CHAPTER – I

INTRODUCTION

1.1 OVERVIEW

1.2 CONCEPTS USED IN THE PRESENT STUDY

1.2.1 STRESS

1.2.2 COPING

1.2.3 PSYCHOLOGICAL WELL-BEING

1.2.4 AUTISM

1.2.5 MENTAL RETARDATION

1.3 THE PRESENT STUDY

1.3.1 STATEMENT OF THE PROBLEM

1.3.2 SIGNIFICANCE OF THE STUDY

1.3.3 OBJECTIVES OF THE STUDY

1.4 SUMMARY
INTRODUCTION

1.1 OVERVIEW

Becoming a parent is significant family life cycle transitions. The birth of any child is not only affects the parents but also the dynamics of the family. Members of the family have to undergo a variety of changes to adapt to the pressure of a new member. Although, parenting is viewed as one of the most joyful and rewarding experiences of life (Pittman, Wright, & Lloyd 1989), it can be a stressful experience due to the demands and hassles of daily living (Cameron, Dobson, & Day, 1991).

The effect of the birth of a disabled child on the family is more profound. Parents of such children face more challenges in everyday living to cope with different stressful events such as medical expenses, financial strain, need of increased attention to the child, etc. (Hastings et al. 2005). Further, special child care demands of children with disabilities causes’ significant stress for parents and even disrupts the family relationships (Hedov, Anneren, & Wikblad, 2002). However, the challenges faced by parents and the ways in which they deal with them vary with the nature (Walker, Van Slyke, & Newbrough 1992) and severity of child’s disability.

Parents vary in their ability to cope with stress. Researchers found that parents of children with developmental delays are at risk of psychological problems such as depression, anxiety, distress, guilt, poor social and marital adjustment, less satisfaction with life, poor parent child-interaction and hopelessness (Abbeduto et al. 2004; Johnston, Goldberg, Morris, & Livenson, 2001; Murphy et al. 2000). For
example, mothers of children with chronic illness or disabling conditions such as autism reported higher rates of depressive symptoms and feelings of increased psychological distress (Rodrique, Morgan, & Geffken, 1992; Venkatesan, 2004).

Studies of coping have many implications for the mental health and the well-being of the parent and the family as well. Lazarus ‘transactional model of coping posits that peoples’ interpretations of an event determine the emotional reactions and coping efforts of them. On the other hand, characteristics of stressful situation, and personal and social resources also influence the people’s interpretation. So, the outcomes of stressful events are determined by person’s demographic features and personality, worldviews, social support and previous experience. As a result, the experience of stress not solely depends on the stressful condition itself, rather, how the persons act, namely their coping strategies are also important in terms of the experienced stress. Therefore, coping strategies of the parents have been evaluated in the present study.

1.2. CONCEPTS USED IN THE PRESENT STUDY

1.2.1 Stress

Stress is a viewed as a component of personality (i.e. trait variable), situational factors (i.e. state variable), or attitudinal variable such as interpersonal attributions and locus of control (Noppe, Noppe, & Hughes, 1990). In earlier theories stress was defined as a nonspecific response to perceived environmental threats called ‘stressors’. Autonomic nervous system is activated in response to stress and prepare body for either attacking (fight) or fleeing (flight) an enemy or
threatening situation (Cannon, 1932). Although, this fight or flight response was vital for survival in human history, in modern life they are less productive considering the longer periods of stress exposure. Thus, stressor in modern life requires more complex responses.

Stress can be any circumstances that threaten or perceived to threaten one’s well-being and thereby tax one’s coping abilities. Thus, threat to ones immediate physical safety, long range security, self-esteem, reputation, or peace of mind can be stressful. Stress is also viewed as the psychological and physiological experience resulting from discrepancies between internal and external demands and perception of the resources available to meet those demands (Moos & Moos, 1983).

The concept of ‘Stress’ was popularized in science and mass media from the work of Hans Selye. Selye (1976) approaches to psychological stress developed within the field of cognitive psychology (Lazarus 1966, 1991; Lazarus and Folkman 1984; McGrath, 1982). Selye (1976) defined stress as ‘a state manifested by a syndrome which consists of all the nonspecifically induced changes in a biologic system’. In a series of studies, Selye exposed animals to varieties of stimulus events such as intense heat, cold, toxic agents, etc. for longer duration and observed that the patterns of physiological arousal experienced by animals were largely the same, regardless of the type of stimulus event. These nonspecifically caused changes constitute the stereotypical, i.e., specific, response pattern of systemic stress. This stereotypical response pattern is called the ‘General Adaptation Syndrome (GAS)’.
According to Seyle, the body’s nonspecific response to the stress proceeds in three stages. In alarm phase, the body first organizes physiological responses to threat. The alarm reaction comprises an initial shock phase and a subsequent counter shock phase. The shock phase exhibits autonomic excitability, an increased adrenaline discharge, and gastro-intestinal ulcerations. Whereas, the counter shock phase marks the initial operation of defensive processes and is characterized by increase dadrenocortical activity. During this phase, when the body is first aroused, the hypotalamus sends signals to the pituitary gland which leads to the secretion of adrenocorticotrophic hormone (ACTH). Corticosteroids are released when ACTH travels via the bloodstream to the cortex of the adrenal glands. Release of adrenaline and the activation of the sympathetic nervous system is result from activation of the adrenal medulla by hypothalamus.

