nursey et al (1990) opine that the doctors see mental handicap in a negative light and so the message they give to parents is likely to reflect their negative perceptions

causing added stress to parents. Developing a healthy parent professional relationship is important to reduce stress levels. Unfortunately parents of retarded children have not always received the help they need from professionals Roos (1975) contends that too often professionals deal with parents in an unproductive and pejorative manner. Providing early information does require sensitivity since parents often find it difficult to absorb details when shocked by an unexpected diagnosis. Being sensitive to parents emotional reactions should help the professionals to judge how much information should be conveyed. The best support a professional can offer may not be his or her services but a contact with other parents who have experienced the same crisis (Pattan et al, 1990). Reeta et al (1995) too report the parents reaction to inadequate service programmes in India for mentally retarded people. Sympson (1998) points out that the helper/professionals should let the parents know the truth about the handicap right at the initial stage. But it should be conveyed in such a way that parents do not lose hope.

In the present investigation father's report increased stress with the use of Coping Factor III in all groups but not mothers excepting in Group IV. Because mothers shoulder most of the responsibility for child care, they may value child related assistance more than fathers. Mothers are also more likely to have contact with persons who can offer supportive counsel such as other parents, educators and health care professionals. Increased stress associated with Coping Factor III for mothers in Group IV may be due to the fact that the identification of handicap may be of recent origin and mothers are still in the process of psychologically adjusting to it. Any way increased level of stress reported by

patents due to the use of Coping Factor III is an interesting area of further research.

Marital satisfaction of father and mother shows a positive correlation for total sample and for the groups separately. Marital adjustment is a key to the psychological well being of both mothers and fathers of developmentally disabled children (Trute', 1995). In the present investigation too it is found that increased marital satisfaction tends to reduce the perception of stress in them associated with handicapped child in the family.

All the coping factors show, a significant positive correlation to each other for both fathers and mothers and between fathers and mothers. This indicates that parental stress is not necessarily predictive of family dysfunctioning. These findings support a competence model in which families may respond to the care of a child with handicaps, with resilience and adaptive functioning (Kazak and Mervin, 1984; Erickon and Upshur, 1989) despite the presence of stress in the family.

The findings of correlational analysis highlights the clinical importance of communicating the different aspects of handicap to the parent in an appropriate manner so that parents do not perceive it as highly stressful. It indicates the need of carrying out parental counselling by trained professionals.

6. Nature of Relationship between some of the Dependent Variables and Child Characteristics

To further understand the effect of some of the child characteristics on dependent variables t-tests are carried out. Groupwise comparison is not done as the sample turned out to be very small when each independent variables are put

into different categories. So the independent variables taken together for the entire group is compared with the dependent variables.

6.1 Sex of the child and its relationship with Dependent variables:

To find out whether there is any significant difference exist between parents perception of stress, nature of coping patterns and marital satisfaction in relation to the sex of the child t-tests are computed.

Table 6. 11

Sex of Child and Dependent variables -'t' values for Fathers

Dependent Variables	**Male N=71**		**Female N=65**		**'t' values**
	Mean	SD	Mean	SD	
TSS	29.2	8.93	28.7	9.33	0.31
TSF-I	10.9	4.31	9.9	5.15	1.28
TSF-II	8.4	2.48	8.5	2.22	0.15
TSF-III	8.0	3.44	8.3	3.50	0.43
TSF-IV	2.0	1.70	2.1	1.46	0.46
CF-I	44.1	8.30	42.3	9.28	1.15
CF-II	32.4	9.42	32.3	10.69	0.10
CF-III	18.7	3.97	18.7	4.06	0.24
MSS	3.1	1.22	3.1	1.35	0.24

Table 6.11 shows the t-values for the total sample on sex of the child and dependent variables for father.

Table 6.11 shows that the sex of the child does not influence the perception of stress, the coping patterns or the marital satisfaction of fathers as there is no significant difference between male and female handicapped child, on these variables.

Table 6.12 shows the 't' values for mothers on dependent variables related to sex of the child.

Table 6.12

Sex of Child and Dependent variables -'t' values for Mothers

Dependent Variables	Male N=71		Female N=65		't' values
	Mean	SD	Mean	SD	
TSS	29.8	8.90	27.5	8.59	1.49
TSF-I	11.2	4.35	9.7	4.54	1.86
TSF-II	8.6	2.22	8.2	2.43	0.83
TSF-III	8.2	3.19	7.8	3.18	0.82
TSF-IV	2.0	1.08	2.0	1.02	0.17
CF-I	45.0	7.85	43.6	8.07	0.97
CF-II	32.9	9.76	32.6	10.56	0.14
CF-III	19.7	10.07	18.5	3.34	3.34
MSS	3.0	1.07	3.2	1.35	0.92

Table 6.12 shows that there is no significant difference between male and female child on perception of stress, coping patterns and marital satisfaction of mothers too.

The findings in this study indicate that both parent's experience of stress, nature of coping patterns and marital satisfaction remains the same irrespective of the sex of their handicapped child. Contradictory finding is reported by Frey et al., (1989) that parents experience greater stress with boys and it is particularly important for fathers. Reeta et al., (1995) report greater impact on family due to female retarded child from India.

6.2 Other handicaps in the child and its relationship with Dependent variables

Other handicaps in the mentally retarded children may pause considerable management problem for the parents. Hence the statistical analysis is done to find out whether there is any significant difference between parents who have mentally retarded children with other handicaps and parents who have mentally retarded children without other handicaps.

Table 6.21 shows t-values for fathers on dependent variables related to other handicaps in child.

Table 6.21 shows that presence of other handicaps in the child does not differ significantly the fathers of handicapped children on stress, coping and marital satisfaction.

Table 6.21
Other handicaps in the child and Dependent variables- 't' values for Fathers

Dependent Variables	Other handicaps present N=26		Other handicaps absent N=110		't' Values
	Mean	SD	Mean	SD	
TSS	31.6	10.50	28.4	8.71	1.53
TSF-I	11.2	5.35	10.2	4.62	0.89
TSF-II	8.6	2.44	8.4	2.34	0.39
TSF-III	9.2	3.61	7.9	3.40	1.54
TSF-IV	2.6	1.92	1.9	1.26	1.98
CF-I	2.6	1.92	1.9	1.26	1.98
CF-II	31.7	11.07	32.5	9.82	0.32
CF-III	19.0	3.47	18.6	4.10	0.47
MSS	3.0	1.66	3.1	1.19	0.36

Table 6.22 indicates the mother's perception of stress, coping patterns and marital satisfaction when the handicapped child has other handicaps and other wise.

Table 6.22

Other handicaps in the child and Dependent variables -'t' values for Mothers

Dependent Variables	Other handicaps present N=26		Other handicaps absent N=110		't' Values
	Mean	SD	Mean	SD	
TSS	32.1	27.48	27.8	8.42	2.22*
TSF-I	11.6	4.56	10.2	4.44	1.42
TSF-II	9.2	2.03	8.2	2.36	1.80
TSF-III	9.2	3.16	7.7	3.14	2.08*
TSF-IV	2.3	1.27	1.9	0.98	1.53
CF-I	44.0	7.98	44.4	7.99	0.19
CF-II	31.8	9.88	33.0	10.22	0.51
CF-III	18.1	3.4	19.3	8.31	0.70
MSS	29	1.38	3.1	1.17	0.60

(* $P<0.05$)

Table 6.22 indicates that there is a significant difference between mothers of children with other handicaps and without other handicaps on total stress ($t=2.22$; $P<0.05$). The mean values on total stress shows that the presence of other handicaps in the mentally handicapped child increase stress for mothers (M=32.1 & 27.8 resp;). Table 6.22 also indicates that on Stress Factor III the two groups of mothers differ significantly ($t= 2.08$; $P<0.05$), the mothers of mentally handicapped children with other handicaps reporting more factor III

stress than other mothers. This can be expected as factor III stress deals with the child characteristics in general. The findings show that the mothers in general experience more stress on having a mentally retarded child with other handicaps than fathers. This may be due to the fact that mothers are more involved with the care taking needs of the child. However, the presence of other handicaps do not influence the coping patterns or marital satisfaction. Similar finding is reported by Beckman (1983) and Blacher etal (1987) that severity of the child's disability has a dramatic impact on the experience of stress of parents. Chetwynd's (1985) findings also support the present investigation.

