CHAPTER - 5

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Mental retardation is one of the most difficult conditions to define. Since, many a times the person affected may not have a conspicuous symptom. Hence, they are identified and/or diagnosed incorrectly. Historically, the affected persons have experienced varied treatment ranging from abandoning them (in early years) to providing them equal opportunities (currently) like typically developing individuals. The mental retardation has been termed as feeble mindedness amentia and sub normality. Generally the term mental retardation refers to weakness or deficiency in mental power. People with below average intelligence who are incapable of managing their lives at their own are included in this category.

AAMR (1992) has defined the term as "mental retardation refers to substantial limitation in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitation in two or more of the following applicable adaptive skill areas. Self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, mental retardation manifests before age 18".

PWD Act 1995

According to the "person with disability (equal opportunity, protection of rights and full participation) act 1995". Mental retardation means a "condition of arrested or incomplete development of mind of a person which is specially characterized by sub-normality of intelligence".

Generally significantly sub average intelligence is determined by intelligence tests using intelligence quotient (IQ). Based on the IQ score obtained by a person, he/she is classified as having certain degree of mental retardation, the classification includes, borderline intelligence (not retarded) mild mental retardation, moderate mental retardation, severe mental
retardation and profound mental retardation. The lower the IQ the more is the
degree of retardation.

There are several causatives factor, which are responsible for mental
retardation. These factors, effect the fetus at conception, before conception,
such as age of the mother health of the mother and/or chromosomal, and
genetic disorders some social and psychological factor also influence mental
retardation. In this personal factors include relative infertility, repeated
abortion, conception after many years of marriage, large family, lack of
family planning, illegitimate unwanted child in child related factor, severe
congenital abnormalities, feeding problems and in parents related factors,
very young or very old parents, mental illness, addictions, single parents
(divorce, separation, bereavement, marital disharmony, poor personal
relationship with family poor family support are important cause of mental
retardation.

The prevalence of mental retardation in India and abroad is 2% general
population. So it is wide spread problem.

It has been observed that due to low level of functioning of child,
certain psychological problems arise in parents. Parent's primary complains
about inappropriate social behaviour, poor communication abilities and
dependence in self care of their child. Parents feel awkward when children do
not have age appropriate social, behavior and communication abilities. They
are unable to communicate effectively others. So, parents are always insecure
about their children.

Murray and Cornell (1991) gave the term "parentalplegia" to focus on
the secondary parental problems caused by children's primary handicapping
condition. Specific care studies of a mental sub-normality and 2 cerebral
palsied children are used to illustrate how parents behaviour is often clearly
modified as a result of their child conditions with misinformation and
distortion of thought serving as precursors and parentalplagia.
Goodman (1978) also studied the feeling, attitude, view problems and practices of parents of mentally sub-normal adults.

The pioneering research by certain psychologist revealed that family members experience significant stress in raising their children with mental retardation. The stress resource coping paradigm has commonly been presented as a working model for understanding parents with disabled children.

Within the stress resource coping paradigm, different researchers have concentrated on the effort on identifying a variety of factors that might increase or decrease parental stress and as defining meaningful interrelations to explain their coping. This model recalls that families with children who have disabilities are not basically different from other families yet they can be expected to face increased amount of stress, to experience greater demands on their personal and families resources and to respond with more avoidance and less active coping mechanism.

Some aspects of parental stress were found to be more specifically associated with children and characteristics (e.g. clinical category, severity of handicapping condition, presence of additional behaviour and health problems) and with the availability of family resources such a community support system.

So parents of mentally sub-normal children especially mothers feel more stress than the parents of normal children. It is also obvious that the personality traits of the parents of disabled children also contribute. Significantly to the level of stress among them infect this issue is widely researched in western countries, but has got only minimum attention of Indian social scientists. Keeping this point in mind, the present study was undertaken to study personality factors as a variable to stress and coping style of the parents of mentally sub-normal children.

Finally the present study was aimed to achieve the following objectives:
1. To study the personality traits of mentally sub-normal as well as normal children.

2. To study the high and the low scorer on different factors of personality in terms of their stress scores.

3. To study the high and the low scorer on different factors of personality in terms of their coping style.

On the basis of previous research findings, personal experience as well as expert opinions, the following hypotheses were formulated for empirical testing in the present study.

