CHAPTER II

REVIEW OF LITERATURE

A literature review is an account of what has been published on a topic by accredited scholars and researchers. It is a piece of discursive prose and a simple summary of the sources (Taylor and Procter, 2005). Comprehensive knowledge of the literature in the field is essential to research papers. The depth and breadth of the literature review emphasizes the credibility of the writer in his or her field (Anson and Schwegler, 2000).

The literatures relevant to the present research conducted in the last 10 years are presented under the following headings

• Parents of Mentally Challenged
• Stress in Parents of Mentally Challenged
• Depression in Parents of Mentally Challenged
• General Well-being in Parents of Mentally Challenged
• Positive Therapy and Stress
• Positive Therapy and Depression
• Positive Therapy and General Well-being

PARENTS OF MENTALLY CHALLENGED

Parents' descriptions and experiences of young children recently diagnosed with intellectual disability done by Boström, Broberg and Hwang (2010). It explored the
variation of parents' descriptions and experiences of their child that was recently identified to have an Intellectual Disability (ID). It applied interpretative phenomenological analysis and analysis of narrative style looking at content and form of parental narratives. Data was collected from nine fathers and eight mothers through semi-structured interviews within 6 months following diagnosis. Results revealed three factors indicated the parents' level of processing (1) emotional expressions regarding the child varying between limited and balanced/affectionate (2) experience of the disability varying between preoccupation and acceptance and (3) time orientation varying in terms of flexibility and temporal focus. Although parents of children with Intellectual Disability describe negative emotions in relation to the child and the disability, most of these parents also describe positive emotions that seemed to balance the negative experiences.

A study on sexuality with the parents of adolescents with intellectual disability was done by Isler, Beytut, Tas and Conk (2009). The objective of this study was to determine the knowledge, opinions, attitudes and concerns of the parents regarding sexuality of their children with intellectual disabilities. Forty parents who have children with intellectual disabilities formed this study's sample from Turkey. The children had mild to moderate intellectual disabilities aged between 15 and 21 years in an occupational school. The data taken from questionnaires was evaluated with SPSS 13.0 package programme. Mothers consisted of 87.5% and the fathers consisted of 12.5%. Seventy five percent parents had not received any professional education on sexuality and 32.5% never talked on sexuality with their children. Fifty-five percent of the parents thought that sexual education should start during elementary school years. While 45% of the parents acknowledged their children engaging in masturbation, more than half had false opinions
on masturbation. Parents stated that 57.5% informed their children on the physical characteristics of the adolescence period and 27.5% provided information to their children on subjects like the reproductive organs. In addition, a large majority of the parents (72.5%) had concerns regarding the future of their children. The parents of the adolescents with intellectual disabilities had not received any professional education on sexual development. It is very crucial that parents with children who have special needs be informed by health care professionals.

Adapting Webster-Stratton's Incredible Years Parent Training (IYPT) for children with developmental delay, a treatment group study, done by McIntyre (2008) on Children with Intellectual or Developmental Disabilities (ID/DD) are more likely than typically developing children to experience behaviour problems. Parent training, such as the Incredible Years Parent Training (IYPT) series, has been a widely used intervention to support families with children with or at-risk for behaviour problems; yet to date, this programme has not been used with parents with young children with developmental delay or disabilities. This preliminary treatment group only study assessed the feasibility of implementing a Modified Parent Training Programme (IYPT-DD) with 25 families with 2–5-year-old children with developmental delay. Intervention consisted of 12 weekly (2.5) sessions with topics covering developmentally appropriate play, praise, rewards, limit setting and handling challenging behaviour. Results suggested preliminary evidence of efficacy in reducing negative parent and child behaviour and increasing parental perceptions of child positive impact. This study provides evidence for the feasibility of the DD modifications applied to the IYPT. Although this approach is promising, additional evidence is needed to address the efficacy of IYPT-DD in children with developmental delay.
Wade, Llewellyn and Mathews (2008) did a study on the parent training interventions for parents with intellectual disability. This research provides an updated perspective on the effectiveness of parent training interventions for parents with intellectual disability. The degree to which these studies meet previous recommendations for future research is explored, particularly with regard to the influence of context on intervention outcomes. Studies published were peer reviewed, from 1994 onwards. Results supported the use of individually administered home-based behavioural intervention for parents with intellectual disability. However, the effect of parent training interventions on child outcomes and the generalization of parenting skills is rarely investigated. Contextual factors that may be associated with intervention success (or failure) were also neglected. There is reasonable evidence of the effectiveness of parent training for parents with intellectual disability. However, investigators have yet to determine the influence of immediate or more distal contextual factors on intervention outcomes. This presents a significant gap in the literature in contrast to other areas of parenting intervention research where the influence of family and the broader community context has been shown to influence the effectiveness of parent training interventions.

Cavkaytar (2007) determined the effectiveness of a parent training programme teaching self-care and domestic skills to children with mental retardation. It was conducted for three mothers, children and classroom teachers. Multiple probe across behaviours design was used. Experimental procedure consisted of three meetings and a home visit. Results showed that children achieved the target skills independently. They continued to use these skills during the follow up phase. Overall findings indicated that parent training programme was effective on teaching self-care and domestic skills.
Bagner and Eyberg (2007) examined the efficacy of randomized controlled trial of Parent-Child Interaction Therapy (PCIT) for treating disruptive behaviours of young children (ages 3 to 6) with Mental Retardation (MR) and comorbid oppositional defiant disorder. Thirty families were randomly assigned to an Immediate Treatment (IT) or Wait List (WL) control group. Results indicated that IT mothers interacted more positively with their children after treatment than WL mothers, and their children were more compliant after treatment. On parent-report measures, IT mothers reported fewer disruptive behaviours at home and lower parenting stress related to difficult child behaviour than WL mothers after treatment. Whether evidence-based treatments for disruptive behaviour require modification before application to children with MR were discussed.

Study attempted to ascertain the level of adjustment and attitude of parents of children with mental retardation by Ravindranadan and Raju (2007). The sample consisted of 50 parents (either mother or father) of children diagnosed as mentally retarded. Parental age group was 25-50 years. The tools used for the measurement of variables were an Adjustment Inventory, Scale of Parental Attitude towards Mental Retardates and a Personal Data Sheet. Subjects were grouped on the basis of Religion, Education, Locality and Income. The data were analyzed using Analysis of Variance (ANOVA) and t-test. The results indicated that parental religion, income and education do not have any significant influence on adjustment variables, but there was change in parental attitude among different religious groups. Locality of parents influences only on the dimensions of social adjustment and parental attitude.

Allen, Hawkins and Cooper (2006) explored parents' experience of managing severe challenging behaviours, their use of physical interventions and access to training
in reactive strategies. A postal survey methodology was employed that utilized a novel 20-item questionnaire. The questionnaire yielded both quantitative and qualitative data concerning the types of challenging behaviour displayed by the children, frequency of use and nature of physical interventions, types of training received and any difficulties experienced in obtaining training. The sample was drawn from the membership of a national charitable organization and comprised of 72 respondents. Results showed that majority of respondents experienced major episodes of challenging behaviour. The emotional impact of living with such behaviours was apparent. Although the vast majority of respondents employed restrictive physical interventions, they received formal training in such strategies. There was evidence that a number of high-risk physical interventions were sometimes being employed. Accessing training appeared more problematic for parents when compared with paid care staff. In this specific sample, parental use of physical intervention was high while parent training in physical intervention was uncommon.

Hurley and Levitas (2004) conducted a therapeutic engagement of the Family for Treatment of Individuals with Intellectual Disability who had experienced chronic sorrow throughout their lives. Parents experienced denial, anger, sadness and acceptance, this cycle repeats itself when the child is passing through major developmental milestones as well as during crises and times when the service system is providing inadequate supports. Suggestions for awareness and helping parents and families were made.