6.3 *Behavioural problems in the child and its relation with other Dependent variables*

Behavioural problems in mentally handicapped children are common and they pause additional problems to the parents. Presence of behavioural problem is of great concern and management problems for the parents. Hence the analysis is carried out to find out whether there is any significant difference between parents when their handicapped child has behavioural problems and when they don't have it.

Table 6.31 indicates the father's report of stress, coping patterns and marital satisfaction in the presence of behavioural problems in the handicapped child

Table 6.31 shows that the presence of behavioural problems in the handicapped child leads to significant difference between fathers on total stress ($t=2.89$; $P<0.01$) The mean values indicate that the presence of behavioural problems increases the stress in fathers ($M=31.9$ & 27.2 respectively). The fathers also differ significantly on Stress Factor III ($t= 2.51$; $P<0.05$) where

Stress Factor III deals with the child characteristics and Stress Factor IV (t=2.89; P<0.01), the physical incapacitation in the child. Presence of behavioural problems in the child increase the stress of fathers. No significant difference is observed for other dependent variables.

Table 6.31

Behavioural Problems and Dependent Variables - 't' values for Father

Dependent Variables	Behavioural Problems Present N=52		Behavioural Problems Absent N=84		't' Values
	Mean	SD	Mean	SD	
TSS	31.9	8.42	27.2	9.04	2.89**
TSF-I	11.3	4.66	9.8	4.74	1.73
TSF-II	8.9	2.24	8.2	2.38	1.81
TSF-III	9.1	3.31	7.6	3.43	2.51*
TSF-IV	2.5	1.67	1.8	1.15	2.89**
CF-I	42.7	9.56	43.5	8.3	0.47
CF-II	32.1	9.64	32.5	10.29	0.23
CF-III	18.8	4.32	18.6	3.80	0.36
MSS	3.0	1.28	3.2	1.28	0.89

(* P<0.05; ** P<0.01)

Table 6.32 indicates the behavioural problems in the child and dependent variables for mothers.

Table 6.32

Behavioural problems and Dependent variables- 't' values for Mothers

Dependent Variables	Behavioural Problems present N=52		Behavioural Problems absent N=84		't' Values
	Mean	SD	Mean	SD	
TSS	30.9	8.09	27.2	8.89	2.35*
TSF-I	11.4	4.60	9.9	4.33	1.82
TSF-II	8.9	2.41	8.1	2.23	1.75
TSF-III	8.8	2.74	7.5	3.36	2.19*
TSF-IV	2.1	1.03	1.9	1.05	1.06
CF-I	43.7	9.43	44.6	6.90	0.62
CF-II	32.9	10.66	32.7	9.84	0.09
CF-III	20.0	11.54	18.5	3.18	1.07
MSS	3.1 3.0	1.41		1.08	0.11

(* P<0.05)

Table 6.32 indicates that the mothers differ significantly (t=2.35, P<0.05) on total stress when the child has a behavioural problem The mothers of children with behavioural problem report more stress than without behaviour problems, the means being 30.9 and 27.2. On Stress Factor III i.e., child characteristics also the mothers differ significantly (t= 2.19; P<0.05) where the mothers of mentally handicapped children with behavioural problems reporting more factor III stress than other mothers. This may be expected as factor III stress deals with

child characteristics. Chetwynd (1985) reports that the stress levels were higher amongst mothers whose children are a management problem are abnormally active or under active and unable to play with others.

The overall findings show that the behavioural problems in the mentally retarded child increase the stress of both parents. Mothers report significant increase in perception of stress when the child has some other handicaps also along with mental retardation Beckman (1983), Blacher et al (1987) and Baxter (1989) report similar findings that specific characteristics of handicapped individuals are strongly associated with higher stress levels in parents. The more severe the child's behavioural problems, the greater the degree of stress for parents (Braddock et al., 1991). Reeta et al (1993) report increased stress in parents when the child has behavioural problems.

The management of behavioural problems using appropriate methods turns out to be very important in reducing stress of parents. Dealing with other handicaps in the child with the suitable management methods also calls for attention in dealing with parental stress. The observation in this investigation invites attention of multidisciplinary approach to management of mental retardation including professionals from medicine, psychology, special education, speech therapy and so on.

The principal finding of the present study in relation to stress is that, moderate stress is experienced by both parents (>60%) with mentally retarded children. Mentally retarded children with IQ below 50 in the younger age group is more stressful for parents than other categories.

In investigating social stress in families, Hill (1949) presented the ABCX formula of crisis. The B factor is the family resources, which help in dealing with the stress. Factors that affect a family's adjustment to stressors identified are family members personal resources, social support, coping etc. An analysis of parents personal resources in the present study indicates that more than 70 per cent of parents had high school education or above. This may have helped the parents to learn more about the condition and implement the appropriate management strategy for their retarded children, leading to the stress perception only at the moderate level. More than 80 percent of children in the present study are attending special schools. All the fathers in the present study have some kind of occupation and their family income is also better off, leading to a better adjustment in terms of financial aspect and to the stress of having a handicapped child in the family. As 85 per cent of mothers are housewives and are free of the dual responsibility of another occupation also would have helped in reducing the effect of stress. They have more time available for the handicapped child while the fathers could concentrate more one their occupation.

The mediating influences of social support in protecting against the effect of stressors are documented by Kaplan (1974) and Gore (1978). In the present study 90 per cent of the parents have one or the other kind of social support available to them. This again emphasises the importance of social support in promoting recovery from stress experienced (Coletta, 1979).

The number of total children in the family is three or less than that in the present study in more than 90% of families. This may also have a moderating

effect on perception of stress of parents as they have more time and energy to share for the handicapped child.

Coping resources have been considered as an important moderator variable in stress research. Mc Cubbin et al (1976) report that coping behaviours will reduce or eliminate stressor events and their hardships. In the present study more than 60 per cent of parents report moderate to extreme helpfulness of using the three distinct coping factors assessed in the presence of a handicapped child in the family. The perception of moderate stress reported by the parents also may have influenced by the frequent use of these coping patterns by them.

Stresses reported by the parents are greatly influenced by the marital satisfaction they experience. Parents functioning moderately along the dimensions of cohesion and adaptability are likely to make a more successful adjustment to stress (Olson et al, 1979) The moderate marital satisfaction reported by more than 70 per cent parents in the present study may be a supporting evidence for Olson's findings.

Hills conceptualisation of the process of a familial reaction to stressor events in his ABCX model of family crisis in particular has provided the foundation for much of the family stress research in the past two decades. His model dismisses the notion of a direct relationship between the stressor event (A) and the resulting family crisis (X). He proposes that there are two major buffering variables, which could protect the family from becoming dysfunctional following exposure to stressor events. The B factor comprises various types of family resources available to that particular family; the C factor is the subjective meaning assigned to the stressor event by the family. (Wikler, 1989)

The B factor has received a great deal of attention by stress researchers in recent years. The family resources identified are (1) the individual variables such as coping skills, health, education, religious beliefs etc.(2) marital variables such as marital satisfaction, communication style, sharing of roles and workloads, mutual emotional support. (3) Family variables such as mutual support, level of adaptability, cohesion, emotional sharing, autonomy and so on. (4) Social supports including friends, community, professionals, family with more personal resources and strong interpersonal informal support net works cope better with stress than do those without those family resources (Ell, 1984).