If noxious stimulation continues, the individual enters the stage of resistance. In this stage, the symptoms of the alarm reaction disappear, which seemingly indicates the individual's adaptation to the stressor. However, as the resistance to the noxious stimulation increases, resistance to other kinds of stressors decreases at the same time. If the aversive stimulus persists the individual enters in the stage of exhaustion. After maintaining high levels of the hormones for a long time, the body not only loses its ability to release the hormones and exhausts its resources but also the incidence of certain types of stress-related diseases, such as coronary disorders increases during this stage. Irreversible tissue damages appear, and, if the stimulation persists, the organism dies.
Selye’s influential work was criticized. For example, Engel (1985) stated that the concept of stress was in danger of losing its scientific value due to Selye’s view. Recent evidence also demonstrated that prolonged stress affects the ability of the immune system to function adequately by releasing neurotransmitters such as serotonin. Mason (1971, 1975) proposed that the hormonal GAS responses were the responses to the specific emotional state rather than the stressors. Mason reported that the animals in Selye’s experiments were in the state of helplessness, uncertainty, and lack of control because the stressors presented by Selye had a common emotional meaning that they were novel, strange, and unfamiliar to the animal. When, Mason (1975) experimentally eliminated the uncertainty and he did not observed GAS. This criticism leads to a more profound argument that the stress experienced by humans is almost always the result of a cognitive mediation (Arnold, 1960; Janis, 1958; Lazarus, 1966, 1974).

Selye also fails to specify the mechanisms that may explain the cognitive transformation of ‘objective’ noxious events into the subjective experience of being distressed. In addition, Selye had not taken into account coping mechanisms as important mediators of the stress–outcome relationship.

Another comprehensive theory of stress is proposed by Lazarus (1966). Lazarus stress theory has undergone several essential revisions (Lazarus, 1991; Lazarus, & Folkman1984; Lazarus, & Launier, 1978). In the latest version, stress is neither defined as a specific kind of external stimulation nor as a specific pattern of physiological, behavioral, or subjective reactions. Instead, stress is viewed as a relational concept (Lazarus, 1984, p. 21; Lazarus, 1991).
In this theory the psychological stress is viewed as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (Lazarus, & Folkman, 1984; Lazarus, & Folkman, 1986). According to Folkman (1984) the relationship between the person and environment is dynamic, bidirectional, and mutually reciprocal. Further, the experience of stress is depends upon influenced cognitive appraisal of the situation and coping methods utilized by the person (Folkman, 1984; Monroe & Kelley, 1995). However, there are individual differences in the perception of stress, a particular environmental change i.e. a demand or an event may be perceived by one person as stressful and by another as benign.

The definition of stress as stated in this theory points to two processes as central mediators within the person-environment transaction, namely, cognitive appraisal and coping. First, ‘appraisal’ refers to the individuals’ evaluation of the significance of what is happening for their well-being. Second, ‘coping’ refers to individuals' efforts in thought and action to manage specific demands (Lazarus, 1993). The concept of appraisal was introduced into emotion research by Arnold (1960) and elaborated with respect to stress processes by Lazarus (1966) and Lazarus and Launier (1978). The concept of appraisal is based on the idea that emotional processes including stress are dependent on actual expectancies that persons manifest with regard to the significance and outcome of a specific encounter. This concept is important for explaining individual differences in quality, intensity, and duration of an elicited emotion in environments that are objectively equal for different individuals.
Lazarus and Folkman (1984), in their model of stress, proposed that evaluating or appraising a stressful situation is a complex process. It is generally assumed that the resulting state is generated, maintained, and eventually altered by a specific pattern of appraisals. According to them, the available coping options and resources determine whether or not the resources will be adequate for coping with the demands of the stressor. They suggested that personal characteristics and environmental factors influence the appraisal of the person-environment relationship.

Personal characteristics includes motivational dispositions, goals, values, and generalized expectancies, beliefs about the individual and the world, and recognition of one’s personal resources for coping namely, problem-solving skills, finances, social skills and level of health and energy. Environmental factors include the proximity and nature of the danger, its ambiguity and duration, as well as the availability and quality of social support resources. Relevant situational parameters are predictability, controllability, and imminence of a potentially stressful event. According to them, individual differences in these personal characteristics can lead to individual difference in the perception of stressful events. Stress occurs due to perceived inability to adequately access internal and external coping resources when dealing with a given situation (Lazarus & Folkman, 1984).

This theory distinguishes two basic forms of appraisal, primary and secondary appraisal (Lazarus, 1966). Primary appraisal concerns whether something of relevance to the individual's well-being occurs, whereas secondary appraisal concerns coping options. Within primary appraisal, three components are distinguished. ‘Goal relevance’ describes the extent to which an encounter refers to issues about which the
person cares. ‘Goal congruence’ defines the extent to which an episode proceeds in accordance with personal goals. ‘Type of ego-involvement’ designates aspects of personal commitment such as self-esteem, moral values, ego-ideal, or ego-identity.

Likewise, three secondary appraisal components are distinguished. ‘Blame or credit’ results from an individual's appraisal of who is responsible for a certain event. ‘Coping potential’ means a person's evaluation of the prospects for generating certain behavioral or cognitive operations that will positively influence a personally relevant encounter. ‘Future expectations’ refer to the appraisal of the further course of an encounter with respect to goal congruence or incongruence.

Specific patterns of primary and secondary appraisal lead to three kinds of stress namely, harm, threat, and challenge (Lazarus, & Folkman, 1984). ‘Harm’ refers to the psychological damage or loss that has already happened. ‘Threat’ is the anticipation of harm that may be imminent. ‘Challenge’ results from demands that a person feels confident about mastering. These different kinds of psychological stress are embedded in specific types of emotional reactions, thus illustrating the close conjunction of the fields of stress and emotions.

This model of stress consists of four different processes. The first process is the perception of an external stressor. The individual can or cannot perceive an event as stressful (Deater-Deckard, 2004; Lazarus, 1984). If the individual perceive an event as stressful, then he/she will experience stress. The second process is characterized by the individual’s cognitive appraisal of the stressor. This allows the individual to conclude whether or not the stressor is aversive or to be avoided. The third process
involves the individual’s use of coping mechanisms to reduce the effects of the aversive stressors. The last process is referred as the stress reaction, the negative effects that occur in one’s mind and body as a result of being exposed to a stressful event (Deater-Deckard, 1998; Deater-Deckard, 2004).