Ly and Hodapp (2002) examined mothers' attributions of the causality of noncompliance in their children with Down Syndrome (n=37) compared with children with other causes of mental retardation (n=22). Mothers rated two vignettes of simple
noncompliance and completed questionnaires about their child's personality and maladaptive behaviours. Instead of attributing causality along the "classical" categories of locus, controllability and stability, mothers in both groups used normalizing-temporary and excuse-making attributions. Higher ratings of normalizing-temporary compared with excuse-making occurred in both groups. There was also an interaction effect such that, compared with mothers in the mixed group, mothers in the Down Syndrome group showed higher normalizing-temporary versus excuse-making attributions. In the Down Syndrome group, normalizing-temporary attribution score related negatively with children's internalizing behaviours and positively with children's personality. Excuse-making attributions correlated with children's externalizing behaviours in the Down Syndrome group and with children's internalizing problems in the mixed group. Results highlighted the importance of understanding parental attributions for noncompliant behaviour among children with different causes of mental retardation.

Cheng and Udry (2002) examined the mentally disabled adolescents' knowledge of sex and birth control and whether their parents discuss these matters with them at home. Empirical results are based on 1994-1995 Wave 1 data from the National Longitudinal Study of Adolescent Health—a school-based sample of 7th-12th graders in the US. Mental disabilities were measured in terms of Add Health Picture Vocabulary Test (AHPVT) scores (lower than 70). Findings suggested that mentally disabled adolescents had little exposure to sex education in school, and their parents tend not to discuss sex, birth control and pregnancy with them. Their "knowledge" is largely incorrect. Nonetheless, a significant proportion of them, particularly boys were sexually active. Among these sexually experienced and mentally disabled adolescents, a higher
percentage of their parents were unaware of their sexual activities, as compared to parents of mentally average adolescents. They concluded that, regardless of much effort, mentally disabled adolescents' specific needs for sex education have not been met. Parents with disabled children need help in implementing sex education at home. More attention should be given to sexual activity among mentally disabled adolescents to protect them from sexually transmitted diseases and pregnancy.

Ansari (2002) investigated on Parental acceptance-rejection of disabled children in non-urban Pakistan. An Urdu version of Rohner's Parental Acceptance-Rejection Questionnaire was administered to 100 parents (50 fathers and 50 mothers) belonging to the lower middle class from 2 small towns in Pakistan. Of these, 80 parents (40 mothers and 40 fathers) had children with various types of disabilities: deaf, blind, physically disabled and mentally retarded (n=20 each); while 20 parents (10 mothers and 10 fathers) had non-disabled children. The questionnaire was administered to the respondents orally due to their low level of literacy. Results indicated that the parents showed greater acceptance for their disabled children, as compared to non-disabled children, when the disability was manifest (when the children were deaf, blind or physically handicapped). When the disability was not manifest, as in case of mentally retarded children, there is no difference between the non-disabled and the disabled children. While gender of the child was not important, the gender of the parent emerged as a significant variable; the fathers showing greater acceptance and the mothers showing relatively greater rejection towards the disabled child.

Savina and Charova (2002) compared the child-rearing beliefs of mothers of retarded or deaf children with the attitudes of mothers of normal children in Russia.
The Parent Attitude Research Instrument was administered to 50 mothers (mean age 35.2 years) of normal children with a mean age of 8 years, 50 mothers (mean age 36.9 years) of deaf children with a mean age of 8 years, and 50 mothers (mean age 38 years) of retarded children with a mean age of 8 years 4 months. Pathology in children was found to have a negative effect on mothers' attitudes. Children's handicaps were shown (1) to limit their mother's ability to communicate with them effectively and (2) to impair maternal perception. The degree of deviation in the mothers' attitudes was linked directly to the degree of child pathology.

Programme efficiency of treatment training for aggressive behaviours of mentally retarded adolescents in residence/rehabilitation was conducted by Tassé, Methot, Belanger and Belanger (2001). Subjects were 24 males and females (mean age 15 years) and their parents in Canada. Families were assigned randomly to the training programme (Intervention for Aggressive Behaviours in a Rehabilitation Residence) or to a waiting list. In 21 families, the mothers received the training. French-language scales on adaptive behaviour, parental stress and well-being were administered. Parents in the intervention group reported significant improvement of (1) their adolescents' behaviour disorders, hyperactivity, sensitivity, susceptibility and quality of life and (2) parental stress.

Behavioural treatment for sleep problems in children with severe intellectual disabilities and daytime challenging behaviour conducted by Wiggs and Stores (2001). Parents of 15 children with severe intellectual disabilities, severe sleep problems and challenging daytime behaviour received treatment for the child's sleep problem and were compared with 15 controls who received no treatment. Parental stresses, sleepiness, locus of control, perceived control and satisfaction with aspects of sleep were assessed.
Successful treatment benefited the mothers, reducing stress, increasing perceived control and making them more satisfied with their sleep, their child's sleep and their ability to cope with their child's sleep. Positive effects in the fathers were limited to increased satisfaction with their own sleep and their child's sleep, fathers tended to feel less control following treatment. Maternal sleepiness and perceived control and aspects of parental satisfaction showed improvements in both the treatment and control groups. The improvements in both control and treatment groups indicated that there may be non-specific effects of taking part in the study that played a therapeutic role.

Roll-Pettersson (2001) examined the feelings and responses of parents of children with cognitive disabilities. Forty six parents of 38 children (aged 7–16 years) with mild to severe cognitive disabilities completed interviews concerning reaction phases, difficulties connected to their child, incidents with other children, comparisons to other children, contact with professionals, acceptance of the situation, coping strategies and concerns related to the future. Results showed that the occurrence or recurrence of difficult events or episodes varied from family to family, while some subjects passed through phases from mourning to adaptation, the majority reported experiencing incidents and events that were critical and difficult.

**STRESS IN PARENTS OF MENTALLY CHALLENGED**

Hill and Rose (2009) conducted a study on Parenting stress in mothers of adults with an intellectual disability. Parental cognitions in relation to child characteristics and family support. It indicated the cognitions of parents of children with Intellectual Disabilities (ID) play an important role in influencing parental stress. However, there is a paucity of evidence about the experience of parents of adult children with ID. This study
sought to apply a model of parenting stress to mothers of adults with ID. Of particular interest were the parental cognitions of parenting self-esteem and parental locus of control. Face-to-face interviews were administered with 44 mothers of adults with ID. They completed the Vineland Adaptive and Maladaptive Behaviour Scale, the Family Support Scale, the Parenting Sense of Competence Scale, a shortened version of the Parental Locus of Control Scale and the Parenting Stress Index. Correlations were observed between parenting stress and the other study variables. Regression analysis revealed that parental cognitive variables predicted 61% of the variance in parenting stress. Parenting satisfaction, a subscale of the measure of parenting sense of competence, mediated the relationships between adaptive behaviour and parenting stress and between family support and parenting stress. The results indicated the importance of cognitive variables in the stress of mothers of adults with ID. Potential avenues of future research might focus on the experience of fathers and the impact of positive perceptions as a cognitive factor.

Parent stress, parenting competence and family-centered support to young children with an intellectual or developmental disability was examined by Dempsey, Keen, Pennell, Neilands and O’Reilly (2009). A family-centered approach to the support of families with a young child with an intellectual or developmental disability was widely adopted in the last decade. Parenting stress and competence was examined in the general family support literature, these variables have received little attention in the family-centered support literature. The pilot study examined the relationship between parent stress and parenting competence and family-centered support. The results suggested that
important components of family-centered practice were significantly associated with parent stress, but that a meaningful association between parenting competence and family-centered practice was yet to be demonstrated.