The 'C' factor perception has received too little attention in family stress research (Boss, 1986) The subjective meaning that members of a particular family assign to the stressor event will weigh as a mediating variable in predicting the course of events for that family. Family members may view the stressor as easy or difficult to manage as 'fate' or as an opportunity to grow from a challenge, or as an overwhelming load. As a result, they may perceive themselves as helpless victims or achieve the role of active agents in their effort to survive (Wikler, 1989).

Crisis (the X factor) is any sharp on decisive change for which old family patterns are inadequate. It is characterised by the families inability to restore stability and by the continuous presence to make changes in the family structure and patterns of interaction. Stress may never reach crisis proportion if the family is able to use existing resources and define the situation.

The ABCX model may take on a greater potential in examining the process of stress in families of child with mental retardation. The subjective

meaning accorded to this stressor by almost everyone is discrediting (Wikler, 1989), due to the stigma attached to it. The ABCX model is reportedly a unique theory suited to studying the stress in families of children with mental retardation.

In the present study the investigator has tried to bring out the importance of A, B, C and X factors in families of children with Mental Retardation. A is the mentally retarded child himself and his various characteristics can be viewed as the C factor which influence the parental perception. The child characteristics like low IQ, younger age and presence of behavioural problems turned out to be significant factors influencing parental perception of increased stress, in the present study.

The B factors analysed in this study are parental education, occupation, total number of children in the family, family income, social support, coping resources and marital satisfaction. It may be found that all the above factors may have a positive influence on parental perception of stress that the parents as a group report only moderate amount of stress on having a mentally handicapped child in the family, possibly due to the buffering effect of the B factors.

QRS-F has helped to bring out the crisis (the X factor), which is the stress experienced by the parents. Thus the present investigation tries to bring out the stress in the families on having a mentally retarded child based on the theoretical framework on family stress proposed by Hill.

The present investigation thus tries to bring out some of the salient features of parental stress and coping on having a mentally retarded child in the

family in the state of Kerala. The observations have many clinical significance, for the families and the professionals working in the field.

The findings in the present study supports a competence model in which the families may respond to the care of a child with handicaps with resilience and adaptive functioning despite the presence of stress in the family. To lessen the stress intervention should be directed at increasing child competence, care taking of the child and changing parental perception of handicap. Helping the families to value or develop their own strength and unique family styles may be necessary.

SUMMARY AND CONCLUSIONS

Aniamma Mathew Puthupakambil “Stress and coping among the parents of mentally handicapped” Thesis. Department of Psychology, University of Calicut, 1999

Chapter V

SUMMARY AND CONCLUSIONS

This investigation has been conducted with the purpose of gaining insight into the stress and coping among the parents of mentally handicapped individuals in India especially in the state of Kerala. The main aim of this study is to find out whether there is any significant difference between parents of different groups of mentally handicapped individuals in terms of the stress they experience, the coping patterns they employ and their marital satisfaction. The secondary objectives of the study are to find out the inter-relationship between the dependent variables and the role of child characteristics on the experience of stress and coping of the parents.

Tools used for the study

The tools used to investigate the above mentioned aims are:

1) Questionnaire on Resources & Stress-Short form (QRS-F; Friedrich, Greenberg, Crnic, 1983)
2) Coping Health Inventory for Parents (CHIP, Mc Cubbin et al., 1983)
3) Marital Satisfaction Scale (MSS; A Visual Analogue Scale, Aitken; 1985

Along with this a detailed demographic data sheet and an interview schedule to elicit some of the relevant details are also used.

Questionnaire on Resources and Stress has four independent factors which are analysed independently along with total stress score.

Coping Health Inventory for Parents has 3 independent factors which are subjected to separate analysis.

On Marital Satisfaction Scale a composite single score is taken separately for analysis.

A summary of the present study is given below.

I. An overview of the Respondents

1.11Sample of the study; Parent characteristics

Both fathers and mothers are considered separately for this study. A total of 136 parent pairs constitute the sample. They belong to the following four groups.

Group I : Parents of mentally handicapped children between the age of 12- 18 yrs. and IQ below 50.

Group II : Parents of mentally handicapped children between the age of 12- 18 yrs. and IQ above 50.

Group III : Parents of mentally handicapped children between the age of 5- 11 yrs. and IQ below 50.

Group IV : Parents of mentally handicapped children between the age of 5-11 yrs. and IQ above 50.

Group I has 23.5%, Group II has 24.3%,Group III has 27.9% and Group IV has 24.3%parent pairs of the total sample.

1.12 Age

Since the age of the mentally handicapped individuals are controlled the age of parents fall within a particular range

a) The mean age of fathers is 45.2yrs, 46.1 yrs, 35 yrs and 34.4 yrs for group I, II, III and IV respectively.

b) The mean age of mothers is 42.4 yrs, 43.2 yrs, 32.2 yrs and 31 yrs for group I, II, III and IV respectively.

1.13 Education

Parental education is divided into four categories of (1) below 7 years, (2) 8-10 yrs (3) 11-15 yrs and (4) above 15 yrs. of education

a) 19.9%, 39%, 31.6% and 5.1% of fathers fall in the above educational categories of 1,2,3 and 4 respectively.

b) 26.5%, 50%, 21.3% and 2.2% of mothers fall in four respective educational categories.

1.14 Occupation

a) Fathers' occupation is classified into four groups of (1) unskilled (2) semi skilled (3) skilled and (4) others. 33.8%, 24.3%, 36.0% and 4.4% of fathers fall into four respective groups.

b) Mothers' occupation is classified into two groups only namely (1) working and (2) housewife. Only 15.4% belong to the working group and 84.6% belong to the group of house wife.

1.15 Income

Income is computed for the family as a unit and not separately for father and mother. Three groups are identified with group (1) monthly income of less than Rs.1500/- group (2) Rs.1501-3500 and group (3) more than Rs.3500/-. 25% of families belong to group I, 27.9% to group II and 47.1% to group III.

1.16 Family social support

Family social support is classified into four major groups in the present study. 35.3% of families have (1) other members of the family as the major

social support. 45.6% has (2) relatives, 3.7% has (3) friends 5.1% has (4) community and 10.3% has (5) no social support at all.

1.17 Total number of children in the family:

An inquiry into the total number of children in the family gives the following details (1) 3.7% of family has only one child who is retarded (2) 62.5% has two children (3) 29.4% has three children and (4) 4.9% has four or more.

1.2 Sample of the study :child characteristics

1.21 Age and IQ of Children:

The four groups of parents are identified based on the age and IQ of mentally retarded children. (1)23.5% belong to the category of 12-18 yrs of age and IQ below 50 (2) 24.3% has 12-18 yrs of age with IQ above 50 (3) 27.9% has 5-11 yrs of age and IQ below 50 and (4) 24.3% belong to the category of 5-11yrs with IQ above 50. The total number of children considered are 136.

1.22 Sex of the child

52.2% of children belong to (1) male sex and (2) 47.8% belong to female sex group.

1.23 Behavioural Problems

(a)38.2% of children are reportedly having behavioural problems while (b) 61.8% has no behavioural problems reported.

1.24 Presence of other handicaps

(a) 19.1% of children have other handicaps along with mental retardation and (b) 80.9% has no other handicaps.

II Pattern of Stress reported by the parents

The present investigation highlights the following findings.

2.11 Moderate stress is reported by 63.3% of fathers and 62.2% of mothers of all mentally retarded children, irrespective of age and IQ of the child.

2.12 When groups are analysed separately, 40% of Group III fathers and 51.5% Group III mothers report extreme stress. That is IQ below 50 in the younger age group is more stressful for parents than other categories.

When four independent factors of stress are analysed separately the following results are noted.

2.2 Stress Factor I (Parent & Family Problems)

2.21 Moderate (45.2%) to extreme (30.2%) stress is reported by fathers of total sample in terms of Stress Factor I. 42.9 percent of Group III fathers report extreme factor I stress .