**Parenting Stress**

Parental stress, particularly, is defined as the stress that directly related to a person’s role as a parent and parenting a child with a disability. The challenges involved in raising a ‘normal’ child are also overwhelming and demanding. Stress related to parenting responsibilities present throughout the span of a child’s development. After the child’s birth parents are responsible for providing immeasurable amounts of nurturance, love, and support to ensure proper development of their infant (Beckman, 1991). Caring for an infant takes center stage in the family (Copeland, & Harbaugh, 2005); more time, energy, and resources are needed for taking care of newborn. Parents become overwhelmed by conditions related to infant’s needs for e.g., crying behaviors, feeding responsibilities, attachment issues, financial and medical demands, career and work obligations, and limited time for self-care, leisure activities, and interpersonal relationships (Wienberg, & Richardson, 1981). Thus, parents eventually experience not only a rapid decline in available family resources, but will also succumb to elevations in parenting stress.

In child’s school age years parents experience slight reduction in parenting stress as the child become self-sufficient in satisfying his/her self-care needs. However, some degree of stress is experienced by parents due to school related issues,
such as safety issues and concern, after school care, social activities, and peer relationships (Sidebotham, 2001). Some parents experience increased stress because their difficulties in managing time constraints related to home, work, community, and personal obligations for self and other family members.

Most of the parents experience increased stress as the child approaches adolescence. However, the amount of stress experienced varies depending on parent-child characteristics. In this period most parents are worried about developmental changes, such as physical, social, and emotional changes, that take place in their adolescent child (Spring, Rosen, & Matheson, 2002). During this developmental stage some adolescents challenge parent’s authority which increase parenting stress. Child-related stressors may include noncompliance and acting out behaviors, argumentative and talking back tendencies, a decline in grades or school performance, and disregard of family rules. Adolescents’ engage in alcohol and drug use, displays of sexual promiscuity, truancy in the school setting, and aggressive tendencies towards others. This also adds the level of parenting stress experienced by the parents.

Especially, parents of children with autism and mental retardation are overwhelmed by their inabilitys to meet the child’s and or the family’s needs such as personal needs, financial concern, medical issues, home, work, and social issues, marital and interpersonal relationship (Beckman, 1991). The parents face a multitude of child-related stressors in the way of behavioral, communication, and social, and sensory limitations immediately after receiving a diagnosis of autism, and mental retardation (Lainhart, 1999). Parental stress among parents increase consistently due to behavioral difficulties such as noncompliance and resistance to change, excessive
crying, screaming and shouting, temper tantrums, and aggressive tendencies such as biting, hair pulling, hitting, head banging, etc., exhibited by their child with disabilities (Keller, & Sterling-Honig, 2004).

Other studies showed that specific behaviour variables such as non-compliance, limited speech and communications skills, irritability, poor self-care skills, and socially withdrawn tendencies are correlated to parental stress (Bitsika, & Sharpley, 2004). Other researchers found that self-injurious behaviour, temper tantrums, obsessive tendencies and acting out behaviours are also contribute to parenting stress (Gray and Holden, 1992). Parents are exhausted, overwhelmed, embarrassed, and confused about the best ways to handle their child’s behavior.

Cognitive appraisal is a very important aspect of how parents will interpret their child’s behavior. The parents’ cognitions about their child’s behaviors and why the behavior is occurring explain why certain parents are more able to effectively navigate the stresses of parenting than others (Deater-Deckard, 2004). For example, the parents who identify the normal activities of childhood as problematic will experience more stress than the parents who label these behaviors as typical or normative (Crnic & Low, 2002). Parents perception are also likely to be influenced by marital difficulty, mood disorders such as anxiety and depression, substance abuse, job stress, low socioeconomic status, daily hassles, and single parenting (Webster-Stratton, 1990).

Parents of these children also face with the difficulties in negotiating issues related to educational concerns, medical and health problem, financial demands, and
overall lack of social support (Elder, 2001). In addition, their stress increases when they face the painful reality of acknowledging limitations in their child’s academic, social, and behavioral capabilities, especially when compared to the functioning of same aged peers.

According to Abidin (1995), evaluating parenting stress is somewhat complicated and several components need to be considered based on interactions of child, parent, and environmental variables. There are three major source domains of stressors for parents: (1) Child characteristics include factors such as the child’s adaptability, demandingness, and level of hyperactivity. (2) Parent characteristics include level of depression, attachment to the child, sense of competence as a parent, and relationship with the spouse, and (3) Situational/Demographic-Life stress includes events such as changing jobs, moving, marriage, divorce, or death of a family member (Abidin, 1995).

Abidin (1995) further described different kinds of stressors which ranges from objective life events such as a death in the family to the parent’s judgment of the child’s activity level or subjective feelings of fulfilling the parent role. According to him, the emotional interpretation of situations by the parents is as important as the objective events or characteristics of the children with regard to the experience of parenting stress.

Lavee, Sharlin, and Katz (1996) also discussed several forms of parenting stress resulting from various stressful life events. These stressors are classified into three categories; (i), normative events, such as the empty nest situation or retirement
that predictably occur in the course of the life cycle; (ii), non-normative events include the death of a child or natural disaster, and (iii) parental stress marked by ongoing role strains and intra-family problems. However, there are several aspects of both the child and the parent that could exacerbate this perception of stress in the parenting role, and are likely contributing factors to greater levels of perceived parenting stress.

Theories of Parenting Stress

According to the daily hassles theory of parenting stress, everyday stress of parenting can have an effect on the parent and the child. Many mundane tasks that can become stressful include child behaviors such as interrupting and whining, parenting concerns and behavior such as straightening up after messes, limited alone time, uncertainty on how to deal with a variety of circumstances a child encounters, coordinating car pools or other child activities, and complicated and conflicting schedules of work and family life (Crnic, & Low, 2002; Deater-Deckard, 2004, p.10). The effects of these minor stressful events can accumulate overtime (Deater-Deckard, 2004) and lead to frustration, irritation, and confusion, which in turn can lead to the experience of stress (Crnic & Low, 2002).