Longitudinal study examined the contribution of child social skills to maternal parenting stress across middle childhood, as well as the direction of the relationship between child social skills and parenting stress by Neece and Baker (2008). Families of children with Intellectual Disabilities (ID) (n = 74) or Typical Development (TD) (n = 115) participated over a 2-year period. Maternal parenting stress, child behaviour problems and child social skills were assessed at child ages six and eight. Child social skills accounted for unique variance in maternal parenting stress above and beyond child intellectual status and child behaviour problems. As the children matured, there was a significant interaction between child social skills and behaviour problems in predicting parenting stress. With respect to the direction of these effects, a cross-lagged panel analysis indicated that early parenting stress contributed to later social skills difficulties for children, but the path from children’s early social skills to later parenting stress was not supported, once child behaviour problems and intellectual status were accounted for. Parenting stress and child social skills were an important variable to consider, especially in the context of child behaviour problems. Early parenting stress predicted child social skills difficulties over time, highlighting parenting stress as a key target for intervention.

Stress in parents of the mentally challenged was conducted by Upadhyaya and Havalappanavar (2008). Fathers and mothers of 628 mentally challenged individuals are assessed for their perceived stress using Family Interview for Stress and Coping in Mental Retardation (FISC-MR). Socio demographic data pertaining to the mentally challenged
individuals and their parents are collected. To assess behaviour disorder, BASIC-MR, Part B is used. Results showed that mothers report higher stress compared to fathers, the difference being significant at 0.01 level. Most of the parents report mild to moderate stress and none of them report very high stress. In the areas of care, emotional and social stress, mothers report higher stress and in the area of financial stress, both fathers and mothers reported equal levels of stress. It is noticed that more than one mentally challenged children in the family; higher levels of behaviour disorder; lower age of the mentally challenged individual, parents and lower income of the family were associated with higher stress.

Perceived benefits and negative impact of challenges encountered in caring for young adults with intellectual disabilities in the transition to adulthood done by Rapanaro, Bartu and Lee (2008). This study investigated the perceived benefits and negative impact associated with stressful events and chronic caregiving demands encountered by parents caring for young adults with an intellectual disability in the period of transition to adulthood. A sample of 119 parents of young adults described these outcomes in a questionnaire, which were then analysed using qualitative content analysis. Result indicates that although parents identified a range of negative outcomes, they also reported positive outcomes (perceived benefits) in relation to stressful events and chronic demands encountered in this period, including personal growth and enhanced personal resources. The result revealed the language of stress and burden often used to describe parents' experiences during the period of their son or daughter's transition to adulthood, needs to coexist with a language of fulfilment, growth and gain, as used by parents themselves. The implications of these findings, in relation to professional interaction with and support of parents in this period were discussed.
Psychological variables (acceptance, mindfulness, avoidant coping) were explored and explained the variance in maternal distress by Lloyd and Hastings (2008). Data was gathered by questionnaire from mothers of children attending special schools at two time points, 18 months apart (n=91 at Time 1, n=57 at Time 2). In addition to measures of the child's functioning, the questionnaire pack included a measure of acceptance of unwanted thoughts/feelings; a measure of attention to the present (mindfulness); a measure of active avoidance coping; measures of maternal anxiety, depression and stress; and a measure of mothers' positive perceptions of their child. In cross-sectional analysis, acceptance was negatively associated with maternal anxiety, depression and stress, such that mothers who were generally more accepting reported fewer psychological adjustment problems. Longitudinal analysis showed that acceptance was bidirectionally related to anxiety and depression. Mindfulness was not significantly related to maternal distress, and avoidance coping was positively cross-sectionally associated with depression only. There were no associations between psychological variables and maternal positive perceptions. Studies revealed that the data suggested acceptance, in particular, may be a construct that explained some variance in maternal distress. Further research could focus on the utility of acceptance-based interventions (e.g. Acceptance and Commitment Therapy) in the support of families with a child with Intellectual Disability.

Upadhyay and Havalippanavar (2007) compared the stress level among parents and single parent of Mentally Retarded Children. Seventy seven single parents with (58 widows and 19 widowers) were compared with 77 parents (matched group). Measuring stress and coping in Families Having Retarded Children (FISC-MR) was used to evaluate the experienced stress, test developed by Girimaji, Shobha, Shekhar and
Subba (1999). Results showed that single parents differed significantly regarding total stress and in all four areas of stress (care, emotional, social and financial stress). Stress was high in emotional and social areas compared to care and financial stress. Widows and widowers showed similar care stress. They differed significantly in their social, financial, emotional and total stress. Single parent families of mentally retarded children experienced higher levels of stress (total and in all areas) compared to such families where both parents were alive. Total, social, emotional and financial stresses were higher than the care stress among widows compared to widowers.

Weiss and Diamond (2005) examined how programmes serving the individual with intellectual disability helped to reduce stress in parents of adult children with intellectual disabilities. It was conducted to test whether parents who frequently watch their children at Special Olympics (SO) competitions reported less stress than those who watch with less frequency. A total of 57 mothers and 39 fathers completed the Parenting Stress Index in reference to their children with intellectual disability, whose ages ranged from 17 to 42.3 years. Frequency of parental attendance at competition and volunteering for SO was also assessed. Parents who frequently attended their children's competitions reported less stress than those who attended with less frequency. Mothers who volunteer, reported more child-related stress than those who did not. A number of other gender-specific relations were found. These results support the hypothesis that parents who frequently see their children compete in Special Olympics had more positive parent-child experience than those who do not attend with the same frequency. Experimental research with controlled pre-post designs, were needed to directly assess any causal effect.
Parenting stress in mothers of children with an Intellectual Disability, the effects of parental cognitions in relation to child characteristics and family support study was investigated by Hassall, Rose and McDonald (2005). Recent theories of stress and coping in parents of children with Intellectual Disabilities (ID) emphasized the importance of cognitive appraisals in influencing parents' levels of stress and their adaptations to difficulties presented by the children. This study investigated the relationships between parental cognitions, child characteristics, family support and parenting stress. The aspects of cognitions studied were parenting self-esteem (including efficacy and satisfaction) and parental locus of control. The group consisted of 46 mothers of children with Intellectual Disabilities. The Vineland Adaptive Behaviour Scales and Maladaptive Behaviour Domain were administered by interview. Mothers also completed four questionnaires, the Family Support Scale, the Parenting Sense of Competence Scale, a shortened form of the Parental Locus of Control Scale and the Parenting Stress Index (Short Form). Data were analysed using Pearson's Correlation Coefficients, Partial Correlations and a Regression Analysis. The results indicated that most of the variance in parenting stress was explained by parental locus of control, parenting satisfaction and child behaviour difficulties. While there was also a strong correlation between family support and parenting stress, this was mediated by parental locus of control. The results demonstrated the potential importance of parental cognitions in influencing parental stress levels.

Fujuan and Li (2005) conducted a study on stress in Parents of children with Mentally Retarded and relevant factor. The sample selected for the study was 200. No significant sexual difference existed in the stress of parents of Mentally Retarded Children. But there was a significant group difference in the stress of Mentally Retarded
Children's Parents. There existed significant correlation between stress of Mentally Retarded Children's Parents and behaviour of Mentally Retarded Children, Coping and Quality of Life.

The study on pre-school children with and without Developmental Delay, Behaviour Problems and Parenting Stress over time was done by Baker, McIntyre, Blacher, Crnic, Edelbrock and Low (2003). Children with intellectual disability are at heightened risk for behaviour problems and diagnosed mental disorder. The authors studied the early manifestation and continuity of problem behaviours in pre-school children with (n=82) and without (n=123) developmental delays. It is found that behaviour problems were quite stable over the year from age 36-48 months. Children with developmental delays were rated higher on behaviour problems than their non-delayed peers and were three times as likely to score in the clinical range. Mothers and fathers showed high agreement in their rating of child problems, especially in the delayed group. Parenting stress was also higher in the delayed group, but was related to the extent of behaviour problems rather than to the child's developmental delay. Result reveals that over time, a transactional model fit the relationship between parenting stress and behaviour problems, high parenting stress contributed to a worsening in child behaviour problems over time and high child behaviour problems contributed to a worsening in parenting stress. Findings for mothers and fathers were quite similar.