2.22 Moderate stress (52.8%) is reported by mothers of the total sample on factor I stress. 53.1 percent Group III mothers report extreme factor I stress than other groups.

2.3 Stress Factor II (Pessimism)

2.31 72.2% fathers of total sample report extreme stress on pessimism as a factor of stress on having a mentally retarded child. Group I fathers (86.7%) and Group III fathers (65.7%) report extreme stress compared to other groups suggesting that low IQ level predicts increased pessimism in fathers.

2.32 69.4 % mothers of total sample report extreme stress on Stress Factor II. 84.4% Group IV mothers report extreme factor II stress compared to other groups.

2.4 Stress Factor III (Child Characteristics)

2.41 49.2% fathers report moderate stress on factor III of stress. When groups are taken separately 63.3% Group I fathers report moderate stress, in terms of child characteristics.

2.42. 50.4 % of mothers of total sample report moderate stress on Stress Factor III. 48.5 % mothers of group III report extreme stress on the this factor.

2.5 Stress Factor IV (Physical incapacitation)

2.51 Stress factor IV is only a low stress for 77.8 % of fathers. However, 25.7 % Groups III fathers perceive it as extremely stressful compared to other groups.

2.52 For 74.4 % mother's Stress Factor IV is reportedly of low stress. However the low IQ in the younger age group (Group III) is of moderate stress in terms of physical incapacitation for 42.4% of mothers.

2.6 The results of 't' values and ANOVA indicate that parents of four groups differ significantly on total stress. Mentally handicapped children of younger age group with low IQ cause more stress for both fathers and mothers.

The results of 't' values and ANOVA for four factors of stress are as follows:

2.61 Group III fathers and mothers differ significantly from other groups and report more stress on Stress Factor I i.e. parent and family problems.

2.62 Groups I and II differ significantly on stress factor II. Low IQ in older age group places more pessimism for fathers. Also among mildly

mentally retarded group younger age group places more factor II stress for fathers.

2.63 Groups II and IV mothers differ significantly where mothers of lower age group children reporting more stress on factor II i.e. Pessimism.

2.64 On Stress Factor III, Group II fathers differ significantly from other groups where Group II fathers report less factor III stress related to child characteristics. The same result is obtained for mothers too.

2.65 On Stress Factor IV, difference is significant for Group III fathers and mothers where Group III parents experience more factor IV stress than other groups.

The overall analysis indicate that the children of younger age group with lower intelligence place more stress on parents than others.

3 Nature of coping patterns employed by the respondents

This study shows the following findings regarding coping patterns.

3.1 Coping factor I Maintaining family integration co-operation and an optimistic definition of the situation.

3.11 Coping Factor I is extremely helpful for 72.7% fathers of the total sample. In Group III 57.6 % only report it as extremely helpful.

3.12 76.2 % mothers of total sample report extreme helpfulness in using Coping Factor I. In Group II 67.7 % mothers only report extreme helpfulness which is slightly less compared to other groups.

3.2 Coping Factor II Maintaining social support self esteem and psychological stability

3.21 52.5 % fathers and 48.4 %mothers report moderate helpfulness in using Coping Factor II on having a mentally retarded child. Group wise analysis

shows that 60.7% Group II fathers and 69% Group II mothers report extreme helpfulness of Coping Factor II which is higher than other groups.

3.3 Coping factor III understanding the medical situation through communication with other parents and consultation with medical staff

3.31. 82.5 % fathers and 96 % mothers report that Coping Factor III is extremely useful in the presence of a mentally handicapped child. Group wise analysis also indicate the same findings.

3.4 The results of 't' values and ANOVA for three coping factors are as follows:

3.41. The difference between group is not significant for Coping Factor I for both fathers and mothers.

3.42 Group II and Group III fathers differ significantly on Coping Factor II where Group II fathers use it more significantly. Four groups of mothers differ significantly on Coping Factor II. Group II mothers use it more frequently than others.

3.43 Four groups of fathers do not differ significantly on Coping Factor III. However mothers of Group IV differ significantly from other groups where Group IV mothers use it more frequently.

4 Nature of Marital satisfaction reported by the groups

The following are the major finding regarding the marital satisfaction.

4.1. 70.5 %of fathers and 72.1% mothers report moderate marital satisfaction on having a retarded child. Group-wise analysis also shows that majority of parents report moderate marital satisfaction in all four groups.

4.2 Analysis of group difference on marital satisfaction for fathers shows that Groups II and IV differ significantly where Group IV parents report more marital satisfaction than Group II.

4.3 No significant group difference is seen for mothers on marital satisfaction .

5 Inter correlation between Dependent variables

The analysis highlights the following findings for the entire group.

5.1 Stress of fathers and mothers and marital satisfaction of fathers and mothers show significant positive correlation for the entire sample. ($r=0.56$ & $r=0.62$ resp; $P<0.01$)

5.2 Coping Factors I and II of fathers negatively correlate with their stress ($r= -0.55$ & $r= -0.45$; $P<0.01$). Coping Factor III shows a positive correlation with stress ($r= 0.54$; $P<0.01$) for fathers.

5.3 All coping factors are positively correlated to each other for fathers and mothers.

5.4 Marital satisfaction is positively correlated with their coping factors.

5.5 Coping Factor I is associated with decreased perception of stress for mothers ($r= -0.40$; $P<0.01$)

5.6 Marital satisfaction of mothers is positively correlated with the three coping factors of fathers and mothers.

The group-wise comparison of various dependent factors brings out the following major findings.

5.7 Significant positive correlation is observed on stress, marital satisfaction and three coping factors between fathers and mothers in all four groups.

5.8 Coping Factor I and II of fathers are negatively correlated with their stress perception in general. However Coping Factor III is positively correlated with fathers stress in all four groups . Similar trend is observed for mothers in Group IV only.

5.9 All three coping factors are positively correlated for both mothers and fathers in all four groups.

6 Child characteristics and its influence on major Dependent variables

The analysis indicates the following findings:

6.1 Sex of the child does not influence the stress, coping and marital satisfaction of fathers or mothers.

6.2 Other handicaps in the child do not influence the fathers stress or coping. Mothers experience more stress on having other handicaps in the child.

6.3 Behavioural problems in the child increase the total stress of fathers significantly. Stress Factor III and Stress Factor IV also show significant difference between groups for fathers. Similar findings are observed for mothers too. No significant difference is observed for the other dependent variables.

Implications of the study and suggestions for further research

The present investigation has many clinical implications which are outlined below.

The major findings of the study suggest that parents of mentally handicapped as a group experience moderate to severe stress. The children in the younger age group with severe retardation cause more stress to parents than other groups. This implies that the parents of this group do require adequate

professional help in understanding the child's problems and dealing with their own emotions in adjusting to the presence of handicap. Many often it is found that parents are misdirected and they shop around a great deal before coming into terms with the handicap. Awareness programme at the community level by professionals in the field would help the parents greatly in understanding their children and planning out adequate management programs for them.

The coping patterns employed by the parents in this study show that they rely heavily on understanding the condition through communication with professionals and other parents to cope with the presence of a handicapped child. However it also indicates that use of this coping pattern tends to increase the perception of stress in parents especially in fathers. This is more prominent in the younger age group possibly because the parents are still undergoing the process of adjusting to the presence of a handicap in the family. This also highlights the need of promoting parent groups of mentally handicapped children where the parents can share their worries with other parents who have similar problems with the help of professionals. From the experiences in western countries and in India, it has been found that such self help groups go a long way in alleviating parent's stress on having a mentally retarded child in the family. With increasing number of families caring for retarded children at home, service providers have a growing responsibility to help them manage stress and develop adaptive coping strategies. There is a need to review the existing predominantly child centred programs and to reorient them to meet needs of the parent and families.