Chronic parenting stress is more likely to have harmful consequences (Deater-Deckard, 2004) and parents may experience changes within the parenting role (Crnic & Low, 2002). Research noted that stressed parents have more difficulties in resolving parenting dilemmas, decreased satisfaction within the parenting role, less
sensitive in responding to their child (Deater-Deckard, 2004) and as a consequence of these factors the parent-child relationship deteriorates (Crnic & Low, 2002).

Parent-Child-Relationship theory of parenting stress stated that there are three domains of parenting stress. Studies found that parent factors such as gender, family history, mood states, beliefs about child development, and ideas on how to best raise a child will have a direct impact on the way in which the parent behaves (Crnic, & Low, 2002; Deater-Deckard, 2004). In addition, Deater-Deckard (2004) reported that stressful child behavior namely; noncompliance, interrupting, inattention, and other general child behavior problems can add stress to parents. Further, Deater-Deckard, (2004) added that the parent-child relationship is also associated with parenting stress.

This theory states that stress in any of the three domains can lead to detrimental effects in the other domains. Similarly, reductions in stress in any of the three domains can lead to positive effects in the other domains (Deater-Deckard, 2004).

1.2.2 COPING

Coping is intimately related to the concept of cognitive appraisal and, hence, to the stress relevant person-environment transactions. In past three decades there has been substantially growth in the research on the processes by which individuals cope with stressful situations (Lazarus, 1991; Zeidner & Endler, 1996). Coping is the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them (Lazarus, & Folkman, 1984). Coping is also viewed as constantly changing cognitive and behavioral efforts to manage
specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). Coping is what an individual does at a specific time and place in order to handle or change the stressor, as well as manage their emotional and physical reaction to it (Lazarus & Folkman, 1984).

In the above given definitions coping actions are not classified according to their effects, but according to certain characteristics of the coping process. This process encompasses behavioral as well as cognitive reactions in the individual. Coping is often characterized by the simultaneous occurrence of different action sequences and, hence, an interconnection of coping episodes.

Coping includes a number of behavioural patterns that draw upon personal, social and environmental resources in an effort to adapt to the demands of the situation and maintain stability (Lazarus & Folkman, 1984). The researchers have identified and classified various coping techniques that people use in dealing with stress. For example, McCrae (1984) identified 28 coping techniques after studying 255 participants, where as Carver, Scheier and Weintrab (1989) found 14 categories of coping tactics, namely; active coping, planning, suppression of completing activities, restraint coping, seeking social support, acceptance, denial, turning to religion, positive reinterpretation and growth, etc.

Coping actions are distinguished by their focus on different elements of a stressful encounter (Lazarus, & Folkman, 1984). Emotion-focused coping strategies refer to the attempts to regulate the negative emotions that occur as a result of stressful conditions. Emotion-focused coping strategies are used to overcome the
distressing emotions when the problem solving coping fails or they may not be used because the problem is too resistant to change. Emotion-focused copings are related to internal elements and try to reduce a negative emotional state, or change the appraisal of the demanding situation. Thus, emotion centered coping strategies are used to control distress and the dysfunction, where there is little or nothing else to be done (Folkman, & Lazarus, 1985).

Problem-focused coping refers to the overt behavioral efforts to alter or to control the problem (Billing, & Moos, 1981; Bright, & Hayward, 1997; Folkman, & Lazarus, 1985). According to Folkman and Moskowitz (2000), problem solving coping refers to thoughts and actions serving to solve the causes of distress and is more commonly used when the personal control over the result is higher. Problem-focused coping can attempt to change the person-environment realities behind negative emotions or stress. If the situation is appraised as amenable to be prevented or to be corrected, the use of problem solving coping is more common.

There are individual differences in the use of coping strategies and coping strategies are also influenced by situational demands. Coping strategy not always guarantee a successful outcome, however, their adaptive value depends on the exact nature of the situation. Gradual increase in stress can result in decline of psychological and emotional well-being. Recent studies suggest that stress in parents of autistic children are the direct result of parents’ inability to access adequate coping resources (Fong, 1991). Walker et al. (1992) proposed that in order to access an adequate number of coping resources, one must have the ability to engage in effective coping behavior and strategies.
Theories of Coping

Theories of coping are classified according to two independent parameters: (a) trait-oriented versus state-oriented, and (b) micro-analytic versus macro-analytic approaches (Krohne, 1996). Trait-oriented and state-oriented research strategies have different objectives: The trait-oriented or dispositional strategy aims at early identification of individuals whose coping resources and tendencies are inadequate for the demands of a specific stressful encounter. An early identification of these persons will offer the opportunity for establishing a selection or placement procedure or a successful primary prevention program.

State-oriented research centers on actual coping and has a more general objective. This research investigates the relationships between coping strategies employed by an individual and outcome variables such as self-reported or objectively registered coping efficiency, emotional reactions accompanying and following certain coping efforts, or variables of adaptation outcome such as health status or test performance. This research strategy intends to lay the foundation for a general modificatory program to improve coping efficacy.

Micro-analytic approaches focus on a large number of specific coping strategies, whereas macro-analytic analysis operates at a higher level of abstraction, thus concentrating on more fundamental constructs. Sigmund Freud's (1926) defense mechanisms conception is an example of a state-oriented, macro-analytic approach. Although Freud distinguished a multitude of defense mechanisms, in the end, he related these mechanisms to two basic forms: repression and intellectualization (Freud
The trait-oriented correspondence of these basic defenses is the personality dimension repression-sensitization (Byrne, 1964; Eriksen, 1966). The distinction of the two basic functions of emotion-focused and problem-focused coping proposed by Lazarus and Folkman (1984) represents another macro-analytic state approach.

In actual research on ‘Ways of Coping Questionnaire’ this macro-analytic approach is extended to a micro-analytic strategy (Folkman and Lazarus 1988; Lazarus, 1991). Lazarus and Folkman (1988) distinguish eight groups of coping strategies such as confrontative coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem-solving and positive reappraisal.

