REVIEW OF LITERATURE

The birth of any child can have a profound impact on the family. The addition of a new family member can cause a disruption to the existing routine as well as present strain on the family’s financial and other support systems. Parents who experience the birth of a child with a handicap generally encounter greater levels of stress than do families with children who don’t have handicaps (Scott, Sexton, and Wood, 1986).

Parenting a child with mental retardation is not an easy job (Peshwaria, 1992). They parents are known to get impacted in many ways because of having a child with mental retardation. These include, parents feeling sad, depressed at various stages of child’s life and experiencing other emotional reactions. Their social life may get affected with recreational and leisure activities getting reduced. Interpersonal relationships with the family members, friends and others also get affected. Marital harmony gets disturbed owing to various child-related reasons such as meeting extra-child care, responsibilities and burden. Financial burdens may mount. Parents’ own physical and mental health is reported to be at a greater risk. However, the quality and quantity of the impact experienced may be quite individualized for each of the parents depending upon the nature of support available to them.

Occasionally parents are confronted with the problem whether to go in for a second child and if so what are the chances that the second child will also have mental retardation. With the child having mental retardation continue to remain at home, the socialization of the family gets restricted. In view of the above, the families are definitely under stress and the social scientists and educators have important role to help families cope up with the situation. Parents having a child with mental retardation experience a variety of stressors and stress reactions related to child’s disability (Orr et al., 1993).
The quality of relatedness of the mentally handicapped child to other persons is a function of both the degree of retardation and the extent of acceptance by parents and siblings. Retardation makes the child appear immature; at a given age, the retarded child’s overall level of functioning will be far below that of his/her age group. The immaturity, which is built into retardation, affects the child’s ability to relate to others. Without the assistance of adults the child’s immaturity is likely to lead to his/her social isolation by other children and foster dependency on the parents long after other children have begun to develop meaningful peer relationships.

Family acceptance also affects the quality of the child’s inter-personal relationships. The child’s early affectionate experiences with parents and siblings shape his/her attitude towards himself/herself (self-concept) and others, which determine his/her general responsiveness to people, and to task situations. Where the parent or family-child interactions is positive and the child feels wanted and loved, a sense of trust and confidence develops which fosters an attitude of openness and approach to new people and experiences. On the other hand, if a child has not experienced covert (if not overt) rejection, his/her unconditional need for love and for persons on whom he/she can depend is frustrated and the child becomes fearful and antagonistic. In this case people become a potential source of discomfort rather than pleasure, and the child adopts a behavioral style which is predominantly avoidance-oriented.

DEFINITIONS OF STRESS

Mc Cubbin and Patterson (1983) has defined family stress as a state that arises from an actual or perceived demand which is characterized by a multi-dimensional demand for adjustment or adaptive behavior. Stress, is therefore, not stereotypic but rather varies depending upon the nature of the situation, the characteristics and its previous soundness. The degree of retardation influences the abilities of the developmentally delayed child to progress along the various
stages of growth towards maturity and to adjust to the hassles or tasks of daily life.

Boss (1988) described family stress as pressure on the family. It is a disturbance of the family’s steady state, i.e., the family system is upset, pressured and disturbed and not at rest. Family stress therefore, is a change in the family’s equilibrium. The author further explained that the family stress need not always be bad and it becomes problematic only when the degree of stress in the family system reaches a level at which family members become dissatisfied or show symptoms of disturbance.

Stress is the pattern of psychological and physiological reactions to demands in the environment that threaten us to devote a great deal of our resources to coping with danger and defending ourselves (Mohan, 2001). It is the non-specific response of our body to any demand. It has very definite effects on physical well-being, psychological adjustment, interpersonal relations, and professional effectiveness. It can be measured in terms of economic/financial loss, breakdown of relationships and above all personal distress. Overall it leads to negative effects and is related to speed of life, philosophy of life, modernization, and psycho-ecological attributes of the individual.

Family stress may result in lowered performance in the family’s usual routines and tasks; and the occurrence of physical or emotional symptoms in individual family members. These symptoms signal danger when the level of stress on family’s structures increases.

While trying to understand family stress it is necessary to keep in mind that family stress does not have to end in trouble. In highly stressed but functional families there is flexibility in family rules, roles and problem solving skills. The family members must be able to change constantly to adapt to the situation at hand and there must be a continuous negotiation between family’s pressures and supports. Such flexible family systems can withstand a lot of pressure.
Parenting itself can be generally a stressful life event, (Giband, Wallston and Wandersman, 1978) and the manifestation of major and child problems may be the most significant of stress across a range of unpleasant parental effects (Weinberg and Richardson, 1981). Mothers of children exhibiting hyperactivity, conduct disorders and other types of handicapping conditions such as cerebral palsy and developmental delay, participate in transactions with their children that are more stressful, or less rewarding and provide considerably less positive feedback than in case for mothers of normal children (Barkley, 1981; Patterson, 1976, 1980).