The coping pattern of maintaining family integration, co-operation and an optimistic definition of the situation is also reported to be of extreme help to the parents. This suggests that not only the parents in the family, but other members especially the siblings of the mentally handicapped should be involved actively in the care taking of the handicapped, which is not done at present. As parents self help group, siblings self help groups also should be formed and promoted so that the parents stress is reduced considerably. Many siblings play a critical role in fostering the intellectual, social and affective development of a handicapped brother or sister (Agarwall & Singh 1998). It is also reported that being in a family that also has a child with mental retardation does not lead to a greater degree of mental distress or pathology for the siblings than is found in families without a child who has mental retardation (Hannah & Milasky 1999). So the siblings may be a tremendous support for parents for the caring of their retarded child.

Behavioural problems in mentally retarded children increase the stress of parents. It is essential that appropriate behaviour modification programs at school and home should be carried out with the help of professionals so that parental stress may be reduced.

It is suggested that the future research in this area may direct towards a more in-depth study taking into consideration many other relevant variables pertaining to the family.

There is also a clear need for further research exploring the complex relationship between stress, coping and adaptation in families with a larger sample. These would include family members personal resources including

economic well being, education, health, problem solving skills, personality characteristics like self esteem, locus of control etc. and the social supports. The present study is a cross sectional one. Longitudinal studies could be taken up to understand the stress and adaptations of families of handicapped in their life cycle. As this types of investigations are hardly reported from India, effort should be made in this direction, so that helping the mentally handicapped and their family would be more meaningful and the rehabilitative efforts taken would be more successful.

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APPENDICES

Appendix I
SOCIO DEMOGRAPHIC DATA SHEET

I Child Characteristics

Name of the child:

1-1 Age	(i) (5-11) yrs	(ii) (12-18) yrs
1-2 Sex	(i) Male	(ii) Female
1-3 Education	(i) Normal School	(ii) Special School
1-4 Other Handicaps	(i) Present	(ii) Absent
1-5 Behavioural problems	(i) Present	(ii) Absent
1-6 IQ	(i) Above 50	(ii) Below 50

II Parent characteristics –Father

2.1 Age		
2.2 Years of education	(i) Below 7 yrs	(ii) 8-10 yrs
	(iii) 11-15 yrs.	(iv) Above 15 yrs
2.3 Occupation	(i) Unskilled	(ii) Semi-skilled
	(iii) Skilled	(iv) Others

III Parent Characteristics –Mother

3.1 Age		
3.2 Years of Education	(i) Below 7 yrs	(ii) 8-10 yrs
	(iii) 11-15 yrs.	(iv) Above 15 yrs
3.3 Occupation	(i) Working	(ii) Housewife

IV Family details

4.1 Number of children in the family	(i) 1 (ii) 2 (iii) 3 (iv) 4 and more
4.2 Family income per month:	(i) . Up to Rs. 1500
	(ii) Rs. 1501 to Rs.3500
	(iii) Above Rs.3500
4.3 Social supports available	(i)Other members in the family
	(ii) Relatives
	(iii) Friends
	(iv) Community
	(v) No supports

APPENDIX II (a)

QUESTIONNAIRE ON RESOURCES AND STRESSES

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 opinions. Please answer all of the questions, even if they do not seems 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 refer 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. 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 T/F
5. The constant demands for care for ---- limit growth and development 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 (eg. Institution 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 stresses	T/F
13.	It bothers one 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.	------- know 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 embarrassed 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/sports	T/F
27.	---------- has too much time on his/her hands	T/F
28.	I am disappointed that ------ doesn't 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 one 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 the time	T/F
52.	------- can walk without help	T/F

Appendix II (b)

QUESTIONNAIRE ON RESOURCES AND STRESS

നിങ്ങളുടെ കുടുംബത്തിലെ വൈകല്യമുള്ള ഒരു കുട്ടിയേപ്പറ്റി നിങ്ങൾക്കുള്ള വിചാരങ്ങളും ചിന്തകളുമാണ് ഈ ചോദ്യാവലിയിൽ കൊടുത്തിരിക്കുന്നത്. കൊടുത്തിരിക്കുന്ന മിക്കവാറും എല്ലാ പ്രസ്താവനയിലും പൂരിപ്പിക്കാത്ത ഒരു ഭാഗമുണ്ട്. നിങ്ങളുടെ കുട്ടിയുടെ പേര് ഇവിടെ പൂരിപ്പിച ്തായി സങ്കല്പിക്കുക. നിങ്ങളുടെ സത്യസന്ധമായ അഭിപ്രായങ്ങളും വിചാര ങ്ങളും മാത്രം എഴുതുക. ദയവുചെയ്ത് എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരം എഴുതുക. ശരിയോ (T) തെറ്റോ (F) എന്നു തീരുമാനിക്കാൻ പ്രയാസമുള്ളപ്പോൾ ഏറ്റവും കൂടുതൽ സമയം നിങ്ങളുടെ കുടുംബം എങ്ങനെ ചിന്തിക്കുന്നു എന്ന് ഉത്തരം കൊടുക്കുക. ചിലപ്പോൾ നിങ്ങളുടെ കുടുംബത്തിനു് ഇല്ലാത്ത ഒരു പ്രശ്നത്തേപ്പറ്റിയാവും ചോദ്യത്തിൽ വിവരിച്ചിരിക്കുന്നത്. എന്നാലും ഉത്തരം നല്കാൻ ശ്രമിക്കുക. എല്ലാ പ്രസ്താവനകൾക്കും ഉത്തരം നല്കുക.

ചോദ്യാവലി

T- True (ശരി)
F- False (തെറ്റ്)

1.	----------സമപ്രായക്കാരുമായി ആശയവിനിമയം ചെയ്യാറില്ല.	T	F
2.	----------നിമിത്തം മറ്റു കുടുംബാംഗങ്ങൾക്ക് പലകാര്യങ്ങളും ചെയ്യാൻ സാധിക്കാതെ വരുന്നു.	T	F
3.	----------വളരെ പ്രധാനപ്പെട്ട കാര്യങ്ങൾ ചെയ്യേണ്ടി വരുമ്പോൾ കുടുംബാംഗങ്ങളെല്ലാവരും ഒരേ അഭിപ്രായത്തിൽ എത്തിച്ചേരുന്നു.	T	F
4.	എനിക്ക് സംരക്ഷിക്കാൻ പറ്റാത്ത അവസ്ഥ വന്നു കഴിയുമ്പോൾ ----------ന് എന്തു പറ്റും എന്നോർത്തു ഞാൻ വിഷമിക്കാറുണ്ട്.	T	F
5.	----------നെ നിരന്തരം ശ്രദ്ധിക്കേണ്ട ആവശ്യമുള്ളതുകൊണ്ട് കുടുംബാംഗങ്ങളിൽ ചിലരുടെ വളർച്ചയും പുരോഗതിയും പരിമിതപ്പെട്ടു പോവുന്നു.	T	F
6.	ജീവസന്ധാരണത്തിന് ആവശ്യമായ ജോലികളിൽ ----------ന് പരിമിതമായ കഴിവുകളേയുള്ളു.	T	F
7.	---------- ഇനിയുള്ള കാലം പ്രത്യേക സ്ഥാപനങ്ങളിലോ മറ്റോ കഴിയേണ്ടി വരുമെന്ന വസ്തുത ഞാൻ അംഗീകരിച്ചിരിക്കുന്നു.	T	F
8.	----------ന് തനിയേ ഭക്ഷണം കഴിക്കാൻ കഴിയും	T	F
9.	----------നെ ശ്രദ്ധിക്കേണ്ടിയിരുന്നതു നിമിത്തം ഞാൻ തീർച്ചയായും ചെയ്യാനാഗ്രഹിച്ചിരുന്ന പല കാര്യങ്ങളും വേണ്ടെന്ന് വച്ചിട്ടുണ്ട്.	T	F