Fathers of children with Down's Syndrome (N=30) versus other types of Intellectual Disability (N=20) were examined in perceptions, stress and involvement by Ricci and Hodapp (2003). The age range of the children in both groups ranged from 3 to 22 years, with average ages of 10-11 years. Fathers and mothers completed questionnaires
about their children's personalities and maladaptive behaviours, their own parenting stress
and the fathers' level of involvement. Results showed that both fathers and mothers rated
their children with Down's Syndrome as having more positive personality traits and less
maladaptive behaviours. Possibly because of these positive perceptions, fathers of
children with Down's Syndrome also reported less child-related stress, particularly in the
areas of acceptability, adaptability and demandingness. The two groups of fathers were
very similarly involved in child rearing. The personality, age and maladaptive behaviours
of the children related to stress levels in the fathers of children with DS, while
maladaptive behaviours, gender and the fathers' education levels related to stress levels in
the fathers of children with other types of Intellectual Disability.

Parental stress of fathers and mothers caring for a child with intellectual disability
was carried out by using a double ABCX model by Saloviita, Itälinna and Leinonen (2003).
Twenty variables based on the Double ABCX Model of adaptation were selected to
measure the parental stress of the mothers (n = 116) and fathers (n=120) of children with
an intellectual disability (age range=1-10 years). Principal component analysis, rotated
into varimax-criterion, was done separately for mothers and fathers. The solution
containing eight factors was considered best for both groups. They accounted for more
than 70% of the total variance of the original variables. These eight orthogonal
components were then entered into a stepwise regression analysis that was done
separately for mothers and fathers. The multiple regression equations explained 72% of
the variance in maternal stress and 78% of the variance in paternal stress. The equations
for mothers and fathers contained six and seven components, respectively. The variables
used in the study were highly successful in accounting for parental stress. The results confirmed the importance of intervening factors in explaining the stress. The single most important predictor of parental stress was the negative definition of the situation.

Duygun and Sezgin (2003) explored the Effects of Stress Symptoms, Coping Styles and Perceived Social Support on Burnout Level of Mentally Handicapped and Healthy Children's Mothers on three dimensions of the Maslach Burnout Inventory (MBI). The sample consisted of 118 mothers of mentally handicapped and 121 mothers of healthy children. The results of one way ANOVA indicated that there were significant differences between the emotional burnout levels and submissive coping style levels of two group of mothers, the mothers of mentally handicapped children having higher scores than the mothers of the healthy children on two factors of MBI and the submissive coping style factor of the Coping Style Scale. Hierarchical regression analysis revealed that personal accomplishment factor of MBI, cognitive-affective factor of the Stress, Self-Assessment Checklist, Submissive Style factor of the Coping Style Scale and seeking for social support factor of the Multidimensional Scale of Perceived Social Support Scale were the best predictors of burnout in the mothers of the mentally handicapped children.

Relationships between social support, stress and mother-child interactions in mothers with intellectual disabilities were examined by Feldman, Varghese, Ramsay and Rajjska (2002). Thirty subjects completed the Parenting Stress Index (PSI), the Telleen Parent Social Support Index (Telleen) and the Interpersonal Support Evaluation List (ISEL). Also, 18 mothers and their children (less than 6 years of age) were observed in a 10 minutes play session at home. The mean Parenting Stress Index total and Child
Domain Stress scores were at the 85\textsuperscript{th} percentile, indicating clinically significant stress. The Telleen support satisfaction (but not support size) and Interpersonal Support Evaluation List total scores were significantly negatively correlated and support need significantly positively correlated with the Parenting Stress Index total score. Only social support satisfaction ratings were significantly (positively) correlated with positive maternal interactions. The study showed that the mothers with intellectual disabilities experienced high levels of stress, were socially isolated and reported a great need for support.

Parenthood and mental retardation, a pilot study was conducted by Lalande, Ethier, Rivest and Boutet (2002). The objective of this study was to describe the relations between parents and children of 11 families (11 mothers and 12 children), of which the mothers are (moderately and mildly) mentally retarded. The main aspects evaluated were social support, services received by the family, parental stress, difficulties of mothers in assuming their parental responsibilities, the level of the general development or the intellectual level of the child and the child's behaviour problems (internal or manifested). The result indicated that independent of the support or services received by the families, 5 mothers perceived themselves as very stressed by the responsibilities in assuming the role of parent and 7 mothers had the difficulties in feeling attached and reinforced by the child. In 81.8\% of the families, the mothers were at a relatively high risk of neglecting the children's care and being unable to resolve their problems and for 63.6\% of families there was a moderate risk of emotional neglect. Two children manifest a global retardation in development and one child is mentally retarded. The majority of children (60\%) were perceived by their mothers as having a high level of behavioural problems.
Baker, Blacher, Crnic and Edelbrock (2002) examined behaviours and parenting stress in families of three-year-old children with and with developmental delays. They examined early evidence of behaviour problems in 225 3-year-old children with or without developmental delays and the relative impact of cognitive delays and problem behaviours on their parents. Staff completed Bayley Behaviour Scales and parent completed Child Behaviour Checklists (CBCLs) showed greater problems in children with delays than in those without delays. Children with delays were 3 to 4 times as likely to have a total Child Behaviour Checklists (CBCL) score within the clinical range. Parenting stress was higher in delayed condition families. Regression analyses revealed that the extent of child behaviour problems was a much stronger contributor to parenting stress than the child's cognitive delay.

Stress attributed by parents to their family member with intellectual disability was investigated by Baxter, Cummins and Yioliitis (2000), over a period of 7 years in relation to specific foci of parental worry and also in relation to stress attributed to the youngest sibling without a disability. Forty four parents of 10–12 year olds, 29 parents of 17–19 year olds and 20 of 24–26 year olds were interviewed. The stress parents attributed to their family member with a disability was about double that attributed to the youngest sibling without a disability. However, multiple regression analysis revealed that the stress attributed to the sibling without a disability actually accounted for most of the variance in explaining the stress attributed to the family member with a disability. The results suggested that the stress attributed to any specific child may be an indicator of more general family stress. It was also found that, while the strength of parental worry decreased, the pattern of worries did not change over time, nor did the specific foci of worry differentiate low-stressed from high-stressed parents.
Richdale, Francis, Gavidia-Payne and Cotton (2000) examined on Stress, behaviour and sleep problems in children with an intellectual disability. Problems usually include settling difficulties, long sleep latencies, night waking and early morning waking. Sleep problems were also likely to be stressful for other family members, particularly parents. In this study 52 children (aged 2–19 years) with an Intellectual Disability (ID) and their families and a comparison group of 25 typically developing children (age 2–17 years) and their families participated. Parents completed a sleep questionnaire, the Developmental Behaviour Checklist, and the Parenting Hassles Scale. Analysis showed that the presence of sleep problems was significantly associated with both the intensity and frequency of hassles and the presence of behaviour problems.

DEPRESSION IN PARENTS OF MENTALLY CHALLENGED

Cook (2009) examined the critical importance of the frequency and quality of interactions between parents and their young children and developmental outcomes. The literature reported that both maternal depression and intellectual disabilities are risks to the normal processes of interaction between parents and their young children. Most available studies examined the relationships in clinical or laboratory settings, rather than natural settings. Investigated in an existing dataset from a national study of parent-child interaction was the extent that these relationships in mother-infant dyads were mediated by these risks. In lieu of more traditional measures of intellectual disability (e.g., IQ), available measures of very low literacy were used as “proxy” measures for intellectual disability.