THEORIES OF STRESS

Some of the common theories of stress are Stimulus oriented theories, Response oriented theories and Interactional theories.

Stimulus Oriented Theories

According to this approach, those aspects of the environment that increase demands upon or disorganize the individual impose stress upon him. Each individual has an innate capacity to withstand environmental stressors. When the cumulative stress experienced is greater than the individual’s tolerance he/she undergoes deterioration in function.

Certain stimulus-based theorists (e.g. Elliot and Eisdorfer, 1982) distinguish among different classes of stimulus stressors and their relative capacities to induce stress. These are acute, intermittent stressors and chronic stressors.

Kanner et al. (1981) devised a hassles scale consisting of everyday events that cause annoyance or frustration, and an uplifts scale consisting of events that make them feel good.
Response Oriented Theories

The response of the individual or organism to the event of the environment defines the presence of stress. Since any catalogue of potential stressors is endless and individuals differ greatly as to what they find stressful, an alternative is to seek to identify a characteristic stress response, which occurs whatever the nature of the stressor. This could theoretically include physiological, psychological and behavioral consequences of stress, although in practice researchers have tended to concentrate on physiological effects, especially those, which may be associated with the development of physical illness. Alarm reaction was the name suggested for the initial response. After continued exposure of the organism to any noxious agent capable of eliciting this reaction, a stage of adaptation or resistance ensures. In other words, alarm reaction is necessarily followed by the stage of resistance. After still more exposure to the noxious agent, the acquired adaptation is lost. Then comes the stage of exhaustion, which inexorably (unstoppable) follow as long as the demand is severe enough and applied for a sufficient length of time. After exhaustion from excessively stressful activity, sleep and rest can restore resistance and adaptability very close to previous levels, but complete restoration is probably impossible.

Interactional Theories

These theories emphasize the characteristics of the organism as major mediating mechanisms between the stimulus characteristics of the environment and the responses they evoke. According to this approach not only does the individual mediate the impact of environmental stimulus upon responses, but, in addition, the perceptual, cognitive, and physiological characteristics of the individual affect and become a significant component of the environment (Cox and Mackay, 1976; Lazarus, 1981).

Stresses are of two types viz. life event stressors and daily hassles.
Life Event Stressors

Life stress process consists of three main structural components (Dohrenwend and Dohrenwend, 1980). The first is the stimulus components of life events, ranging from extreme situations such as man-made or natural disasters to more usual events such as marriage, the birth of a child, divorce and job loss. The second component is ongoing social situation that includes individual’s occupational circumstances, domestic arrangements and arrangements and social network, which existed before the occurrence of life events. The third component consists of the personal characteristics or disposition of the individual exposed to the life event. It includes the individual’s genetic vulnerabilities, past experiences with episodes of physical illnesses and personality characteristics.

The relations how these components of the life stress process hold the strongest clues as to whether, to what extent, and how environmental stress induces adverse health changes. All these components require conceptual and methodological development. Life events is said to be the trigger component that set changes in other two components or their relations to each other in motion (Dohrenwend, 1979). Dohrenwend and Dohrenwend (1980) have extracted the most important objective stress-inducing properties of a life event:

- the event’s negative valence;
- it is fatefulness-(control over occurrence);
- the extent to which the event is life threatening;
- the magnitude of change in usual activities that is likely to be brought about for an average person experiencing the events; and
- whether the change is likely to be physically exhausting.

Meaning and subjective appraisal provide important information about the processes by which the objective components of life stress are related to one another in determining health outcomes.
Daily Hassles and Uplifts

Hassles are irritants—things that annoy or bother us, they can make one upset or angry whereas uplifts are events that make one feel good, joyful, glad or satisfied (Kanner et al., 1981). Daily hassles were defined as the “irritating, frustrating, distressing demands that to some degree characterize everyday transactions with the environment (Kanner et al., 1981).

Minor events or daily hassles and uplifts are those stressors which a person experiences in the process of his everyday life situation. They are different from major life events and tend to have different negative behavioral outcomes (Kanner et al., 1981). With regard to daily hassles, Lazarus and Delongis, 1983 have identified the stress-inducing potential of relatively mundane, chronic daily events. They have shown that daily hassles not only parallel major life events in their potential to endanger stress, but have an even stronger relationship than traditional life events measures in predicting physical health status (Delongis et al., 1982; Kanner et al., 1981).