10. ----------ന് കുടുംബാംഗങ്ങളുമായി യോജിച്ചു പോവാൻ കഴിവുണ്ട്. T F

11. ചില സമയങ്ങളിൽ ഞാൻ ----------നെ പൊതുസ്ഥലങ്ങളിൽ കൊണ്ടു പോകുന്നത് ഒഴിവാക്കുന്നു. T F

12. വർദ്ധിച്ചു വരുന്ന ഉത്തരവാദിത്വങ്ങളും സാമ്പത്തിക ബുദ്ധിമുട്ടുകളും മൂലം ഭാവിയിൽ ഞങ്ങളുടെ കുടുംബത്തിന്റെ സാമൂഹികജീവിതം പ്രയാസകരമായിത്തീരും. T F

13. ---------- എന്നും ഇത്തരത്തിൽത്തന്നെ ആയിരിക്കും എന്നത് വിഷമിപ്പിക്കുന്നു. T F

14. ----------നെ പൊതുജനമദ്ധ്യത്തിൽ കൊണ്ടുപോകുമ്പോൾ അമിതമായ മാനസികസംഘർഷം അനുഭവിക്കുന്നു. T F

15. ഞാനാഗ്രഹിക്കുന്ന സമയത്ത് സുഹൃത്തക്കളുമൊത്ത് സന്ദർശനങ്ങൾക്ക് പോവാൻ എനിക്കു കഴിയുന്നു. T F

16. ---------- നെ ഒഴിവുകാല വിനോദവേളകളിൽ കൊണ്ടു പോവുന്നത് കുടുംബാംഗങ്ങളുടെ മുഴുവൻ സന്തോഷം നശിപ്പിക്കുന്നു. T F

17. ----------ന് സ്വന്തം മേൽവിലാസം അറിയാം T F

18 മുൻപു ചെയ്തിരുന്ന പോലെത്തന്നെ അത്രയും കാര്യങ്ങൾ ഇപ്പോഴും കുടുംബാംഗങ്ങൾ ഒരുമിച്ചു ചെയ്യുന്നു. T F

19 താൻ ആരാണെന്ന് ----------അറിയാം. T F

20 എന്റെ ജീവിതം മുമ്പോട്ടു പോകുന്ന രീതിയോർത്ത് ഞാൻ വിഷമിക്കുന്നു. T F

21 ചിലപ്പോൾ ഞാൻ ----------കാരണം വളരെ നാണം കെട്ടതായി തോന്നുന്നു. T F

22 ----------തനിക്കു ചെയ്യാവുന്ന അത്രയും കാര്യങ്ങൾ ചെയ്യുന്നില്ല. T F

23 മറ്റുള്ളവർ പറയുന്നതു മനസ്സിലാക്കാൻ ബുദ്ധിമുട്ടുള്ളതുകൊണ്ട് -------മായി ആശയവിനിമയം നടത്താൻ പ്രയാസമാണ്. T F

24 ---------- കുടെ വരുമ്പോൾ ഒരു കുടുംബത്തെപ്പോലെ ഉല്ലസിക്കാവുന്ന ധാരാളം സ്ഥലങ്ങൾ ഉണ്ട്. T F

25 ---------- അമിതമായി സംരക്ഷിക്കപ്പെട്ടിരിക്കുന്നു. T F

26 ---------- ന് കായികമത്സരങ്ങളിലും കളികളിലും പങ്കെടുക്കുവാൻ കഴിയും T F

27 ---------- ന് ധാരാളം സമയം സ്വന്തമായി കിട്ടുന്നു. T F

28	---------- ഒരു സാധാരണജീവിതം നയിക്കുന്നില്ല എന്നതിൽ ഞാൻ നിരാശനാണ്.	T	F
29	---------- ന് സമയം ഇഴഞ്ഞു നിങ്ങുന്നു; പ്രത്യേകിച്ച് ഒഴിവുസമയം	T	F
30	----------ന് ദീർഘനേരം ശ്രദ്ധകേന്ദ്രകരിക്കീൻ കഴിയുന്നില്ല.	T	F
31	എനിക്ക് വിശ്രമിക്കാൻ എളുപ്പമാണ്.	T	F
32	----------ന് പ്രായം ചെല്ലുമ്പോൾ അവനെ/അവളെ എന്തു ചെയ്യണമെന്നോർത്ത് ഞാൻ ആകുലപ്പെടുന്നു.	T	F
33	അമിതമായ ക്ഷീണം നിമിത്തം എനിക്കൊന്നും ആസ്വദിക്കാൻ പറ്റുന്നില്ല	T	F
34	---------- നെ സംബന്ധിച്ചിടത്തോളം ഞാൻ വിലമതിക്കുന്ന ഒരു കാര്യം അവന്റെ/അവളുടെ ആത്മവിശ്വാസമാണ്.	T	F
35	ഞങ്ങളുടെ കുടുംബത്തിൽ വളരെയധികം അമർഷവും അനിഷ്ടങ്ങളും ഉണ്ട്.	T	F
36	---------- ന് തനിച്ച് പ്രഥാമികാവശ്യങ്ങൾ (മലമൂത്രവിസർജനം) നിർവ്വഹിക്കുവാൻ കഴിയുന്നു.	T	F
37	ഇപ്പോൾ പറയുന്നത് അടുത്തനിമിഷം ---------- ന് ഓർമ്മിക്കാൻ കഴിയുന്നില്ല.	T	F
38	---------- ന് ബസിൽ യാത്ര ചെയ്യാൻ കഴിയുന്നു.	T	F
39	---------- മായി ആശയവിനിമയം നടത്തുക എളുപ്പമാണ്.	T	F
40	----------ന്റെ നിരന്തരമായ പരിചരണാവശ്യങ്ങൾ എന്റെ വളർച്ചക്കും ഉയർച്ചക്കും പരിമിതി വരുത്തുന്നു.	T	F
41	---------- തന്നെ സ്വയം ഒരു വ്യക്തിയായി അംഗീകരിക്കുന്നു.	T	F
42	----------നെപ്പറ്റി ചിന്തിക്കുമ്പോൾ എനിക്കു ദു:ഖമുണ്ട്.	T	F
43	എനിക്ക് ---------- നെ സംരക്ഷിക്കാൻ പറ്റാത്ത ഒരവസ്ഥ വന്നു കഴിയുമ്പോൾ അവന്/അവൾക്ക് എന്തു സംഭവിക്കുമെന്നോർത്ത് ഞാൻ വിഷമിക്കാറുണ്ട്.	T	F
44	---------- എന്താണു പറയാൻ ശ്രമിക്കുന്നത് എന്ന് മറ്റുള്ളവർക്കു മനസ്സിലാക്കാൻ കഴിയുന്നില്ല.	T	F
45	---------- നെ പരിചരിക്കുന്നത് എന്നെ ആയാസപ്പെടുത്തുന്നു.	T	F
46	മറ്റു കുടുംബങ്ങൾ ചെയ്യുന്ന കാര്യങ്ങൾ ഞങ്ങളുടെ കുടുംബാംഗങ്ങൾക്കും ചെയ്യാൻ സാധിക്കുന്നു.	T	F

47	--------- ഞങ്ങൾക്കെന്നുമൊരു പ്രശ്നമായിരിക്കും.	T	F
48	തന്റെ വികാരങ്ങൾ മറ്റുള്ളവരോടു പ്രകടിപ്പിക്കാൻ--------- നു കഴിയുന്നു.	T	F
49	---------- ന് ബെഡ്പാൻ (മൂത്രമൊഴിക്കുവാനുള്ള പ്രത്യേക സൗകര്യം) ഉപയോഗിക്കേണ്ടി വരുന്നു.	T	F
50	ഞാൻ വളരെ ചുരുക്കമായ വിഷമിക്കാറുള്ളു.	T	F
51	ഞാൻ മിക്കപ്പോഴും ദു:ഖിതനാണ്.	T	F
52	---------- ന് പരസഹായം കൂടാതെ നടക്കാനാവും	T	F