Unlike the macro-analytic, trait-oriented approach that generated a multitude of theoretical conceptions, the micro-analytic, trait-oriented strategy is mostly concerned with constructing multidimensional inventories (Schwarzer and Schwarzer, 1996). Almost all of these measurement approaches, however, lack a solid theoretical foundation (Krohne, 1996).

Many trait-oriented approaches in this field have established two constructs central to an understanding of cognitive responses to stress. ‘Vigilance’, that is, the orientation toward stressful aspects of an encounter, and ‘cognitive avoidance’, that is, averting attention from stress-related information (Janis, 1983; Krohne, 1978, 1993; Roth and Cohen, 1986).

Approaches corresponding to these conceptions are repression-sensitization (Byrne, 1964), monitoring-blunting (Miller, 1980, 1987), or attention-rejection
(Mullen & Suls, 1982). With regard to the relationship between these two constructs, Byrne's approach specifies a uni-dimensional, bipolar structure, while Miller as well as Mullen and Suls leave this question open. However, Krohne (1996) explicitly postulates an independent functioning of the dimensions vigilance and cognitive avoidance.

The repression-sensitization construct relates different forms of dispositional coping to one bipolar dimension (Byrne, 1964; Eriksen, 1966). When confronted with a stressful encounter, persons located at one pole of this dimension i.e., repressor tend to deny or minimize the existence of stress, fail to verbalize feelings of distress, and avoid thinking about possible negative consequences of this encounter. Persons at the opposite pole i.e., sensitizers react to stress-related cues by way of enhanced information search, rumination, and obsessive worrying. The concept of repression-sensitization is theoretically founded in research on perceptual defense (Bruner & Postman, 1947), an approach that combined psychodynamic ideas with the functionalistic behavior analysis of Brunswik (1947).

The conception of monitoring and blunting (Miller, 1980, 1987) originated from the same basic assumptions formulated earlier by Eriksen (1966) for the repression-sensitization construct. Miller conceived both constructs as cognitive informational styles and proposed that individuals who encounter a stressful situation react with arousal according to the amount of attention they direct to the stressor. Conversely, the arousal level can be lowered, if the person succeeds in reducing the impact of aversive cues by employing avoidant cognitive strategies such as distraction, denial, or reinterpretation. However, these coping strategies, called
blunting, should only be adaptive if the aversive event is uncontrollable. Examples of uncontrollable events are impending surgery or an aversive medical examination (Miller, & Mangan 1983).

If control is available, strategies called monitoring, i.e., seeking information about the stressor, are the more adaptive forms of coping. Although initially these strategies are associated with increased stress reactions, they enable the individual to gain control over the stressor in the long run, thus reducing the impact of the stressful situation. There are relatively stable individual differences in the inclination to employ blunting or monitoring coping when encountering a stressor.

**Parental Coping**

Coping is an important factor in determining how parents experience stress. McConachie (1986) reported that parents of children with disabilities passes through the series of different stages while adjusting the situation arise from the birth of disable child. Early parental reactions following the diagnosis of a handicap of a child include ambivalence, anger, confusion, denial, self-pity, and blame, feelings of helplessness, depression, disappointment, grief, guilt, mourning, rejection, shock, impulses to kill the child and suicidal impulses (Mary, 1990; McConachie, 1986; Ntombela, 1991).

A state of shock is experienced at the initial disclosure, i.e. a feeling of not being able to register or understand the news and thus the parents are more likely to withdraw. This will be followed by a reaction stage, during which emotions of denial, sadness, anger, etc., may be felt in a rush. Then gradually parents will enter an
adaptation stage when they, for example, begin to ask questions about what can be done, and finally a reorganization stage when they seek help and begin to plan ahead.

For parents, the effectiveness of how well they deal and cope with the stressors created by their child, either by changing the stressful event or attempting to minimize their reactions to it, will determine the degree to which they experience a stress response and all of its negative consequences. Parents who are less reactive and more able to regulate their thoughts, emotions, and behaviors are able to adapt more readily in the face of minor or major parenting stressors (Deater-Deckard, 2004, p.53).

Parents require coping skills to cope with stress resulting from extra familial factors, interpersonal factors, or child factors (Webster-Stratton, 1990, p. 303). The effect of these stressors on the parent depends upon the parent’s psychological well-being and the amount of support they receive from friends, family, and other personal resources. Parents have to learn to effectively implement strategies and techniques that best fit their families’ goals and objectives (Olsen & Fuller, 2003, p.167).

1.2.3 PSYCHOLOGICAL WELL-BEING

Well-being is positive or optimal functioning and the fulfillment of basic needs and inner potential. Well-being involves more than emotional happiness and life satisfaction well-being is a global combination of emotional well-being, psychological well-being and social well-being.

Psychological well-being is somewhat malleable concept which is to do with people’s feelings about everyday life activities. Such feelings may range from
negative mental states or psychological strains such as anxiety, depression, frustration, emotional exhaustion, unhappiness, dissatisfaction, to a state which has been identified as positive mental health (Jahoda, 1958; Warr, 1978). A theory of psychological well-being focuses on the human capacity to develop, function effectively, and flourish. Theoretical beliefs about what constitutes psychological well-being derive from the philosophical and psychological writings of Abraham Maslow and Carl Rogers.

According to Maslow, human behavior was characterized by movement toward self-actualization and, at the same time, limited by more basic processes such as physiological and safety needs. If basic needs were met, self-actualization is attainable. Similarly, Rogers stated that self-actualization is an inherent possibility and posited that certain interpersonal conditions, such as empathy, respect, and genuineness, facilitate movement toward self-actualization. Thus, consistent with Maslow and Rogers, current psychological well-being theory holds that the development of human potential involves two processes: (1) the inherent human drive for self-actualization, and (2) the creation of the conditions under which that drive might be optimized.

Subjective well-being is also known as emotional well-being and happiness. Theories of subjective well-being such as the emotional model posited by Diener and others (Diener, 1984; Diener, & Lucas, 1999), suggested that individuals appraisals of their own lives capture the essence of well-being. Objective approaches to understanding psychological well-being and social well-being have been proposed by Ryff, (1989) and Keyes (1998), respectively. Researchers view is that psychological
and social well-being provides useful frameworks for conceptualizing human functioning. Subjective descriptions of emotional well-being and objective descriptions of psychological and social well-being constitute a more complete portrayal of mental health (Keyes, & Lopez, 2002).