Hartley and MacLean (2009) investigated the experience of stressful social interactions, negative causal attributions and the use of maladaptive coping efforts help maintain depression over time in the general population and similar experience occurs
among adults with mild intellectual disability. They compared the frequency and stress impact of such interactions, identified causal attributions for these interactions and determined the coping strategies of 47 depressed and 47 non-depressed adults with mild intellectual disability matched on subject characteristics. The depressed group reported a higher frequency and stress impact of stressful social interactions, more negative attribution style and more avoidant and less active coping strategies did than the non-depressed group.

Parental bereavement and the loss of a child with intellectual disabilities was explored by Reilly, Hastings, Vaughan and Huws (2008). Inequalities in health care and other risk factors mean that children with intellectual disabilities were more likely to predecease their parents. Research on the effects on family members when a child with intellectual disability dies is sparse. The authors described 5 studies of bereavement in intellectual disability and then turn to general parental bereavement research to inform the field of intellectual disability. In particular, professionals should be aware of dissatisfaction with care pre-loss, disenfranchised grief and post-loss support needs of family members.

Stressful social interactions, coping and depression among adults with mild intellectual disability was investigated by Hartley (2008). Perceptions of stress were related to psychopathology among adults with mild Intellectual Disability (ID). Adults with mild Intellectual Disability perceive stressful social interactions as occurring more frequently and as having a greater impact than other types of negative life events. Adults with mild Intellectual Disability also reported a lower rate of adaptive coping to deal with stressful social interactions than for other categories of stressors. Stressful social
interactions, the causal attributions for them and coping may be salient features of depression in adults with mild Intellectual Disability. In the stressful social interactions, category of others with whom these interactions occur, specific interpersonal components of social interactions perceived as stressful and coping strategies of 114 adults with mild Intellectual Disability were assessed. Stressful social interactions involving other people with Intellectual Disability occurred most frequently and had the highest stress impact. Controlling aggression, being involved and sociable and self-assertion were the most stressful components of social interactions. Adults with mild Intellectual Disability reported using Problem-Focused coping more frequently than Emotion-Focused or Support Seeking coping. Active coping was negatively related to psychological distress. Again, in the stressful social interactions, casual attributions and coping strategies of 62 adults with mild Intellectual Disability with and without depression were evaluated. Depressed adults with mild Intellectual Disability reported a higher frequency and stress impact of stressful social interactions, exhibited a more negative attribution style and utilized fewer active and more avoidant coping strategies than non-depressed adults. Findings have implications for theory building and development of interventions to increase the psychological well-being of adults with mild Intellectual Disability.

Depressive Symptoms in Adults with Mild to Moderate Intellectual Disability and their Relation to Maternal Well-being was conducted by Esbensen, Seltzer and Greenberg (2006). Little is known about the impact on the family of caring for an individual with both intellectual disability and a mental-health problem. It examined the relationship between depressive symptoms in adults with mild to moderate intellectual disability and concurrent maternal well-being as measured by depression, pessimism, subjective burden
and the mother’s perception of the quality of the relationship with her son or daughter. Also examined the extent to which the adult’s depressive symptoms predicted later maternal well-being after controlling for behaviour problems and identified covariates. Seventy-one interviews were conducted with mothers regarding their own well-being and their children’s behaviour problems as part of a larger longitudinal study of mothers more than 55 years old caring for a coreiding adult son or daughter with intellectual disability. The adult with mild to moderate intellectual disability was interviewed about his or her depressive symptoms. The depressive symptoms of the adult with intellectual disability were correlated with concurrent maternal depression and were predictive of future maternal depression, pessimism and subjective burden. They also predict some measures of maternal well-being and do so beyond what is predicted by behaviour problems. The findings suggested that raising an adult child with a dual diagnosis may be more stressful than raising an adult child with intellectual disability only.

Esbensen (2005) evaluated two cognitive theories of depression for their relevance and applicability to individuals with Mental Retardation, the Cognitive Triad Theory of Depression (Beck, 1967, 1970, 1976) and the Learned Hopelessness Theory of Depression (Abramson, Metalsky & Alloy, 1989). The focus in Beck’s theory is that cognitive distortions lead to a negative cognitive triad and then subsequently to depression. In comparison, the learned hopelessness theory emphasizes that it is the combination of stressful life events and specific attributions that leads to hopelessness and subsequently depression. Seventy-three adults with mental retardation who met screening criteria were interviewed, on two separate occasions four months apart, about depressed mood, associated cognitive constructs, stress, self-esteem and social support.
Informants provided information about the individual's depressed affect, social skills, social support and stress. Informants also provided information about a comparison group of 49 adults with mental retardation who did not meet screening criteria. The results provided partial support for the cognitive triad theory of depression. The cognitive triad did not serve as a mediator between automatic thoughts and depressed mood among individuals with mental retardation, which failed to support the theory. However, there were indications that automatic thoughts may serve as a mediator between the cognitive triad and depressed mood. The results also provided partial support for the hopelessness theory of depression. Among individuals with lower receptive vocabulary, stress was the predominant predictor of subsequent depressed mood, consistent with the child literature. No clear predictor was obtained among individuals with higher receptive vocabulary. Continuing to evaluate and refine the cognitive theories of depression is necessary in order to develop evidence-based cognitive treatment for individuals with mental retardation.

Veisson (2004) investigated on Depression Symptoms and Personality Traits in Parents of Intellectually Disabled and Non-Disabled Children. First, to measure the personality characteristics and self-esteem in parents of disabled children and non-disabled children in Sweden and Estonia. Secondly, to compare personality characteristics of parents of disabled children with Estonian norms for the general population. Third, to find out, if there were differences between parents of disabled children and nondisabled children in depression symptoms and emotional states. The assessments in the first study were the Adjective Check List (ACL) by Gough and Heilbrun (1983), Eysenck Personality Inventory (1987) and Self-Esteem Inventories,
Adult Form (SEI) by Coopersmith (1990). In the second study they used a five-factor personality inventory (NEO-PI). The third investigation was carried out in Estonia and focused on the depressive symptoms and emotional states. Beck Depression Inventory (Beck et al., 1961) and Emotional States Scale by Leskinen (1994) were used. Comparisons of the two parent groups did not give any statistically significant differences with respect to EPI and SEI in the Swedish-Estonian study. However the results of the Estonian study showed that parents of disabled children were significantly more introvert than parents of non-disabled children. Comparisons of personality characteristics between the two groups gave the following results: 1) mothers and fathers of disabled children have a significantly lower Extraversion and Openness level compared to the Estonian norms for women and men 2) Neuroticism mothers of disabled children score higher than the Estonian women's norm, but fathers score higher only in some Neuroticism facets 3) Agreeableness, neither mothers nor fathers differ from Estonian norms 4) Conscientiousness fathers of disabled children score higher than the norms for men, but the data of mothers do not differ. The results of the third study showed that parents, especially mothers of disabled children, had significantly more negative emotional states and also significantly more depressive symptoms than parents in the control group. Significant differences in depression symptoms between the disabled and control parent groups were found in most cases.