QRS

Scoring Directions

1	T	27	T
2	T	28	T
3	F	29	T
4	T	30	T
5	T	31	F
6	T	32	T
7	T	33	T
8	F	34	F
9	T	35	T
10	F	36	F
11	T	37	T
12	T	38	F
13	T	39	F
14	T	40	T
15	F	41	F
16	T	42	T
17	F	43	T
18	F	44	T
19	F	45	T
20	T	46	F
21	T	47	T
22	T	48	F
23	T	49	T
24	F	50	F
25	T	51	T
26	F	52	F

APPENDIX –III (a)

CHIP

COPING HEALTH INVENTORY FOR PARENTS

The Coping Health Inventory for Parents was developed to record what parents find helpful or not helpful to them in the management of family life when one or more of its members is ill for a brief period or has a medical condition which call for continued medical care to complete this inventory you are asked to read the list of "Coping behaviours" one at a time and record how 'helpful' it is to you , as given below

		Extremely Helpful	Moderately Helpful	Minimally Helpful	Not Helpful
		3	2	1	0
1	Trying to maintain family stability				
2	Engaging in relationships and friendships which help me to feel important and appreciated				
3	Trusting my spouse (or former spouse) to help support me and my child(ren)				
4	Sleeping				
5	Talking with the medical staff (nurses, social worker, etc.) when we visit the medical centre				
6	Believing that my child (ren) will get better				
7	Working, outside employment				
8	Showing that I am strong				

9	Purchasing gifts for myself and/or other family members				
10	Talking with other individuals/parents in my same situation				
11	Taking good care of all the medical equipment at home				
12	Eating				
13	Getting other members of the family to help with chores and tasks at home				
14	Getting away by myself				
15	Talking with the Doctor about my concerns about my child (ren) with the medical condition				
16	Believing that the medical centre/hospital has my family's best interest in mind				
17	Building close relationships with people				
18	Believing in God				
19	Develop myself as a person				
20	Talking with other parents in the same type of situation and learning about their experiences				
21	Doing things together as a family (involving all members of the family)				

22	Investing time and energy in my job				
23	Believing that my child is getting the best medical care possible				
24	Entertaining friends in our home				
25	Reading about how other persons in my situation handle things				
26	Doing things with family relatives				
27	Becoming more self reliant and independent				
28	Telling myself that I have many things I should be thankful for				
29	Concentrating on hobbies (art, music, jogging, etc.)				
30	Explaining our family situation to friends and neighbours so they will understand us				
31	Encouraging child (ren) with medical condition to be more independent				
32	Keeping myself in shape and well groomed				
33	Involvement in social activities (parties, etc.) with friends				
34	Going out with my spouse on a regular basis				
35	Being sure prescribed medical treatment for child (ren) are				

	carried out at home on a daily basis				
36	Building a closer relationship with my spouse				
37	Allowing myself to get angry				
38	Investing myself in my child (ren)				
39	Talking to someone (not professional counsellor/ doctor) about how I feel				
40	Reading more about the medical problem which concerns me				
41	Talking over personal feelings and concerns with spouse				
42	Being able to get away from the home care tasks and respon-sibilities for some relief.				
43	Having my child with the medical condition seen at the clinic/ hospital on a regular basis				
44	Believing that things will always work out				
45	Doing things with my children				

Appendix III (b)
COPING HEALTH INVENTORY FOR PARENTS

നിങ്ങളുടെ കുടുംബത്തിൽ ആർക്കെങ്കിലും ഒരാൾക്ക് തുടർച്ചയായ വൈദ്യ സഹായം ആവശ്യമുള്ള രോഗമോ അവസ്ഥയോ (ഉദാ: ബുദ്ധിമാന്ദ്യം)ഉള്ളപ്പോൾ മാതാപിതാക്കൾ എന്ന നിലക്ക് കുടുംബജീവിതം മുന്നോട്ടു കൊണ്ടു പോവാൻ നിങ്ങൾ അവലംബിക്കുന്ന ചിലമാർഗ്ഗങ്ങൾ താഴെ ക്കൊടുത്തിരിക്കുന്നു. ഇവ നിങ്ങൾക്ക് എത്രമാത്രം സഹായ കരമായിരിക്കുന്നു എന്നാണ് നിങ്ങൾ എവുതേ ണ്ടത്. ഓരോന്നും വായിച്ചശേഷം താഴെ പറയുന്ന രീതിയിൽ ഉത്തരം എഴുതുക.

		വളരെ യധികം സഹായ കരമാണ്	കുറെ യൊക്കെ സഹായ കരമാണ്	വളരെ കുറച്ചു മാത്രം സഹായ കരമാണ്	സഹാ യകര മാണ്
		3	2	1	0
1	കുടുംബസ്ഥിരത കാത്തുസൂക്ഷിക്കാൻ ശ്രമിക്കുന്നു.				
2	എനിക്ക് പ്രാധാന്യവും അംഗീകാരവും നല്കുന്ന ബന്ധങ്ങളിലും സുഹൃദ്വല യങ്ങളിലും സമയം ചിലവഴിക്കുന്നു.				
3	എന്നെയും എന്റെ കുഞ്ഞിനെയും പരിപാലിക്കുന്നതിന് സഹായിക്കാൻ എന്റെ ജീവിതപങ്കാളിയിൽ ഞാൻ വിശ്വസം അർപ്പിക്കുന്നു.				
4	ഉറങ്ങുന്നു.				
5	ആരോഗ്യകേന്ദ്രങ്ങൾ സന്ദർശിക്കുമ്പോൾ നഴ്സുമാർ, സാമൂഹികപ്രവർത്തകർ തുടങ്ങിയവരുമായി സംസാരിക്കുന്നു.				
6	എന്റെ കുട്ടി സുഖം പ്രാപിക്കുമെന്ന് വിശ്വസിക്കുന്നു.				
7	സാധാരണ ജോലിക്കു പുറമെ മറ്റു ജോലികൾക്കൂടി ചെയ്യുന്നു.				
8	ഞാൻ ശക്തനാണെന്ന് കാണിക്കുന്നു.				
9	എനിക്കോ എന്റെ കുടുംബാംഗങ്ങൾക്കോ വേണ്ടി സമ്മാനങ്ങൾ വാങ്ങുന്നു.				
10	എന്റെ ഇതേ അവസ്ഥയിലുള്ള വ്യക്തികൾ, മാതാപിതാക്കൾ എന്നിവരുമായി സംസാരിക്കുന്നു.				
11	വീട്ടിലുള്ള എല്ലാ വൈദ്യോപകരണങ്ങളും നന്നായി സംരക്ഷിക്കുന്നു.				
12	ഭക്ഷണം കഴിക്കുന്നു.				
13	കുടുംബത്തിലെ മറ്റംഗങ്ങളെ വിവിധ ജോലികളിൽ പങ്കുചേർക്കുന്നു.				

