Chapter Five: SUMMARY, CONCLUSIONS AND SUGGESTIONS FOR FURTHER RESEARCH

(1) Summary
(2) Conclusions
(3) Suggestions for further research
Chapter 5:

SUMMARY, CONCLUSIONS, AND SUGGESTIONS FOR FURTHER RESEARCH

The mentally retarded child poses various stresses to the family members. The family tries to cope with the problem by using various coping strategies. The problem of the present research is the study of stress and coping in the families of the mentally retarded. The proposed study was to include parents and significant others. The number of significant others was found to be 37 (4 sisters, 14 brothers, 12 grandmothers, 6 grandfathers and 1 auntie). This number of significant others was considered to be too small for the present study. So, the proposal to include the significant others for the study was dropped. So, the present study is mainly focused on stress and coping in the parents of mentally retarded.

The following are the main research issues which are studied in the present research.

1. The factors predicting, or attributing to stress in the families of the mentally retarded individual.

2. The mediating factors which help in reducing the stress and the factors that make the mediating factors adequate.

3. The coping strategies that are used by such family members and the factors predicting coping.
Hypotheses

Hypotheses are grouped into three categories – (I) related to stress; (II) related to mediating factors; and (III) related to coping.

(I) Hypotheses related to stress

(1) The mothers experience higher stress than the fathers.
(2) The parents of mentally retarded females experience higher stress than the parents of mentally retarded males.
(3) Lower the age of the mentally retarded individual higher is the stress experienced by the parents.
(4) The parents of profoundly and severely mentally retarded children experience higher stress than those of moderately and mildly mentally retarded children.
(5) Parental stress is higher when they have more than one mentally retarded child in the family.
(6) The stress is higher in case of parents with all the child / children being mentally retarded than in the case of those with normal child / children as well.
(7) The parents experience higher stress when mental retardation is associated with behaviour disorder.
(8) The younger parents experience higher stress than the older parents.
(9) The educated parents experience higher stress than the uneducated parents.
(10) Agricultural / rural families experience higher stress than non-agricultural / urban families.
(11) The parents with lower income experience higher stress than those with higher income.
(12) Families having grandparental support experience lower stress than those without grandparental support.

(13) The mothers experience higher anxiety and depression than do the fathers.

(II) Hypotheses related to mediating factors

(14) The level of adequacy of mediating factors is associated with the level of stress.

(15) Fathers and mothers differ from each other with regard to mediating factors.

(III) Hypotheses related to coping strategies

(16) Lower stress is associated with better coping.

(17) Fathers use problem-focused coping more often than the mothers and mothers use emotion-focused coping more often than the fathers.

Tools Used

In total seven tools are used in this study and they are:-

(1) Binet-Kamath Test of intelligence;
(2) Problem Behaviour Screening Schedule;
(3) BASIC-MR, Part-B;
(4) Hamilton Anxiety Rating Scale;
(5) Beck’s Depression Inventory;
(6) Family Interview for Stress and Coping in Mental Retardation; and
(7) Coping Checklist.

Pilot Study

Pilot study has been done on 114 families. Statistical analysis indicated that presence of behaviour disorder, age, education and income of the family as factors influencing stress. Awareness and social support are having a mediating
role in reducing stress. Problem solving, religion–faith and denial–blame are the more often used coping strategies by parents. Pilot study inspired the present researcher to continue the study further and eventually the study involved 628 families.

Kannada versions of all rating scales are used in the present study. Test-retest reliability for all these Kannada versions has been established on a sample of 35 fathers and 35 mothers.

Sample

All cases of mental retardation attending the outpatient department of Karnataka Institute of Mental Health, Dharwad during the period from 2002 to 2003 were taken up for the study. There were 651 cases of mental retardation out of the total of 6209 in 2002 and there were 564 cases of mental retardation out of the total of 6165 in 2003. Thus, total number of cases available for the study was 1215. Out of these 1215 cases, 587 cases were rejected due to various reasons. Finally 628 cases were selected for the study. Incidental sampling is adopted in the present study.