Studies had confirmed the threefold structure of emotional well-being that consists of perceptions of happiness and satisfaction with life, along with the balance of positive and negative affects (Bryant & Veroff, 1982; Lucas, Diener, & Suh, 1996; Shmotkin, 1998). Conceptually psychological well-being is related to subjective well-being, although not identical to it. Subjective well-being is related to judgments of relative happiness and quality of life, whereas psychological well-being has more to do with the management of the existential challenges of life such as having meaning in one’s life and growing and developing as a person.

Based on descriptions of positive psychological and social well functioning Ryff and her colleagues have developed a model of ‘psychological well-being’ (Keyes, 1998; Keyes, Shmotkin, & Ryff, 2002; Ryff & Keyes, 1995; Ryff & Singer, 1998). Ryff (1989) pointed out that some of the favorable outcomes described by positive psychologists can be integrated into a model of psychological well-being. Ryff’s conceptualization of positive functioning includes six components namely, self-acceptance, personal growth, purpose in life, environmental mastery, autonomy, and positive relations with others. ‘Self-acceptance’ refers to the positive attitude toward oneself, accepting of varied aspects of self, and feeling positive about past life. ‘Personal growth’ includes feelings of continued development and effectiveness and open to new experiences and challenges.
‘Purpose in life’ characterized by possessing goals and beliefs that give direction to life, feeling life has meaning and purpose. ‘Environmental mastery’ involves feeling competent and able to manage complex environment and able to create personally suitable living situation. ‘Autonomy’ refers to feeling comfortable with self-direction; possess internal standard and resists negative social pressures from others. ‘Positive relation with others’ is characterized by warm, satisfying, and trusting relationships with others; capable of empathy and intimacy.

Three types of studies have provided the empirical foundation for psychological well-being theory: (1) factor analytic studies of the organization among individual characteristics of well-being, (2) developmental studies of the changes in well-being across the life span, and (3) neurophysiological studies of the biological correlates of expressions of well-being.

One of the more well-developed measures of psychological well-being incorporates six theory-driven dimensions: positive self-evaluations, a sense of continued growth and development, the belief that life is purposeful, and the possession of quality relations with others, the capacity to manage one’s surroundings effectively, and a sense of self-determination. Data from national surveys, longitudinal studies, and experimental laboratory studies have indicated that psychological well-being indicators are influenced by broad social factors such as age, gender, socio-economic status, race, and culture.
1.2.4 AUTISM

Autism is a pervasive developmental disorder manifesting before three years of age and characterized by deficits in social interaction, communication abilities, and behavioural functioning (American Psychiatric Association, 1994). This disorder is characterized by severe, pervasive behavioral deficits and bizarre behavioral patterns for example, qualitative impairments in social interaction and communication, as well as behavior, interests, and activities that are unusually restrictive and repetitive (American Psychological Association, 1994; Schriebman, 1998; Zwaigenbaum et al. 2009). This disorder has the intense lifelong effects not only on the diagnosed individual but also on his or her family (Dyches, Wilder, Sudweeks, Obiakor, & Algozzine, 2004).

History of Autism

Autism derived from Greek word ‘autos’ which means ‘within the self’ or ‘self’. The term was initially coined in 1911 by Swiss psychiatrist, Eugen Bleuler and later used by Leo Kanner in the late 1939’s to describe the behaviour of a group of 11 children at John Hopkins Hospital in Baltimore, Maryland. Kanner (1943) observed that children with autism are self-satisfied, they does not observe the fact that anyone comes or goes, and never seems glad to see father or mother or any playmate. They seem almost to draw into their shell and live within themselves.

Additional behavioural observations noted by Kanner (1943) included an anxious and obsessive desire for sameness, excellent rote memory, a hypersensitivity to stimuli, and limitations in the variety of spontaneous activity. Some of the children
with autism may have mild to severe speech deficits that further impaired their ability to interact with others in the environment. Such children are presented with ‘odd’ social tendencies and demonstrated an uncanny desire to engage in isolated play behaviours (Mesibov et al. 2000).

Kanner (1943) noted the lack of connectedness between the child and mother that was not only limited to the child’s deficits, but may also be related to the mother’s lack of responsiveness to the child (Allen, & Mendelson, 2000). After this the medical community attributed the blame of autism to the lack of availability and emotional responsiveness from mothers (Mesibov et al. 2000; Szatmari, 2003).

In 1960’s a child psychologist, Bernard Rimland challenged the “refrigerator theory”. In his book, ‘Infantile Autism’ Rimland proposed that biological causes are more important in the development of autism, thus it is a biological disorder and not an emotional illness (Rimland, 2000). McBride, Anderson and Hertzig, (1998) found that biological deficits such as non-specific raised blood serotonin are also responsible for the development of autism. However, new studies reported that the main cause of autism is related to genetic factors (Haq & LeCouteur, 2004; Szatmari, 2003; Reichenberg, Smith, Schmeidler, & Silverman, 2007).

**Diagnosis**

Children with autism are typically diagnosed during the preschool years. Children with autism have problems in social interaction and understanding, verbal and non-verbal communication and inflexibility of thinking and behaviours, including problems with imagination (Whitaker, 2005). The problems faced by each child with
regards to these three aspects can vary greatly. The diagnosis of autism requires that
the characteristic symptoms be present prior to the age of three, although this is not
the case for Asperger's Disorder or PDD-NOS (American Psychiatric Association,
1994). According to DSM-IV, all three characteristics or behaviours, often referred as
the ‘triad of impairments’, must be present for the diagnosis of Autistic Spectrum
Disorder. Criterions stated in fourth edition of Diagnostic Statistical Manual (DSM-
IV) are used for the diagnosis of Autism (Frith, 2003).