1. The parents of mentally sub-normal as well as of normal subject will differ significantly in terms of their scores on:
   - Reserved vs. Outgoing
   - Low intelligence vs. High intelligence
   - Lower ego strength vs. Higher ego strength
   - Submissiveness vs. Dominance
   - Desurgency vs. Surgency
   - Weaker super ego strength vs. Stronger super ego strength
   - Shy, timid, threat sensitive vs. Venturesome, uninhibited, socially bold
   - Tough-minded, self reliant vs. Tender-minded, sensitive clinging, overprotected
   - Trusting, accepting condition, vs. Suspicious, hard to fool
   - Practical ‘down to earth’ concerns vs. Imaginative, absent-minded
   - Artlessness vs. Shrewdness
   - Untroubled adequacy vs. Guilt proneness
   - Conservatism of temperament vs. Radicalism
   - Group adherence vs. Self-sufficiency.
• Low self-sentiment integration vs. High strength of self-sentiment
• Low ergic tension vs. High ergic tension, Trait of personality.

2. The high and the low scorer on Factor-A will differ significantly in terms of their score on stress scale.
3. The high and the low scorer on Factor-B will differ significantly in terms of their score on stress scale.
4. The high and the low scorer on Factor-C will differ significantly in terms of their score on stress scale.
5. The high and the low scorer on Factor-E will differ significantly in terms of their score on stress scale.
6. The high and the low scorer on Factor-F will differ significantly in terms of their score on stress scale.
7. The high and the low scorer on Factor-G will differ significantly in terms of their score on stress scale.
8. The high and the low scorer on Factor-H will differ significantly in terms of their score on stress scale.
9. The high and the low scorer on Factor-I will differ significantly in terms of their score on stress scale.
10. The high and the low scorer on Factor-L will differ significantly in terms of their score on stress scale.
11. The high and the low scorer on Factor-M will differ significantly in terms of their score on stress scale.
12. The high and the low scorer on Factor-N will differ significantly in terms of their score on stress scale.
13. The high and the low scorer on Factor-O will differ significantly in terms of their score on stress scale.
14. The high and the low scorer on Factor-Q1 will differ significantly in terms of their score stress scale.
15. The high and the low scorer on Factor-Q2 will differ significantly in terms of their score on stress scale.
16. The high and the low scorer on Factor-Q3 will differ significantly in terms of their score on the stress scale.

17. The high and the low scorer on Factor-Q4 will differ significantly in terms of their score on the stress scale.

18. The high and the low scorer on Factor-A will differ significantly in terms of their coping style.

19. The high and the low scorer on Factor-B will differ significantly in terms of their coping style.

20. The high and the low scorer on Factor-C will differ significantly in terms of their coping style.

21. The high and the low scorer on Factor-E will differ significantly in terms of their coping style.

22. The high and the low scorer on Factor-F will differ significantly in terms of their coping style.

23. The high and the low scorer on Factor-G will differ significantly in terms of their coping style.

24. The high and the low scorer on Factor-H will differ significantly in terms of their coping style.

25. The high and the low scorer on Factor-I will differ significantly in terms of their coping style.

26. The high and the low scorer on Factor-L will differ significantly in terms of their coping style.

27. The high and low scorer on Factor-M will differ significantly in terms of their coping style.

28. The high and low scorer on Factor-N will differ significantly in terms of their coping style.

29. The high and low scorer on Factor-O will differ significantly in terms of their coping style.

30. The high and low scorer on Factor-Q will differ significantly in terms of their coping style.
31. The high and low scorer on Factor – Q2 will differ significantly in terms of their coping style.

32. The high and low scorer on Factor – Q3 will differ significantly in terms of their coping style.

33. The high and low scorer on Factor – Q4 will differ significantly in terms of their coping style.

The study has been made on 300 parents of whom (150) were parents of mentally sub-normal children and (150) were parents of normal children. 16 Personality Factor Scale and Stress and Coping Style Scale with a Personal Data Schedule have been administered on the sampled subjects individually.

The finding were as follows

1. Out of 16 personality factors, 6 factors namely factor, C, E, H, M, O and Q3 were found to be significant in differentiating between the parents of normal as well as mentally sub-normal children.

2. Personality factors namely, factor A, B, F, G, I, N, Q, Q2 and Q4 were found to be insignificant in differentiating between the two groups.