Method

When a case of mental retardation gets registered in the outpatient department, usual workup is done (and socio-demographic data is collected). IQ is assessed using the Binet-Kamath test of intelligence. IQ is the basis on which cases are selected for the study. Cases are rejected based on the exclusion criteria. After screening for behaviour disorder in their children using the Problem Behaviour Screening Schedule, the BASIC-MR Part B is administered to parents of those children who had problem behaviours. Hamilton's Anxiety Rating Scale and Beck's Depression Inventory are administered in the first and second sessions, if both parents came together. If other family members attended, they were asked to send the parents next time. Parents are asked to attend again.
When parents attend the next time, assessment of stress and coping are undertaken. In general, three sessions and at times four sessions are required for completing each case. Fathers and mothers are assessed together, and their ratings are entered separately for each scale. Data is entered into the computer and statistical analysis has been done.

**Statistical Analysis**

Raw scores are converted into standard scores where the denominators of the subscales are not equal (as in case of stress, mediators and coping scores). Where only a single uniform score has been taken for further analysis they are not standardized (as in case of problem behaviour score, anxiety score and depression scores). For correlation purpose the total problem behaviour score has been taken. During further analysis of problem behaviours, the sub scores of areas of problem behaviours have been used. As all the sub and total scores are in the form of percentages, no standardization is done for these scores. Statistical methods used in analysis of data are as follows:

1. **Student's t-test**: This is used to find the significance of difference between means of two independent groups.
2. **ANOVA**: Analysis of variance technique is used to test the significance of difference between means of more than two different independent groups.
3. **Correlation**: Karl Pearson's coefficient of correlation is computed to measure the linear relationship between any two groups. Student's t-test is used to test it's significance and critical value has been mentioned.
4. **Regression Analysis**: Linear regression is used to measure the magnitude of dependency of dependent variable on the independent variable.
5. **Descriptive Statistics**: Other than the above mentioned ones; descriptive statistics namely: frequency distributions; mean and standard deviations; percentages; and graphical figures are used to present the results.
Results

The results of the present study have been summarized under the three main research issues namely: stress; mediating factors; and coping.

The factors predicting or attributing to stress: severity of behaviour disorder in the mentally retarded child; increased levels of anxiety and depression in parents; the inadequacy of mediating factors; presence of more than one mentally retarded child in the family; lower age of the mentally retarded child; lower age of parents; and lower income of the family.

Sex of the mentally retarded individual; severity of retardation; number of siblings in the family; educational level of parents; agri / rural and non-agri / urban status; presence or absence of grandparental support in the family; and coping are not significantly related to stress.

(2) The mediating factors which help in reducing the stress:
Adequate levels of awareness; expectations and attitudes; and child rearing practices reduce social and financial stress. Adequate levels of social support and global adaptations reduce emotional, social, and financial stress. Care stress is found to be not related to the adequacy of mediating factors.

The factors attributing to adequacy of mediating factors: lower stress; no or mild behaviour disorder; better coping; urban status; higher income; higher education; and higher age of parents.

(3) The coping strategies that are used by such family members:
The most commonly used coping strategies are problem solving, acceptance-redefinition, religion faith, denial-blame and social support. Positive distraction and negative distractions are rarely used. Most of the strategies for coping remain unutilized by most of the parents.
Fathers use problem-focused coping more often than the mothers. Mothers use emotion focused coping more often than the fathers. Fathers and mothers use problem focused coping more often than the emotion focused coping in general.

Factors predicting better coping: father’s higher education and age; mother’s higher education; non-agricultural / urban status; higher income; higher levels of behaviour disorder in the retarded children; higher levels of anxiety; higher levels of depression; and adequacy of mediating factors.

Conclusions derived from results have been grouped into three sub-headings: stress, mediating factors and coping. The conclusions are limited to the study sample and any generalization is not claimed by the present researcher.