Hassles are the minor negative events while uplifts are positive events (Stone et al., 1987). Hassles and uplifts are related to the health of an individual. The influence of stress may be more apparent if it is linked in time with the health outcome investigated and therefore the best measure for illness research is likely to be minor events (Swartz, 1991). Monroe (1983) also found that hassles were significantly related to psychological symptoms than the life events.

Researchers have also implicitly assumed that all minor events are equivalent, summing them into an overall measure of everyday stress for analytic purpose (Bolger et al., 1989). Stone et al., (1987) found that increase in the frequency of hassles and decrease in the uplifts predict illness onset. Gannon and Pardie (1989) found that number of everyday stresses experienced was significantly correlated with depressive symptom levels. Evans et al., (1989) and Evans and Edgerton (1991) obtained significant effects only for decreases in
uplifts may be primary importance when considering the effects of minor events on illness. Delongis et al., (1982) found the daily hassles to be more strongly associated with somatic health.

Hassles are experiences and conditions of daily living appraised as silent and harmful or threatening to well-being (Lazarus, 1984).

The following are some of the studies on family stress with a mentally handicapped child.

Families with a child who has developmental delays experience a variety of stressors and stress reactions related to the child’s handicap. Two major sources of stress emanating from the child include behavior problems and number of handicapping conditions (e.g., Cameron & Orr, 1989; Quine & Pahl, 1985). In addition, Beckman (1983) reported that the child characteristics of responsiveness, temperament, repetitive behavior patterns, and need for greater care increased stress in parents of infants with handicaps whose mean age was 21.6 months.

Parenting is an enduring commitment that continues even after the child has become an adult (Lancaster, Altmann, Rossi, and Sherrod, 1987). This durable role may assume the attributes of a “career” – namely, the acquisition of specialized skills, the development of competence and particularized knowledge, and an ability to contextualize routine and acute events within a larger time frame (Aneshensel, Pearlin, Mullin, Zarit, & Whitlach, 1995; Pearlin, 1992).

Although mental retardation is an “event” that effects one member of the family, such events have ripple effects on all family members (Pruchno, Peters, and Burant, 1996). These effects are manifested on the levels of both family functioning and individual well-being. These secondary effects differ between mothers and fathers (Krauss, 1993; Noh, Dumas, Wolf, and Fisman, 1989), among siblings (Krauss, Seltzer, Gordon, and Friedman, 1996; Seltzer, Begun, Seltzer, and Krauss, 1991), and among the social service systems that assist

In a study of older children (mean age 83 months), Frey, Greenberg, and Fewell (1989) found that sex of child (boys) and low levels of child communication both increased parental stress. Some of the parent stress reactions studied by researchers include chronic sorrow (Blacher, 1984; Olshansky, 1962; Wikler, 1986), social isolation (Mc Andrew, 1976; Roos, 1977; Wikler, 1981), low self-esteem as a parent (Cummings, Bayley & Rie, 1966), depression (Bristol, 1987), and marital problems (Bristol, 1987; Mc Andrew, 1976). Although the passage of time will likely mitigate the effects of some stressors and make responses to them more routine, it is also likely that the changing nature of the child and the increasing expectations associated with growing older would generally increase the magnitude of stress that parents experience.

Moudgil et al., (1985) had undertaken an investigation to understand the quantum of stress on the parents of mentally retarded children. Three aspects, namely, what social and emotional support systems they adopt to cope with the stress. How the interpersonal relations of the parents are affected and how the social image of the family is affected in the community because of the retarded child were studied. A Semi structured Interview Schedule (prepared to tap information regarding various stresses and problems of these unfortunate children) and the Measure of Emotional Support was administered to the eighteen pairs of parents of mentally retarded children.

It is found that because of the mentally retarded child in the family, parents feel depressed most of the time, worry about getting their children admitted to school, have to pay more attention to retarded child, and their marital harmony and relations with their family members are disturbed. The social-image of the parents is also affected. It was found that those parents who get maximum social and emotional support from spouse, family members, parents, relatives and
friends experience less stress and problems as compared to those parents who are not getting much social and emotional support. It was also found that the parents could not achieve more social and emotional problems.