There is a current debate over early diagnosis of autism (Matson, Nebel-
Schwalm, & Matson, 2007). Traditionally it was thought that the diagnosis of autism
was clinically possible only at around 6 to 10 years of age and it was not possible to
diagnose autism before one year of age (Gillberg, Nordin, & Ehlers, 1996). However,
early diagnosis is important for successful interventions and treatments for autism.

Prevalence

Earlier autism was thought to be a rare disorder. However, recent prevalence
estimates indicated that autism spectrum disorders may be as high as five to six per
1000 (Bryson and Smith, 1998). Over the past decade, there has been an increase in
the number of children diagnosed with an autism spectrum disorder. According to the
California Health and Human Services Agency (2004), the number of children
diagnosed with autism has increased by an alarming rate of 634% since 1987. Autism
spectrum disorder is now considered to be the second most common developmental
disability affecting children in the United States (Newschaffer et al. 2007). According
to the Center for Disease Control and Prevention (2004), 1 out of every 110 children
in the United States meets criteria for an autism spectrum disorder. It is estimated that such figures will continue to rise by at least 10% to 17% each year, reaching elevations of 4 million individuals by the year 2015 (Autism Society of America, 2010).

Autism occurs in three to four times more prevalent in males than females (Bryson and Smith, 1998). Approximately 75% to 80% of individuals with autism also have mental retardation as a co-morbid condition when tested on formal intelligence measures (Haq & LeCouteur, 2004; World Health Organization, 1993). Approximately 30% of individuals with autism develop seizures by early adolescence (Bryson and Smith, 1998).

Researchers have noted that 50% of individuals with autism never achieve ‘useful speech’ (Haq, & LeCouteur, 2004). Other researchers found that children and adults with autism have difficulties in understanding what other people are thinking (Haq & LeCouteur, 2004; Yirmiya, Erel, Shaked, & Solomonica-Levi, 1998). Few studies reported that children with autism may have attachment problems (Van Ijzendoorn, Rutgers, Bakermans-Kranenburg, Van Dallen, Dietz, Swinkells, Naber & Van-Engeland, 2007). However, Rutgers et al. (2004) found that children with autism do show attachment; although it is less secure when compared with other children and parents of autistic children are equally sensitive as parents of non-autistic children.

Children with autism have deficits in adaptive behavior e.g. getting dressed, taking public transit (Bishop, Richler, Cain, Lord, & Floyd, 2007; Tomanik, Harris, & Hawkins, 2004). Researchers had found that challenging behavior such as self-injury,
aggression, and non-compliance (Matson, Nebel-Schwalm, & Matson, 2007) are much more prevalent in children with autism (Whitaker, 2005). Other researchers had also found problems such as obsessive compulsive disorder (OCD), social anxiety, attention deficit hyperactivity disorder, and depression among individuals with autism (Folstein, 2006; Haq & LeCouteur, 2004). The presence of these challenging behaviours makes autism different from other developmental behaviours (Sigafoos, Arthur, & O’Reilly, 2003). These conditions can cause isolation for families (Woodgate, Ateah, and Secco, 2008).

Although behavioral, educational, and pharmacological interventions can greatly improve the outcomes for individuals with autism, there is currently no cure. Ongoing research continues to identify biological markers and other genetic and neurological etiologies. As such, the lifelong emotional, social, and financial costs to individuals with autism and their families continue to accrue (Bristol, Mellvane, & Alexander, 1998). Due to this, parents of children with autism reported highest levels of stress in comparison to all other parenting groups (Elder, 2001).

1.2.5 MENTAL RETARDATION

The American Association on Mental Retardation (AAMR) defined mental retardation as a significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period, before the age of 18 (Drew, Logan, and Hardman, 1992; Kaplan, and Sadock, 1998; Luckasson et al. 1992).
The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defined mental retardation as a significantly sub-average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas, namely; communication, self-care, home-living, social/inter-personal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety (American Psychiatric Association, 1994).

Tenth revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) refers mental retardation as condition resulting from a failure of the mind to develop completely (World Health Organization, 1993; Kaplan and Sadock, 1998). According to ICD-10 mental retardation is a condition of arrested or incomplete development of the mind characterized by impaired developmental skills that contribute to the overall level of intelligence (Kaplan and Sadock, 1998). ICD-10 suggested that cognitive, language; motor, social and other adaptive behavior skills are affected by mental retardation and thus, should be used to determine the level of intellectual impairments.

Prevalence

The World Health Organization (WHO) reported that the overall prevalence of mental retardation is 1% to 3% (Berry, & Jones, 1995). According to the criterion stated in DSM-IV, 3% of the population has mild mental retardation, 0.4% has moderate mental retardation, and 0.1% has severe mental retardation. Epidemiological studies in India also indicated that 2% to 3% of children in India are suffering from
mental retardation (Kuppuswamy, 1968). According to Madhav (2001), the prevalence of mental retardation in India is 4.2 per 1000 population. Kumar et al. (2008) found that 2.3% in rural community of Karnataka had problem of mental retardation. Most people with mental retardation are diagnosed prior to or during the first years of school.

**Classification of Mental Retardation**

Four categories of mental retardation are given in fourth edition of Diagnostic and Statistical Manual of Mental Disorders based on intelligence quotients (IQ), namely, mild mental retardation (IQ 50-55 to approximately 70), moderate mental retardation (IQ level 35-40 to 50-55), severe mental retardation (IQ level 20-25 to 35-40) and profound mental retardation (IQ level below 20 or 25) (American Psychiatric Association (APA), 1994; Kaplan, and Sadock, 1998).

Kaplan and Sadock (1998) added that these levels of mental retardation reflect the degree of intellectual impairment. Individuals with mild mental retardation develop social and communication skills during the preschoolers (ages 0 to 5 years) and they are often not distinguishable from children without mental retardation a later age. They can acquire academic skills up to approximately the sixth-grade level. As adults they may need supervision, guidance, and assistance. They can usually live successfully in their community, either independently or in supervised settings (APA, 1994). Individuals with moderate mental retardation acquire communication skills during early childhood. They profit from vocational training and with moderate supervision. They are unlikely to progress beyond the second grade level in academic
subjects. As adults they are able to perform unskilled and semi-skilled work under supervision in sheltered workshops or the general workforce (APA, 1994).