**Stress**

* Most of the parents reported mild stress.
* Mothers perceived more stress than fathers in daily care, emotional and social areas. Financial stress is experienced equally by fathers and mothers.
* Sex of the mentally retarded individual is not significantly related to stress.
* Lower age of the retarded individual is associated with higher stress in parents.
* More than one mentally retarded child in the family increases the stress in parents significantly.
* Stress is not related to number of siblings in the family; and parents having all of the child / children being mentally retarded do not report higher stress than those with normal child / children as well.
* Behaviour disorder in the mentally retarded individual increases the stress in parents.
* In general, mothers report problem behaviours more often than fathers. Fathers report hyperactivity more often than the mothers.
* The most commonly reported problem behaviours are temper tantrums; hyperactivity; rebellious behaviour; and misbehaving with others.
* Younger parents experience more stress compared to older parents.
* Higher level of education reduces the stress.
* Occupation of the family has no influence on stress.
* Rural and urban parents do not differ in their stress levels.
* Income is not related to stress.
* Grandparental support is not related to the stress.
* Anxiety and depression are associated with increased experience of stress.
  * Anxiety is slightly more in fathers and depression is much more in mothers.

**Factors predicting stress:**
- Severity of behaviour disorder in the child;
- Increased levels of anxiety and depression;
- Inadequacy of mediating factors;
- More than one mentally retarded child in the family;
- Lower age of the mentally retarded individual;
- Lower age of the parents; and
- Lower income of the parents.

**Mediating factors**

* Mediating factors help in reducing stress in emotional, social and financial areas. Mediating factors have little influence on daily care stress.
* Adequate mediating factors reduce stress.
* Adequate mediating factors increase coping.
Factors predicting adequacy of mediators:
- Lower stress in parents;
- No or mild behaviour disorder in the child;
- Better coping in parents;
- Urban status of parents;
- Higher education of parents; and
- Higher age of parents.

Coping

* Most of the coping strategies remain unutilized by most of the parents. Problem solving, acceptance-redefinition, religion-faith and denial-blame are more commonly used coping strategies than social support. Positive distraction and negative distraction are rarely used strategies.

* Fathers use problem-focused coping more often than the mothers and mothers use emotion focused coping more often than the fathers. In general fathers and mothers use problem focused coping more often than the emotion focused coping.

* Coping is not directly related to stress. Coping is related to mediators; and mediators are related to stress.

Factors predicting coping:
- Higher age and educational level of fathers;
- Higher educational level of mothers;
- Non-agricultural occupation of parents;
- Higher income of parents;
- Urban status of parents;
- Higher levels of behaviour disorder in mentally retarded children;
- Higher levels of anxiety and depression in parents; and
- Adequate level of mediating factors.
(1) A larger sample may be studied from the community rather than restricting the sample to those attending an Institution only, as is done in the present study.

(2) Samples with specific variables may be studied, namely: parents of mentally retarded individuals who also have physical handicaps in addition to retardation; mentally retarded of lower and higher age levels; parents from urban area; highly educated; high income group; employed mothers; joint families; and a group of widows and widowers.

(3) Grandparents and siblings may be studied in the same line.

(4) Care takers of such children who are institutionalized may also be studied for their stress and coping.

(5) Open ended interview may be used; other than using structured or semi-structured interview schedules; which gives more often an open answer to the areas of stress and ways of coping.

(6) Psycho-social and family factors in addition to coping strategies may be studied from a social work perspective.

(7) Positive perceptions by parents and other family members may be studied separately.

(8) Needs of care takers of a mentally retarded individual require further research.
(9) Attitudes of the family members and others in the society may be studied.

(10) Awareness of general, therapeutic and legal aspects of mental retardation may be studied further.

(11) Further research is to be pursued in the areas of early intervention, parental training, counseling, behavioural and cognitive therapies.

(12) Problems of the married mentally retarded persons may be studied.

(13) Etiological factors, mainly the factor of consanguinity needs further research.

(14) Influence of family planning movement on incidence of mental retardation may be studied.

(15) Also, stress and coping in the families of alcoholic persons; chronic schizophrenic patients; and terminally ill persons may be studied.

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