Glidden and Schoolcraft (2003) conducted a study on Depression and its trajectory and correlates in mothers rearing children with intellectual disability. Rearing a child with an Intellectual Disability (ID) is a lifelong activity and research needs to reflect the extended nature of the task as well as its complexity. The present longitudinal study reports on an 11-year follow-up of adoptive and birth families rearing children with
intellectual disability, aged between 12 months and 12 years at study entry, participated. Its focus was on depressive symptoms and how these changed over time in a sample of 187 mothers. In particular, the authors were interested in whether initial differences in depression between adoptive mothers who knowingly and willingly decided to rear their children with disabilities and birth mothers for whom the diagnosis of disability was unexpected and frequently crisis-inducing, would persist over time. A longitudinal method with three times of measurement provided data which were analysed with analysis of variance and regression techniques. Moreover, several other individual and family adjustment measures were examined with respect to their correlations with depression and an outcome variable that measured subjective well-being with regard to the child. Results showed that both adoptive and birth mothers reported low depression, not significantly different from each other, at the 11-year follow-up.

Association between perceived social support and strain, and positive and negative outcome for adults with mild intellectual disability was explored by Lunsky and Benson (2001). Social strain was a trigger for both depression and physical health problems. The present study contrasted the effects of social support with social strain on depressive symptoms, somatic complaints and quality of life over time in 84 adults (aged 20–65 years) with mild intellectual disability. Measures included the Social Support Self Report for Mentally Retarded Adults, the Inventory of Negative Social Interactions, the Birleson Depressive Short form Self-Rating Scale and the Quality of Life Questionnaire. The level of social support explained a significant proportion of variance in quality of life 6 months later, but not depressive symptoms or somatic complaints. In contrast, the level of social strain accounted for a significant proportion of variance in depressive symptoms
and somatic complaints 6 months later, but not quality of life. The results suggested that interpersonal relationships can be both positively and negatively associated with physical and mental health for people with intellectual disability.

The assessment of emotional distress experienced by people with an intellectual disability was done by Bramston and Fogarty (2000). The assessment of emotional disorders such as anger, depression and stress among people with an intellectual disability was traditionally used 1 of 3 methodologies: ratings by a significant other, a clinical interview, or self-report. It assessed the convergence among these 3 approaches for 147 people with a mild or moderate intellectual disability (aged 18–63 years) across the affective domains of anger, depression and stress. The results showed the overlap among the 3 methods to be consistently low, although limited convergence was found between self-report and clinical interview. Ratings by work supervisors discriminated least clearly between anger, depression and stress while self-report was the most discriminating between these 3 overlapping but conceptually distinct states.

**GENERAL WELL-BEING IN PARENTS OF MENTALLY CHALLENGED**

Quality of life (QoL) of Australian family carers: Implications for research, policy and practice was investigated by Burton-Smith, McVilly, Yazbeck, Parmenter and Tsutsui (2009). As part of an international, multicentered project, the burden of care, health and subjective well-being experienced by selected Australian family carers supporting a relative with disability at home were investigated. Some 448 family carers residing in New South Wales and Tasmania completed a battery of instruments, including a Self-report Demographic Survey, the Family Caregiver Burden Inventory, the General Health Questionnaire and the Personal Well-being Index. Respondents were
predominantly females (mean age 48 years), married and supporting a son or daughter with an intellectual disability (mean age 18 years). Although caring for their family member was not perceived to be a burden, respondents reported notable limitations on their social networks and social activities. They reported higher levels of unemployment than would be expected for the general population and were over represented in lower income groups. They reported seriously low levels of mental health and personal well-being when compared with the general population. The findings revealed that this group of family carers was at high risk of social and economic disadvantage and at high risk of mental health challenges. Social policy makers and service providers should take these factors into account, both in the interests of promoting the health and well-being of the carers and considering the long-term needs of family members with disability who rely on family carers for daily support when designing services.

Parent and professional reports of the quality of life of children with cerebral palsy and associated intellectual impairment study was done by White-Koning, Grandjean, Colver and Arnaud (2008). To examine parent-professional agreement in proxy-reports of child Quality of Life (QoL) and the factors associated with low child QoL in children with Cerebral Palsy (CP) and associated intellectual impairment. Professional (teacher, therapist or residential carer) and parent reports of QoL for 204 children (127 males, 77 females, mean age 10 years 4 months range 8-12 years) with CP and IQ ≤ 70 were obtained in 2004 to 2005 in nine European regions, using the KIDSCREEN questionnaire. Parent-professional agreement was studied using correlation and mean differences; multilevel logistic regression was used to determine factors influencing QoL reports and agreement. The mean parent-reported scores of child QoL.
were significantly higher than the professional reports in the Psychological well-being domain and significantly lower for Social Support. The average frequency of disagreement (parent-professional difference >0.5SD of scores) over all domains was 62%. High levels of stress in parenting negatively influenced parent reports of child QoL compared with professional reports, while child pain was associated with professionals rating lower than parents. Proxies do not always agree when reporting the QoL of children with severe disabilities. Parental well-being and child pain should be taken into account in the interpretation of QoL reports in such children.

Olsson, Larsman and Hwang (2008) examined a study on Relationships among risk, sense of coherence and well-being in parents of children with and without intellectual disabilities. The authors studied the nature and function of the relationships of the comparative level of risk, Sense Of Coherence (SOC) and well-being, over time, in mothers and fathers of preschool children with and without Intellectual Disabilities (IDs). The hypothesis that SOC functions as a moderator between risk and well-being was tested. Parents of children with IDs (mothers: n = 62 (46 at follow-up) and fathers: n = 49 (37 at follow-up)) and control parents (mothers: n = 178 (131 at follow-up) and fathers: n = 141 (97 at follow-up)) answered self-report measures on risk factors (i.e., child behaviour problems, negative impact on the family and socioeconomic situation) and sense of coherence. Well-being and quality of life were used as outcomes and were measured at baseline and at a one-year follow-up. The hypothesis of moderation was tested conducting multiple linear regression analyses. The level of well-being was moderately stable over the two time points, with parents of children with ID having lower level of well-being than control parents both initially and after one year. Well-being was
also related to level of SOC and cumulative risk with parents experiencing lower SOC or more risk also reporting lower well-being. The hypothesis of SOC acting as a moderator in the relation between cumulative risk and well-being found some support in the longitudinal analyses, but only for well-being (BDI-2r) among control mothers.

Mental health problems in young people with intellectual disabilities and its impact on parents was explored by Faust and Scior (2008). Young people with intellectual disabilities seem to be at increased risk of developing mental health problems. The present study examined the impact such difficulties can have on parents. Semi-structured in-depth interviews were carried out with 13 parents and one adult sibling of 11 young people with intellectual disabilities and additional mental health problems. Results revealed that, Parents described far reaching negative consequences of the young person's mental health problems. In many parents these re-evoked intense past feelings of grief and triggered feelings of helplessness and despair. The outcome of the study showed that Parents' experienced characteristics by confusion, loss and hardship.

Minnes, Woodford and Passey (2007) conducted a study of increasing numbers of adults with an intellectual disability were being cared for at home by ageing parents. The purpose of this study was to determined the carer resources (i.e. social support and formal service use) and carer appraisals of ageing and stress/burden mediate the relationships between (1) maladaptive behaviour and carer depression (2) carer health and carer depression (3) maladaptive behaviour and carer quality of life and (4) carer health and carer quality of life. Eighty parents over the age of 50 were interviewed using a number of measures concerning their overall health, perceptions of ageing and stress, depression and their child's maladaptive behaviour. Results revealed that carer
perceptions of ageing and stress emerged as significant mediators of the relationship between carer health and depression. In addition, perceived carer stress emerged as a significant mediator of the relationship between maladaptive behaviour and carer depression. Resources and appraisals did not emerge as significant mediators in analyses using quality of life as a positive outcome. Results highlighted the important contributions of appraisals to well-being and raise questions for future research regarding the role of resources such as informal and formal support in the coping process.