Wilton and Renaut (1986) examined the family stress levels using the Questionnaire on Resources and Stress (QRS) in 42 New Zealand families with pre-school intellectually handicapped (moderately and severely retarded) children and 42 families with non-handicapped pre-school children. Maternal age was employed as a blocking factor (less than 30 years versus 30 years and above). The families with intellectually handicapped children showed significantly higher stress levels on 13 of the 15 QRS scales, but maternal age did not appear to be implicated in family stress levels. The results suggested that stress levels are somewhat elevated in families with intellectually handicapped children. The implications of these findings for family intervention and support programs are considered, together with the need for research onto the various ecological contexts of the individual, family, peer group and social institutions.

Donovan (1988) investigated the mothers’ perceptions of family stress and ways of coping with adolescents who were autistic or had mental retardation. Sample comprised of thirty-six (36) mothers from each group, Stress was measured with QRS Revised from (Friedrich, Greenberg and Crinc, 1983). The Locke Wallace Marital Adjustment Scale Short Form (Locke and Wallace, 1959) was used as the measure of the marital adjustment and an indirect measure of the extent to which child stress impacted on broader family functioning. The Coping Health Inventory for parents Form D (Mc Cubbin and Cauble, 1979) was used as the measure of parental coping. Results indicated group differences among maternal reports of family stress. All comparisons of child related stress revealed that mothers with an adolescent who was autistic perceived greater level of family stress than did mothers with an adolescent who had mental retardation. Marital adjustment did not differ by group. Further, maternal coping styles were consistent across groups, indicating that mothers with adolescents who had a
handicap relied heavily on community resources and professional help for coping. The findings suggested that when the demands associated with parenting adolescent with handicaps exceed the resources of the family, mothers choose to cope by actively seeking support, advice and help outside the family system.

Minnes (1988) studied the family resources and stress associated with having a mentally retarded child. Basing on the concepts drawn from family stress theory and current empirical information on families of handicapped children, the investigator analyzed the factors influencing parental adjustment to stress associated with such children living at home. Parental stress was measured with QRS-Short Form (Holroyd, 1982), Family Environment Scale (Moos and Moos, 1981) was used to measure internal family resources, Family Crisis-Orientation Personal Evaluation Scale (Mc Cubbin and Thompson, 1987) was used to measure external family resources and child and parent characteristics were noted with a checklist. Sixty (60) mothers filled up the above four questionnaires.

Results of multiple regression analysis indicated those child characteristics and the family’s crisis meeting resources were significant predictors of various forms of stress. Child characteristics and family crisis meeting resources did not emerge together as significant predictors of stress in all regression analysis and when they did emerge significant together the proportion of variance accounted for was not consistent in each case. The varying percentages of variance accounted for by individual predictors in this study highlight the complexity of the processes involved in stress management and coping.

Peshwaria and Menon (1992) were optimistic in saying that parents and families are no doubt the biggest strength in India at present, though there are difficulties encountered while working with the families of children with mental handicap. Among the difficulties observed are financial burdens with no support from anywhere, large size of the families, misconceptions in parents regarding the condition of mental handicap, parent reliance on magical medical cures, and transportation problems in reaching available services. Another problem parents
face in our cultural set up, where guests are welcome anytime at home the parents are not able to carry out the program at home due to this extra burden. Sometimes the over involvement and interference of neighbors and relatives, who suggest to parents methods of managing the child with mental handicap with other than systematic training leaves parents very confused. The problem of both the parents working with no extra support at home is posing a major challenge for parents of children with mental handicap and the service providers. Nevertheless, the strength of parents cannot be ignored and the fact that parents in India live and work for their children cannot be forgotten.

Orr et al., (1993) hypothesized that stress in families increases as a child with developmental delays grows older. Mothers with children ranging in age range from 2 to 18 years were assigned to a preschool, middle childhood, or adolescent group and asked to complete the Parenting Stress Index (PSI). Results indicated that Child Domain scores were high for all groups, but Parent Domain scores were within normal limits. The middle childhood group was consistently higher in both domains than either the younger or older groups. Degree of handicap was not associated with mothers’ stress in the preschool group, but was related to PSI scores for both other groups. Behavior problems were highly correlated with maternal stress for the middle childhood and adolescent groups.

WAYS OF COPING EXPERIENCED BY PARENTS OF MENTALLY RETARDED CHILDREN

Coping is described as either a subcategory of defense (Cohen and Lazarus, 1979) or a reaction that appears only in extremes (White, 1974). Coping was reported as a behavior that protects people from being psychologically harmed by problematic social experience (Pearlin and Schooler, 1978).

Dewe, et al., (1996) defined coping with a focus on stress. Coping may be defined in terms of the response to work or work-related encounters that tax individual abilities and resources. According to them, “Coping is defined as the
cognition’s and behaviors, adopted by the individual following the recognition of a stressful encounter, that are in some way designed to deal with that encounter or its consequences”.