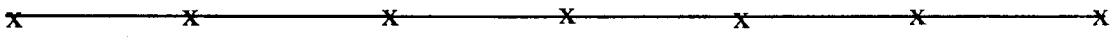
14	സ്വയം എങ്ങിനെയെങ്കിലും രക്ഷപ്പെടുന്നു.				
15	എന്റെ കുട്ടിയുടെ ആരോഗ്യസ്ഥിതിയേപ്പറ്റിയും എന്റെ ഉൽക്കണ്ഠകളേപ്പറ്റിയും ഡോക്ടർമാരുമായി സംസാരിക്കുന്നു.				
16	ആശുപത്രികൾക്കും ആരോഗ്യകേന്ദ്രങ്ങൾക്കും എന്റെ കുടുംബത്തിൽ അങ്ങേയറ്റം താല്പര്യമുണ്ടെന്നു വിശ്വസിക്കുന്നു.				
17	മറ്റാൾക്കാരുമായി അടുത്ത ബന്ധം കെട്ടിപ്പടുക്കുന്നു.				
18	ദൈവത്തിൽ വിശ്വസിക്കുന്നു.				
19	ഒരു വ്യക്തിയായി ഞാൻ വളരുന്നു.				
20	എന്റെ അതേ അവസ്ഥയിലുള്ള മാതാപിതാക്കളുമായി സംസാരിക്കുകയും അവരുടെ അനുഭവങ്ങളെപ്പറ്റി പഠിക്കുകയും ചെയ്യുന്നു.				
21	ഒരു കുടുംബമെന്ന നിലക്ക് എല്ലാവരേയും ഉൾപ്പെടുത്തുക്കൊണ്ട് കാര്യങ്ങൾ ചെയ്യുന്നു.				
22	സമയവും പ്രയത്നവും എന്റെ ജോലിക്കായി ഉപയോഗിക്കുന്നു.				
23	എന്റെ കുട്ടിക്കു പരമാവധി ലഭ്യമായ വൈദ്യസഹായം ലഭിക്കുന്നുമെന്നു വിശ്വസിക്കുന്നു.				
24	സുഹൃത്തക്കളെ വീട്ടിൽ വിളിച്ചു സൽക്കരിക്കുന്നു.				
25	എന്റെ അവസ്ഥയിലുള്ള മറ്റുവ്യക്തികൾ കാര്യങ്ങൾ എങ്ങിനെ കൈകാര്യം ചെയ്യുന്നുമെന്ന് വായിച്ചു മനസ്സിലാക്കുന്നു.				
26	കുടുംബത്തിലെ ബന്ധുക്കൾ ഒത്തുചേർന്ന് കാര്യങ്ങൾ ചെയ്യുന്നു.				
27	കൂടുതൽ സ്വതന്ത്രനും സ്വാശ്രയശീലനുമാവുന്നു.				
28	എനിക്ക് നന്ദി പറയാൻ ഒരു പാടു കാര്യങ്ങൾ ഉണ്ടെന്ന് സ്വയം പറയുന്നു.				
29	കല, സംഗീതം തുടങ്ങിയ മറ്റു ഹോബികളിൽ ശ്രദ്ധ കേന്ദ്രീകരിക്കുന്നു.				
30	ഞങ്ങളെ മനസ്സിലാക്കാൻ വേണ്ടി ഞങ്ങളുടെ കുടുംബത്തിന്റെ അവസ്ഥയേപ്പറ്റി സുഹൃത്തക്കളോടും സമീപവാസികളോടും വിവരിച്ചു കൊടുക്കുന്നു.				

31	വൈദ്യസഹായം ആവശ്യമുള്ള കുട്ടിയിൽ കൂടുതൽ സ്വാശ്രയശീലം വളർത്താൻ പ്രോത്സാഹനം നല്കുന്നു.				
32	സ്വയം ആരോഗ്യവാനായി നല്ല രീതിയിൽ നടക്കുന്നു.				
33	സുഹൃത്തുക്കളുമായി സാമൂഹികപ്രവർത്തനങ്ങളിൽ ഏർപ്പെടുന്നു.				
34	ജീവിത പങ്കാളിയുമൊത്ത് പുറം സവാരി നടത്തുന്നു.				
35	ഡോക്ടർമാർ കുട്ടിക്കുവേണ്ടി കൊടുത്തിട്ടുള്ള നിർദ്ദേശങ്ങൾ വീട്ടിൽ കൃത്യമായി പാലിക്കുന്നുണ്ടെന്ന് ഉറപ്പുവരുത്തുന്നു.				
36	ജീവിത പങ്കാളിയുമായി കൂടുതൽ അടുപ്പത്തിൽ ബന്ധം കെട്ടിപ്പടുക്കുന്നു.				
37	സ്വയം ദേഷ്യത്തിനടിമപ്പെടാൻ അനുവദിക്കുന്നു.				
38	എന്നെ കൂടുതലായി കുട്ടികൾക്കു വേണ്ടി അർപ്പിക്കുന്നു.				
39	എന്റെ മനസ്സിൽ എന്തു തോന്നുന്നു വെന്ന് ആരോടെങ്കിലും സംസാരിക്കുന്നു.				
40	എനിക്ക് ഉൽക്കണ്ഠയുണ്ടാകുന്ന ആരോഗ്യപ്രശ്നത്തേപ്പറ്റി കൂടുതൽ വായിച്ചു മനസ്സിലാക്കുന്നു.				
41	വ്യക്തിപരമായ മാനസികാവസ്ഥയേയും ഉൽക്കണ്ഠകളേയും പറ്റി ജീവിത പങ്കാളിയുമായി സംസാരിക്കുന്നു.				
42	വീട്ടിലെ ഉത്തരവാദിത്വങ്ങളിൽ നിന്നും, ജോലികളിൽ നിന്നും ഒരല്പം ആശ്വാസത്തിനായി മാറി നില്കുന്നു.				
43	വൈദ്യസഹായം ആവശ്യമുള്ള എന്റെ കുട്ടിയെ ആസുപത്രിയിൽ കൃത്യമായി കാണിക്കുന്നു.				
44	കാര്യങ്ങളെല്ലാം എപ്പോഴും നേരേ ആവുമെന്നു വിശ്വസിക്കുന്നു.				
45	എന്റെ കുട്ടികളുമായി ചേർന്ന് കാര്യങ്ങൾ ചെയ്യുന്നു.				

APPENDIX IV (a)

Marital Satisfaction Scale

The numbers 0 to 6 given below on the line indicate the overall level of happiness or satisfaction one experiences in his/her marital relationship. Please indicate your level of satisfaction regarding your married life by circling the appropriate number considering all aspects of your marital relationship.



0	1	2	3	4	5	6
Extremely unsatis-factory	Very unsatis-factory	More unsatis-factory	Satis-factory	More satis-factory	Very Satis-factory	Extremely satis-factory

Appendix IV (b)
Marital Satisfaction Scale

താഴെ കൊടുത്തിരിക്കുന്ന വരയിൽ പൂജ്യം മുതൽ ആറുവരെയുള്ള നമ്പറുകൾ നിങ്ങളുടെ വിവാഹബന്ധത്തിലുള്ള സന്തോഷത്തിന്റെ അളവിനെ സൂചിപ്പിക്കുന്നു. ഭൂരിപക്ഷം ബന്ധങ്ങളിലുമുള്ള സന്തോഷത്തിന്റെ അളവിനെ പ്രതിനിധീകരിക്കുന്നു. നിങ്ങൾ നിങ്ങളുടെ വിവാഹബന്ധത്തിലുള്ള സന്തോഷം (സംതൃപ്തി) എന്തു മാത്രമെന്ന് താഴെയുള്ള വരയിൽ കൊടു ത്തിരിക്കുന്ന ഉചിതമായ നമ്പറിനു ചുറ്റും ഒരു വലയമിട്ടുകൊണ്ട് അടയാളപ്പെടുത്തുക. നിങ്ങളുടെ വിവാഹബന്ധത്തിന്റെ എല്ലാ വശങ്ങളും പരിഗണിച്ചു കൊണ്ടായിരിക്കണം അടയാളപ്പെടുത്തുന്നത് .

0	1	2	3	4	5	6
പരിപൂർണ്ണമായും അസംതൃപ്തമാണ്	വളരെയധികം അസംതൃപ്തമാണ്	വളരെ അസംതൃപ്തമാണ്	സംതൃപ്തമാണ്	വളരെ സംതൃപ്തമാണ്	വളരെയധികം സംതൃപ്തമാണ്	പരിപൂർണ്ണമായും സംതൃപ്തമാണ്

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