3. Out of 16 personality factors 7 factors namely factor A, B, E, F, H, O and Q4 were found to be significant in contributing to stress level of the respondents. However a majority of personality factors like factor C, G, I, L, M, N, Q, Q2 and Q3 were found to be insignificant in corroborating the stress level of the subject.

4. Personality factors were found to be more significant in effecting coping style namely confront and complain. Acceptance and more even avoidance coping style were found to be free from the impact of personality factors. As discussed earlier personality factors like factor A, C, E, F, G, I, L and O were found to be significant in contributing significantly to the confront coping style. Similarly personality factors A, B, C, F, G, H, I, M, N, O, Q2, Q3 and Q4 were found to be significant to contribute significantly to the complain coping style.
Only personality factors like E, I and Q; were found to contribute significantly to the acceptance and the personality factors like G and Q; to the avoidance coping style.

The following general conclusion can be drawn from the present study.

1. The parents of mentally sub-normal children having more personality traits like affected by feeling, emotionally less stable, easily upset, lower ego strength, submissiveness, shy, restrained, conventional careful, apprehensive, worrying, depressive, troubled, guilt prone undisciplined, self conflict and careless of protocol, in comparison to the parents of normal children.

2. The parents of sub-normal children with reserved, detached and critical personality traits having more stresses.

3. The parents of sub-normal children with less intelligence and concrete thinking, having more stresses.

4. The parents of sub-normal children with assertive, independent, aggressive personality traits having high stresses.

5. The parents of sub-normal children with happy go lucky and enthuistic personality traits having more stresses.

6. The parents of sub-normal children with ventursome, socially bold and spontaneous personality traits having more stresses.

7. The parents of sub-normal children with apprehensive, worrying, depressive and troubled personality traits having more stresses.

8. The parents of sub-normal children with tense frustrated and overwrought personality traits having more stresses.

9. Personality traits contribute significantly more to confront and complain coping style.

10. The parents of sub-normal children with reserved, detected, critical, personality traits use confront and complain coping styles.
11. The parents of sub-normal children with less intelligent, concrete thinking, personality traits use complain coping styles.

12. The parents of sub-normal children with affected by feelings, emotionally less stable, easily upset, personality traits use confront and complain coping styles.

13. The parents of sub-normal children with humble, mile, accommodating, conforming personality traits use confront and acceptance coping styles.

14. The parents of sub-normal children with sober, prudent, serious, taciturn, personality traits use confront and complain coping styles.

15. The parents of sub-normal children with expedient evident rules, feels few obligations, personality traits use confront and complain coping styles.

16. The parents of sub-normal children with shy, restrained, diffident, timid personality traits use complains coping styles.

17. The parents of sub normal children with tough minded, self reliant, realistic, personality traits use confront, acceptance and complain coping styles.

18. The parents of sub-normal children with suspicious, self opinionated, hard to food personality traits use confront coping style.

19. The parents of sub-normal children with practical, careful, conventional, regulated by external realities personality traits use complain coping style.

20. The parents of sub-normal children with forthright, natural, artless, sentimental, personality traits use complains coping styles.

21. The parents of sub-normal children with placid, self-assured and confident, serene personality traits use confront coping style.
22. The parents of sub-normal children with conservative, respecting, established ideas, tolerant of traditional difficulties personality traits use avoidance and acceptance coping styles.

23. The parents of sub-normal children with group dependent, A 'joiner' and sound follower, personality traits use complain coping style.

24. The parents of sub-normal children with undisciplined, self-conflict, careless of protocol, personality traits use complain coping style.

25. The parents with relaxed, tranquil, torpid, not frustrated personality traits use complain coping styles.

The present study, in spite of encouraging and expected findings has limited focus. It is based on 300 parents of mentally sub-normal as well as of normal children. Several limitations to this study can be identified. First the participant pool developed was based on specific criteria, the sample size was small, and generalisation may be limited. The participants were not equivalent on all demographic variables such as education level, family income, and number of children in the home, making generalisation even more of a challenge. Similar study needs to be carried out in rural, semi-urban and urban settings covering relevant variables. It may also be pointed out that variables as covered in the present investigation are not exhaustive. Some attempt should be made to know the role of SES, education, values, temperament and some modern cultural and technical developments in the growth of stress level among the parents of sub-normal children. Equal number of children from various categories could not be selected due to heterogenous population and non availability of subjects. In spite of certain limitation of the present study it may used as a guideline for future researches in this area.