Coping mechanisms include individual’s own attempt directly to alter the threatening condition and include the individual attempts to change their appraisal of stressors as less threatening and include the individuals attempts to regulate emotions of distress.

When stress crosses an optimum levels it losses its positive aspect and becomes ‘distress’. Such a stress does not maximize performance but decreases effectiveness. With the development of increasingly sophisticated models of stress and the influences of intervening variables, interest has increased in intervening variables, such as coping (Baum, 1990).

A number of different theoretical approaches have contributed to our understanding of coping concept. These include coping as psychoanalytical process, as a personal trait or style, as description of situational specific strategies (Cox and Ferguson, 1991).

Lazarus and Folkman (1984) describe coping to operate in two different ways.

- Problem focussed i.e. by changing the person environment relationship to decrease stress.
- Emotion focussed i.e. by changing only the way we intend to or interpret the stress.

Moos and Schaefer (1993) have proposed four basic types of coping process that is as follows:

(i) **Cognitive approach coping**: encompasses paying attention to one aspect of the situation at a time, drawing on past experiences, mentally repressing alternative actions and their probable consequences and accepting the reality of a situation but restricting it to find something favorable.
(ii) **Behavioral approach coping:** includes seeing guidance and support and taking concrete action to deal directly with a situation or its aftermath.

(iii) **Cognitive avoidance coping:** comprises response aimed at denying or minimizing the seriousness of a crisis or its consequences, as well as accepting a situation as it is and deciding that the basic circumstances cannot be altered.

(iv) **Behavioral avoidance coping:** covers seeking alternate rewards that is trying to replace the losses involved in certain crises by becoming involved in new activities and creating alternate sources of satisfaction.

Coping strategies refer to the efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies are efforts to do something active to alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events (Folkman and Lazarus, 1980). The predominance of one type of strategy over another is determined, in part, by the type (e.g., some people cope more actively than others) and also by the type of stressful event; for example, people typically employ problem-focused coping to deal with potential controllable problems such as work-related problems and family-related problems, whereas stressors perceived as less controllable, such as certain kinds of physical health problems, prompt more emotion-focused coping.

Coping has two main functions the regulation of emotions i.e. emotion focussed coping and the management of the problem that is causing the distress i.e. problem focussed coping. Both these above-mentioned functions are used in most stressful encounters and their relative proportion varies according to the severity of the encounter (Folkman and Lazarus, 1980).
An additional distinction that is often made in the coping literature is between active and avoidant coping strategies. Active coping strategies are either behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into activities (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events. Generally speaking, active coping strategies, whether behavioral or emotional, are thought to be better ways to deal with stressful events, and adverse responses to stressful life events (Holahan and Moos, 1987).

Pearlin and Schooler (1978) asked 230 people how they coped with problems across several aspects of their lives. No single coping mechanisms was effective at reducing stress in all situations, and “having a particular weapon (coping strategy) in one’s arsenal (was) less important than having a variety of weapons”. As a number of different coping strategies endorsed for any given aspect of life stress increased, reported stress in that area got decreased.

The presence of a child with mental retardation in the family calls for a lot of adjustment on the part of the parents and the family members (Peshawaria and Menon, 1991). Whether the family is able to meet the needs or not is dependent on number of factors like nature of the event, the family resources and its perception of the event. Unmet needs, tangible or intangible however create stress. Research has indicated that families who are successful in coping with having a child with mental retardation, are able to mobilize their internal and external means of support to deal effectively with the special needs of their child (Kirk and Gallagher, 1989).

Resources that act as facilitators of effective coping can be of two types: internal coping strategies (i.e. coping through passive appraisal, reframing, spiritual and religious support) and external coping strategies (i.e. coping through use of social support or formal support).
According to Turnbull and Turnbull (1990), the most common internal coping strategies used by parents of children with mental retardation include use of passive appraisal, reframing and spiritual support.

I) **Coping and Internal Resources**

(i) **Coping style:** A general propensity to deal with stressful events in a particular way.

(ii) **Avoidance vs. confrontation:** Some people cope with a threatening event by using an avoidant (minimizing) coping style whereas others use a confrontation (vigilant) coping style by gathering information or taking direct action.

(iii) **Disclosure:** Talking to others follows one to gain information about the events or about effective coping, it may also elicit positive reinforcement and emotional support from others.

(iv) **Problem-focused coping:** Attempts to do something constructive about the stressful conditions that are harming, threatening, or challenging an individual problem.