Emerson, Hatton, Llewellyn, Blacker and Graham (2006) investigated a study on Socio-economic position, household composition, health status and indicators of the well-being of mothers of children with and without intellectual disabilities. Studies reported that mothers of children with Intellectual Disabilities (IDs) were more likely to show signs of psychological distress and had lower well-being than mothers of "typically developing" children. The study involved secondary analysis of happiness, self-esteem and self-efficacy variables in a nationally representative sample of 6954 British mothers with dependent children under the age of 17 years, 514 of whom were supporting a child with an ID. Results indicated that, Mothers of children with IDs reported lower levels of happiness, self-esteem and self-efficacy than mothers of children without IDs. Statistically controlling for differences in socio-economic position, household composition and maternal characteristics fully accounted for the between-group differences in maternal happiness and accounted for over 50% of the elevated risk for poorer self-esteem and self-efficacy. A socially and statistically significant proportion of the increased risk of poorer well-being among mothers of children with IDs may be attributed to their increased risk of socio-economic disadvantage.
Blacher and McIntyre (2006) examined the specificity and behavioural disorders in young adults with Intellectual Disability (ID) and Cultural Differences in family impact. Behaviour disorders in young adults with moderate to severe ID were assessed from information provided by 282 caregivers during in-home interviews. The sample consisted of 150 Anglo participants and 132 Latino, primarily Spanish-speaking, participants drawn from Southern California. Results revealed Behaviour disorders and maternal well-being showed the same pattern across disability syndromes. Autism was associated with the highest scores in multiple behaviour problem areas as well as maternal reports of lower well-being. Down syndrome was associated with the lowest behaviour problem scores and the highest maternal well-being. When behaviour problems were controlled for, diagnostic groups accounted for no additional variance in maternal stress or depression. The pattern of behaviour problems and well-being did not differ by sample (Anglo vs. Latino), although level on well-being measures did. Latina mothers reported significantly higher depression symptoms and lower morale, but also higher positive impact from their child than did Anglo mothers. Study concluded that caregivers of young adults with autism report more maladaptive behaviour problems and lower personal well-being or stress, relative to other diagnostic groups, regardless of cultural group. However, cultural differences exist in caregiver reports of depression, morale and positive perceptions.

Shin and Crittenden (2003) compared an evaluation of the Double ABCX model in a cross-cultural context, psychological well-being of mothers of children with mental retardation in USA and Korea. The Double ABCX model of stress proposed by McCubbin and Patterson (1983) was evaluated for the two national groups. Thirty-eight
American and 40 Korean mothers participated in the home-visit interview. The path models partially supported the ABCX model, but different path models for the two national groups provided important explanations for the well-being of mothers from the two nations. The cause of stress for the American Mothers was specific to the individual variables. For Korean Mothers, cultural values that carry social influence were more strongly associated with their attitudes towards the child and their experience of stress.

Stress, social support and well-being of Arab mothers of children with intellectual disability who are served by welfare services in northern Israel a study was reported by Duvdevany and Abboud (2003) based on the level of stress and the sense of personal well-being of 100 Israeli Arab mothers of young children with special needs. In the Nazareth area 50 mothers were served by the welfare services, while 50 did not get help on a regular basis. A comparison was done between educated, urban mothers, and less-educated, rural mothers. The results revealed a relationship between informal support resources and the marital and economic stress of the mothers, the higher the amount of the informal support resources, the lower the level of stress that was experienced by the mothers. A relationship between the amount of informal support and level of parental stress was not confirmed. A relationship between the amount of support resources and the personal well-being of the mothers was found: the higher the amount of informal support resources, the higher the sense of well-being of the mothers. A relationship between formal support and level of stress or personal well-being was not found. Educated mothers from urban areas used the formal support less than less-educated mothers who lived in rural areas.
The role of coping in maintaining the psychological well-being of mothers of adults with intellectual disability and mental illness study was done by Kim, Greenberg, Seltzer and Krauss (2003) investigated on Mothers with Intellectual Disability (ID) child or mental illness face a lifetime of care giving responsibilities and challenges. A sample of 246 ageing mothers of adults with ID and 74 mothers of adults with mental illness was drawn from two parallel longitudinal studies of later-life caregiving. Results showed 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 ID, 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.

Kroese, Hussein, Clifford and Ahmed (2002) examined the impact of social support networks of mothers with intellectual disabilities (N=15) on their psychological well-being and their views of parenting. As part of a semi-structured interview, mothers were asked about parenting role and the support. Adapted psychological questionnaires were presented which measured affect, assertiveness and self-esteem. Mothers were also asked about the benefits, burdens and future expectations of parenthood. It was hypothesized that the larger, more recent and more helpful the support network was reported to be, the better the psychological well-being and the more positive the views on parenthood. Data analysis included quantitative and qualitative methods. Results showed
significant associations between the number of reported social contacts and positive affect, the recency of reported social contacts and self-esteem and the lack of self-esteem and reported burdens of parenting. The average number of social contacts reported was 6.8 persons, with only half of these being described as very helpful. Very few non-family members were part of the support networks.

Well-being and family role strains among Cuban American and Puerto Rican mothers of adults with mental retardation was conducted by Magaña, Seltzer, Krauss, Rubert and Szapocznik (2002). They examined predictors of depressive symptoms and caregiving burden in Cuban-American and Puerto Rican Caregivers of adult children with Mental Retardation. There were 44 Puerto Rican Mothers (aged 55+ years) and 49 Cuban-American Mothers (aged 55+ years) of mentally retarded adult children completed questionnaires concerning: (1) services received by the child, such as therapy, psychological and legal services (2) family problems (3) depressive symptoms and (4) caregiver burden. Results showed that Cuban-American subjects reported higher socioeconomic status than did Puerto Rican subjects. There was a substantial amount of within-group heterogeneity in family socio-demographic characteristics, linked closely with immigration patterns for Cuban-American subjects. However, subjects in families with more problems had higher levels of burden and depressive symptoms, even after accounting for socio-demographic diversity and ethnicity.

POSITIVE THERAPY AND STRESS

A study on, ‘Management of stress in Tea Estate Workers through Positive Therapy’ was conducted by Gayatridevi and Preetha (2011). Fifty Tea Estate Workers from Devi Tea Estate, Pallada, Nilgiris, were screened using Case Study Schedule
Thirty two subjects (23 Females and 9 males) in the age range of 17-50 years were selected by Purposive Sampling Method. Positive Therapy was used as the Psychological Intervention to help the sample to manage stress. The subjects were divided into 3 batches of 10 to 11 in each batch and were given Positive Therapy for one hour per session. Five sessions were given for five consecutive days. Two weeks after the therapy, the sample was reassessed using Case Study Reassessment Schedule and Stress Inventory. The results showed initially, the entire sample (100%) had ‘High’ stress. After the treatment of Positive Therapy, most of them (81%) had ‘Low’ stress. There was statistically significant reduction in the mean stress of sample from ‘High’ to ‘Low’. The main sources of stress were, heavy workload and procrastination. The symptoms of stress reported by most of the sample were insomnia, loss of concentration and anxiety. The negative emotions experienced by majority of the sample were fear, worries, anger and anxiety. After the administration of Positive Therapy, there was an enormous reduction in the number of subjects experiencing symptoms and negative emotions due to stress. Thus, there was a great influence of Positive Therapy in reducing the stress, symptoms and negative emotions of the selected Tea Estate Workers.