Individuals with severe mental retardation acquire little or no communicative speech. During the school age period they may learn to talk and can be trained in self skills. However, they are limited in terms of instruction in pre-academic subjects, such learning the alphabet and simple counting. As adults they are able to perform simple tasks in closely revised settings (APA, 1994). Individuals with profound mental retardation have an identified neurological condition that counts for their mental retardation. They display considerable impairments in sensory motor functioning during their early childhood years. Motor development and self-care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings (APA, 1994).

**Etiology**

The etiology of mental retardation can be categorized into genetic, physical, and cultural-familial or multi-factorial causes and the resultant syndromes or conditions that arise from these causes. Genetic causes account for only about 8% to 12% of the population with mental retardation. Heredity plays an obvious part since the chance for retardation is greater for children born into families with parents who are significantly intellectually limited. There are several trisomies associated with Down Syndrome, Trisomy 21 is the most common. This most widely known of the genetic syndromes affects both males and females, is characterized by the presence of an extra chromosome and accounts for ten to twenty percent of the individuals with
moderate and severe mental retardation and approximately five percent of all persons with mental retardation.

Specific defective genes include congenital ectodermoses such as tuberous sclerosis; metabolic storage disorders or inborn errors of metabolism such as galactosemia and phenylketonuria (PKU), the former a carbohydrate disorder and the latter a well known protein disorder; disorders of endocrine function; and familial cranial anomalies such as familial microcephaly.

Some prenatal factors that can cause mental retardation includes maternal malnutrition, acute maternal infections like Rubella, chronic maternal infections like Syphilis, maternal sensitization like Rh factor, maternal dysfunction for e.g., hypertension, diabetes, anoxia, radiation, and drugs including alcohol. Some conditions during the neonatal state for e.g., prematurity, apnea or asphyxia, birth injury can lead to mental retardation. Postnatal causes of mental retardation includes traumatic head injury, brain tumors, infections (e.g. meningitis), toxins (e.g. lead). Some forms of cretinism, microcephaly and hydrocephaly can also result from brain damage.

For the remaining eighty percent of the population with mental retardation, mental retardation is caused by cultural/familial, multifactorial, psychosocial, or unknown factors. The environmental factors include cultural, familial or sub-group attitudes, indifferent maternal care, parental rejection, sensory deprivation and institutionalization. However, environmental factor cause mild to moderate level of retardation.
1.3 PRESENT STUDY

1.3.1 STATEMENT OF THE PROBLEM

To compare stress, coping mechanism and psychological well-being among parents of children with autism, mental retardation and normal children.

1.3.2 SIGNIFICANCE OF THE PRESENT STUDY

In Western countries, the population of parents of children with physical and psychological disabilities including mental retardation and autism was subjected to the research. However, much of these researches conducted on stress and coping mechanism among parents of children with mental retardation and autism heavily relied upon maternal reports (Kramer, 1997). In many of these studies fathers or male caregivers were excluded because they less commonly occupy this role (Phares, 1996). Few studies have investigated the reactions of fathers to the birth of children with special needs (Hornby, 1994). The majority have reported mothers' responses or mothers' perception of fathers' reactions, feelings and needs (Herbert, 1995).

Thus, there is a large gap in our understanding of the coping strategies of parents, and particularly of fathers, following the birth of a child with special needs. Fathers were largely ignored by health professionals and supporting agencies. Indeed no attempt was made to gauge paternal reactions. The present study is an attempt to fill this gap. Thus, the researcher included both father and mother of children with mental retardation and autism in this research. It was assumed that inclusion of both parents will make the results of this study more comprehensive compared to earlier
studies. The understanding of these gender differences and possible causes may help in understanding gender specific reactions and emotions.

Further, most of the study on the population of parents of children with mental retardation and autism focused only on negative aspects like parenting stress. However, in present research an attempt was made to include positive aspects such as psychological well-being. The concept of psychological well-being is new in the literature about the parents of children with autism.

The previous literature of stress revealed that different stressors cause different degree of stress in an individual. Thus, the researcher not only wants to study the impact of having disable child (child with mental retardation or autism) on parents but also want to compare parents of children with different disabilities (mental retardation or autism) on various dimensions like stress, coping and psychological well-being.

Further, it was observed that, in India, parents of children with mental retardation and autism are very much neglected population. There is paucity of research on disability such as mental retardation and autism and its impact on sufferers; their parents and family at large. In addition, this study will also help in understanding the extent to which the findings reported in Western countries on stress, coping and psychological well-being among parents of children with mental retardation and autism can be generalized to parents in India.

The researcher believes that this study will increase awareness about various psychological disabilities like mental retardation, autism, etc. in Indian society. Further, it was assumed that the findings of this study will not only help the
professionals in the field of special education and rehabilitation to understand the parents of disabled children in much better way but also to deal with them more effectively. The finding of this study will also contribute to the development of effective clinical interventions with parents.

1.3.3 OBJECTIVES OF THE STUDY

1) To find out the differences in terms of Stress, Coping and Psychological well-being among parents of children with Autism, Mental Retardation and Normal children.

2) To find out the gender differences in terms of Stress for parents of children with Autism, Mental Retardation and Normal children.

3) To find out the gender differences in terms of Coping Mechanism for parents of children with Autism, Mental Retardation and Normal children.

4) To find out the gender differences in terms of Psychological well-being for parents of children with Autism, Mental Retardation and Normal children.

1.4 SUMMARY

The concepts used in the study namely, stress, coping, psychological well-being, autism, and mental retardation were presented in this chapter. This study aimed at investigating group wise and gender wise differences among children with autism, mental retardation and normal children on stress, coping, and psychological well-being. The relevant objectives were also stated briefly and the significance of this study was discussed in the chapter.