(v) **Emotion-focused coping:** Efforts to regulate emotions experienced because of stressful event, emotional focused coping skills develop some what in the later childhood or early adolescence.

(vi) **Eight coping strategies identified by Folkman and her colleagues.**

(a) **Confrontative coping:** Aggressive efforts to change the situation

(b) **Seeking social support:** Efforts to obtain emotional comfort and information from others.

(c) **Planful problem solving:** Deliberate problem focused efforts to solve the situation.

(d) **Self control:** Efforts to regulate one’s feeling
(e) Distancing: Efforts to detach oneself from stressful situation

(f) Positive reappraisal: Efforts to find positive meaning in the experience by focusing on personal growth

(\xi) Escape avoidance: Wishful thinking (I wished the situation would go away).

II) Coping and External Resources

Time, money, education, a decent job, children, family, and standard of living, the presence of positive life event, and the absence of other life stressors. Individuals with greater resource typically cope with stressful event better.

(a) Social support: Information from others that one is loved and cared for esteemed and valued, and part of a network communication and mutual obligations from parents, a spouse or lover, other relatives, friends, social and community contacts such as churches or dupes.

(b) Appraisal support: Helping the individual understand the stressor better and what resources and coping strategies may be mustered to cope with it.

(c) Tangible assistance: The provision of material support such as money, foods, or goods.

(d) Informational support: Providing information about a stressful event (e.g., recovery from surgery).

The presence of the retarded child represents a significant on-going stressor within the family, precipitating numerous minor and major crises. Subsequent familial response to each stress will involve the various coping resources available both to the individual and the family as a whole. The various ecological domains in which the family members interact mediate the coping resources available as well as how and when they are used.
Me Cubbin et al., (1980) defined family coping as the group’s management of a stressful event or situation by the family as a unit with no detrimental effects on any individual in the family.

Family coping according to Boss (1988) is the cognitive, effective and behavioral process by which individuals and the family system as a whole manage rather than eradicate stressful events or situations.

Rastogi (1981) conducted a study in detail about parental approach of retarded children. It was found that mothers were having negative attitude than their fathers. Fathers were hostile and aggressive. Families having mentally retarded children experience multiple problems and tend to withdraw from social activities. Rastogi also reports the presence of positive approach though overall parental approach was negative. Similar trend was reported by Ramgopal (1988). He found that some parents tend to accept and hence not aggressive or hostile towards their retarded children. In this study unfavorable parental approach was seen with regard to education and self-direction. Parents were guilty, and pessimistic about their retarded children. They were also overprotective.

Freidrich et al., (1985) used a multidimensional and longitudinal framework for studying coping resources and adjustments in families with a child who has mental retardation. A sample of one hundred and forty (140) mothers of mentally retarded children whose age ranged from 3 to 19 years were the respondents. It was hypothesized that four dimensions of coping resources; utilitarian, health/energy/morale, social support and belief systems as well as child characteristics would predict parenting outcome as measured by factor I Parent and Family problems of QRS-F. the focus in this study was the child characteristics which were divided into two variables; one, medical involvement which was closely associated with severity of the disability; the other, medical problems including both internalizing and externalizing behavior. Results of regression analysis indicated that three of the four categories of coping resources were significant contributors of additional variance beyond that of behavioral and
physical problems of the child. For validational purposes one hundred and four (104) mothers of the original sample were re-examined 10 months later. The original analysis was supported and changes in marital satisfaction were related to an increased in parent and family problems over the elapsed time. The data from this study clearly indicated the importance of a variety of sources in the coping process.

Goldberg et al., (1986) in a study of the effect of child’s handicap on fathers and mothers emphasizes the focus on father’s separately. Fathers reported fewer distress symptoms, higher self-esteem. More internal locus of control and less support than did mothers. Even mothers experienced stress caused by five factors relationships outside on family, anxiety over child’s present and future development, disagreement with the husband about the child, and obstacles to self actualization (Umeura and Nimmi, 1981).

Mohan et al., (1988) in a study on psychological correlates of parental attitude towards mentally retarded child revealed that the mothers of mentally retarded children differed significantly on the attitudes of uncertainty and rejection towards their retarded children as compared to mothers of normal children, whereas the fathers of mentally retarded children, besides differing on these two factors, also differed for responsibility and desurgency vs. surgency as compared to that of the normal children. The overall attitudes of the parents of the mentally retarded children towards their retarded children was found to be more moderately favorable as compared to that of the parents of normal children.

Friedrich et al, (1985) examined. Coping resources and parenting mentally retarded children. Four broad dimensions of coping resources (utilitarian resources, energy/morale, general and specific beliefs, and social support) were assessed with a sample of 140 mothers of mentally retarded children. The dimensions were related to a measure of the adequacy of parental coping, i.e., Questionnaire on Resources and Stress-Friedrich Factor 1, parent and Family Problems. Three of the four categories of coping resources were significant.
contributors in a regression analysis and contributed additional variance beyond
that of behavioral and physical problems of the child. For validation purposes, 104
of these mothers were reexamined 10 months later. The original analysis was
supported, and changes in marital satisfaction were related to an increase in parent
and family problems over the elapsed time span.

Indian parents report that the major things found most useful in coping up
with the situation of having a mentally retarded child include getting physical help
for looking after the mentally retarded child especially by the spouse/ husband or
grand parents. Other things found useful include acceptance of the mentally
retarded child especially by the paternal grand parents, financial help, early and
timely advice provided by the professionals and their empathetic attitude. Above
all, parents of mentally retarded children reported that having faith in god does
help to ease to their tension from time to time (Peshwaria et al., 1994).

Research has indicated that families who are successful in coping with
having a child with mental retardation, are able to mobilize their internal and
external means of support to deal effectively with the special needs of their child
(Kirk & Gallagher, 1989). Research in India has indicated that inability to perform
routine social and household work satisfactorily in the family, interpersonal
conflicts either between the parents and other children, additional responsibilities,
marital disharmony and social isolation were major inhibitors to effective coping
(Moudgil, Kumar & Sharma, 1985).

Seltzer et al., (1995) investigated the differences in coping by 105 aging
mothers of adults with mental illness and 389 similar mothers of adults with
mental retardation. Although no differences in problem-focused coping were
found, mothers of adults with mental illness used more emotion-focused coping,
which predicted greater maternal depression. For mothers of adults with
retardation, depressive symptoms were a function of their child’s behavior
problems, although this source of stress was buffered by coping. For mothers of
adults with mental illness, depression was a function of care-giving demands, but
coping did not buffer the effects of stress. Explanations for findings include maternal perceptions of the context of care, of her control over the disability, and her care-giving efficacy.

MARITAL ADJUSTMENT EXPERIENCED BY PARENTS OF MENTALLY RETARDED CHILDREN

Marital adjustment can be considered to be that state of accommodation in marital relationship and environment which is characterized by a tendency in spouses to resolve and solve conflicts and by an overall feeling of happiness and satisfaction with marriage and with one another. In marital adjustment the emphasis is upon the harmonious relations of wife. Broadly speaking, “marital adjustment” can be defined as that state of relationship in marriage in which there is an overall feeling in husband and wife of happiness and satisfaction with their marriage and with each other.

Locke and Williamson (1958) have defined marital adjustment as “the presence of such characteristics in a marriage as a tendency to avoid or resolve conflicts, a feeling of satisfaction with the marriage and with each other, the sharing of common interests and activities and fulfilling of the marital expectations of the husband and wife”.

Vincent (1981) opines that the goal of marital adjustment is self-fulfillment for both the partners without sacrificing their individual self-fulfillment. There is no such thing as a state of absolute adjustment in marriage. There is no static achievement that successfully married couples possess once and for all. Rather adjustment is an ongoing process that is achieved for a period in some areas of living.

Coldenson (1984) defines marital adjustment as the ability to meet the demands and opportunities of marriage especially (a) the sharing of experiences, interests and values; (b) respect for the partners individual needs, aims and temperament; (c) maintenance of open lines of communication and expression of
feeling; (d) clarifying of roles and responsibilities; (e) co-operation in decision
making, problem solving and rearing of children; and (f) attainment of mutual
sexual gratification.

The child with mental retardation may also influence the interactions and
relationships between the parents. Studies have indicated that having a child with
mental retardation can have negative impact on the parent’s marriage (Reed &
Reed, 1965; Gath, 1977; Featherstone, 1980; Murphy, 1982). In addition, research
with mothers and fathers suggests that the presence of a child with mental
retardation can alter traditional expressive or instrumental roles parents are
accustomed to (Gumz & Gumbrium, 1972; Gallagher et al., 1981). Although most
of the studies have indicated negative effects in the family because of having a
child with mental retardation, few studies have also indicated the positive effect.
Positive effects reported include stronger marriage (Summers, 1987), more
tolerance and patience.

Research has indicated 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 (Bristol, 1984,
Gallagher, 1986).

Floyd and Zmich (1991) examined the quality of the parents’ marital bond
and their ability to work together in the parenting role. The subjects included for
the study were the parents of school-aged children (ages 6-18) with mild and
moderate mental retardation (n=38) and a comparable group of parents of
typically developing children (n=34). Significantly more negative functioning for
the parents of mentally retarded children was observed during marital interactions,
and parent-child interactions but was not reflected in their self-reports of marriage
and parenting, suggesting that expectations about marital and parenting strains
may modulate negative sentiments for these parents. Across both groups, marital
quality and the parenting partnership, tougher with child behavior problems,
accounted for 23% to 53% of the variance in parenting confidence and in aversive

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parent-child exchanges. Negative marital interaction was a particularly important predictor of aversive parent-child exchanges.

PSYCHOLOGICAL WELL-BEING EXPERIENCED BY PARENTS OF MENTALLY HANDICAPPED CHILDREN

Srivastava et al., (1981) studied the personality characteristics of mothers of educable mentally retarded children with the help of Cattle’s 16 PF Questionnaire. Results show that the mothers of mentally retarded children were found to be significantly more reserved, emotionally less stable, humble, suspicious, imaginative, apprehensive and tense in comparison to mothers of normal children.

It is widely acknowledged that having a child with disability presents new and often unexpected challenges, and that a variety of factors affect the course of parental adaptation (Glidden and Floyd, 1997). Well-being is conceptualized typically as having multiple components, including the parent’s satisfaction with and adaptation to the child’s temperamental and behavioral characteristics (commonly labeled child-related stress) and the parent’s own emotional resources and adjustment to the parental role (commonly labeled parent-related stress). Investigators have examined the extent to which parent’s report difficult adjusting to such child characteristics as poorer self-regulatory skills, temperamental instability, or behavioral changes (Duis, Summers and Summers, 1997; Innocenti, Huh and Boyle, 1992). There is a remarkable overall consistency that parents of children with disabilities report significantly higher stress associated with the characteristics of their children than parent’s of typically developing children. With respect to studies of parent-related stress, investigators target the personal impacts on the parents) of having a child with disability and study aspects of personal well-being such as depressive symptoms, family problems and sense of competence as a parent (Frey et al., 1989).
Ryde-Brandt (1990) assessed anxiety and depression in mothers of mentally retarded children and children with psychotic disorders using HAD scale. The sample comprised of eighteen (18) mothers of mentally retarded children and a comparative group of eighteen (18) mothers of children with motor handicaps. Anxiety and depression scores were significantly high among the mothers of psychotic children although no definite signs of depression were recorded.

Tangri and Verma (1992) reported that mothers of mentally handicapped children reported higher social burden than those of physically handicapped children. Same authors reported that mothers of female mentally handicapped children more often reported burden because of disruption in family leisure and effect on mental health. Majority of the mothers rated the overall burden as moderate to severe.

Warfield (2001) examined the influence of employment on parenting stress among mothers of 5 year old children with developmental disabilities and the influence of parenting demands (i.e., care-giving difficulty and behavior problems) and family support on their work quality and absenteeism from work. No significant associations were found between employment status and parenting demands, family support, or stress for the sample as a whole. Among employed mothers, those who rated their jobs as interesting reported significantly less parenting stress when they experienced low or mean levels of parenting demands. Mothers’ interest in work did not moderate the negative influence of high levels of parenting demands on stress. Finally, parenting demands increased absenteeism but had no effect on work quality.

Kim et al., (2003) investigated changes over time in how mothers cope with the challenges of caring for an adult child with disabilities and the effects of changes in coping on maternal well-being. A sample of 246 aging mothers of adults with intellectual disability and 74 mothers of adults with mental illness was drawn from two parallel longitudinal studies of later-life care giving. There was
considerable variability at the individual level in the degree to which mothers changed over time in their use of problem-focused and emotion-focused coping strategies. For both groups, an increase in their use of emotion-focused coping led to declining levels of well-being. For the parents of adults with intellectual disability, an increase in their use of problem-focused coping resulted in a reduction in distress and an improvement in the quality of the relationship with their adult child. For the parents of adults with mental illness, an increase in the use of problem-focused coping had no effect on levels of distress, but led to an improved relationship with their adult child.

The review of literature does provide a clear view of the various problems and difficult situations faced by the parents of mentally retarded children. Varieties of reactions are reported by the parents of a retarded child ranging from shocking reaction to acceptance. The impact of the retarded child on the family unit is an ongoing problem. As the child grows, new problems would arise for example, entering school, finding a job, sexual maturity, etc. Therefore there is a need for early intervention, active parental counseling and training of parents to handle the retarded child. Also, there is a need for research to explore and enhance positive feelings of parents and family members towards retarded children.