‘Management of Stress in Entrepreneurs through Positive Therapy’ was carried out by Yasodha and Gayatridevi (2010). Forty Entrepreneurs from Podanur, Coimbatore, Tamil Nadu, were selected by Purposive Sampling method. The age range of the sample was 21–40 years. They were assessed using Case Study Schedule (Hemalatha, 2009) and Stress Inventory (S.I) (Hemalatha and Nandini, Revised 2005). Five sessions of Positive Therapy were given over a period of two weeks after which, they were reassessed using
Rohini and Saranya (2010) conducted a study on ‘Management of Stress and Enhancement of Self-esteem in School Teachers through Positive Therapy’ was conducted in Navarasam Matriculation Higher Secondary School, Erode (N=50). The sample consisted of female teachers in the age range of 25 to 50 years. Case Study Schedule constructed and standardized by Hemalatha (2008), Stress Inventory constructed by Hemalatha and Nandini (2005), Rosenberg Self-esteem Scale constructed and standardized by Rosenberg (1965) and Case Study Reassessment Schedule constructed by Hemalatha (2008) were used to collect the data. Psychological Intervention named Positive Therapy was given to reduce stress and enhance the self-esteem of teachers. The results indicated that the effectiveness of Positive Therapy in the sample with the mean stress of 16.52% before intervention and 4.38 after intervention and significant at 0.01 level. The self-esteem was 9.34 before intervention and it increased to 22.92 after intervention.

Sivasakthi and Preetha (2010) conducted a study on, ‘Management of Stress and Enhancement of Emotional Intelligence in IT Professionals through Positive Therapy’. Forty five IT professionals from software company in Coimbatore, were screened using Case Study Schedule (Hemalatha, 2009), Stress Inventory (Hemalatha and Nandini, 2005) and Emotional Intelligence Test (Chadha and Dalip, 2004). Out of them, 40 subjects (22 male and 18 female) in the age range of 22-29 years, were selected by Purposive
Sampling, mostly belonging to urban areas. As psychological intervention, Positive Therapy evolved by Hemalatha (2004), a package combining the Eastern techniques of Yoga and Western techniques of Cognitive Behaviour Therapy was used. The sample was divided into 3 batches of around 13 in a batch for Positive Therapy. Six sessions of Positive Therapy were given in two weeks, with each session lasting for one hour. After two weeks, the subjects were reassessed using the Case Study Reassessment Schedule, Stress Inventory and Emotional Intelligence Test. Initially, 70% of the sample had ‘High’/‘Very High’ stress. After Positive Therapy, none of them had ‘Very High’ stress and only 10% had ‘High’ stress. There was a significant reduction in the mean stress from ‘High’ (12.68) to ‘Low’ (3.68) and increase in the mean emotional intelligence from ‘Moderate’ (211) to ‘High’ (255) after Positive Therapy. There was a negative correlation (r = -0.561) between stress and emotional intelligence in the sample. The major causes of stress reported by the sample were lack of time for socialization, adjustment problems at home, lack of recreation, work overload, responsibilities and technological uncertainty. Some of the common symptoms of stress identified in the sample were short temper, confusion and restlessness. Majority of the sample had back pain and headache. The common negative emotions reported by the sample were anger, fear, worry and anxiety. After Positive Therapy, there was a significant reduction in the symptoms, pain and negative emotions experienced by the sample.

A study on, ‘Management of stress in parents of special children through Positive Therapy’ was conducted by Thenu and Hemalatha (2009). Forty parents of mentally retarded children from the Special Education Department of Avinashilingam University for Women, Coimbatore, were screened using Case Study Schedule (Hemalatha, 2008)
and Stress Inventory (Hemalatha and Nandini, 2005). Out of them, 35 subjects were selected by Purposive Sampling. There were 10 males and 25 females. They were in the age range of 25-50 years. The sample was divided into 3 batches of around 12 in a batch for Positive Therapy. Positive Therapy evolved by Hemalatha (2004) is a package, combining the Eastern techniques of Yoga and Western techniques of Cognitive Behaviour Therapy. Six sessions of Positive Therapy was given in two weeks. Each session lasted for one hour. After two weeks, the subjects were reassessed using the Case Study Reassessment Schedule and Stress Inventory. Initially, 86% of the sample had ‘High’/‘Very High’ stress and none of them had ‘High’/‘Very High’ stress after Positive Therapy. There was a significant reduction in the mean stress from ‘High’ (16.47) to ‘Moderate’ (6.29) after Positive Therapy. The entire sample had worry, the other common negative emotions being depression, fear, irritation, anxiety, anger and hatred. The symptoms reported by majority of the sample were sleep disturbance, confusion, fatigue, loss of appetite, headache, weakness and body pain. After Positive Therapy, there was a drastic reduction in the negative emotions and symptoms of the sample.

Mary and Hemalatha (2009) conducted a study on, ‘Management of Stress in Nurses through Positive Therapy’. Forty female nurses from KG Hostel, Coimbatore, Tamil Nadu, India, were screened using Case Study Schedule (Hemalatha, 2008) and Stress Inventory (S.I) (Hemalatha and Nandini, 2005). Out of them, 32 subjects with ‘Very High’ / ‘High Stress’ were selected by Purposive Sampling and were given the psychological intervention called, Positive Therapy. Positive Therapy was given for 6 sessions thrice a week for 2 weeks. The duration of each session was 1 hour. After 2 weeks of Positive Therapy, they were reassessed using Case Study Reassessment
The results revealed that initially, most of the subjects had ‘High’/‘Very High’ stress. After Positive Therapy, the stress in most of the subjects had come down to ‘Low’ level. The mean stress reduced from ‘High’ (M=17.69) to ‘Low’ (M=4.25) after Positive Therapy. The results clearly indicated not only the efficacy of Positive Therapy in the management of stress but also in minimizing the symptoms and negative emotions of the selected nurses.

Management of stress in diabetic patients through Positive Therapy was examined by Saranya and Gayatridevi (2009). From the Sri Sai Trust, Coimbatore, 50 diabetic patients were screened using Case Study Schedule (Hemalatha, 2008) and Stress Inventory (Hemalatha and Nandini, 2005). Out of them, 35 were selected by Purposive Sampling Method. They were in the age range of 34-78 years. The Case Study Schedule was used to obtain information from the sample. The information gathered includes the demographic details, risk factors, negative emotions and effects of stress. Stress Inventory was administrated to the sample to assess their level of stress. The entire sample was provided with the Psychological Intervention called Positive Therapy. Positive Therapy evolved by Hemalatha (2004) is a package, combining the Eastern techniques of Yoga and Western techniques of Cognitive Behaviour Therapy. Six sessions of Positive Therapy was given in two weeks. Each session lasted for one hour. After two weeks, the subjects were reassessed using the Case Study Reassessment Schedule and Stress Inventory. Initially, the sample had either ‘High’ (83%) or ‘Very High’ (17%) stress. But after Positive Therapy, none of them had ‘High’/‘Very High’ stress. There was a significant reduction in the mean stress from ‘High’ (15.77) to ‘Moderate’ (2.69) after Positive Therapy, significant at 0.01 level. The entire sample had
fear the other common negative emotions experienced by the sample were worry, hostility, hopelessness and anger. The symptoms reported by majority of the sample were pain, sweating, sleep disturbance, swelling of legs, general weakness, excessive hunger, frequent urination, giddiness, itching and stiffness. After Positive Therapy, there was a drastic reduction in the negative emotions and symptoms of the sample.

‘Management of Stress and Pain in IT professionals through Positive Therapy’ was carried by Vandana and Hemalatha (2008). Seventy eight IT Professionals from ORACLE and Customer Driven Company, Bangalore, Karnataka, were screened using Case Study Schedule (Hemalatha, 2008) Occupational Stress Index (Srivatsava and Singh, 1981) and Patient Pain Questionnaire (Ferrell, 1998). Out of them, 30 subjects (18 males and 12 females) were selected by purposive sampling. Positive Therapy (Hemalatha, 2004) was used as the psychological intervention, which was given for 6 sessions to help the sample manage job stress. The results revealed that initially, the entire sample had ‘High Job Stress’ and ‘High Pain’. After the administration of Positive Therapy, 53% had ‘Low Job Stress’ and 47% had ‘Moderate Job Stress’. The mean job stress significantly reduced from ‘High’ (M=162.85) to ‘Moderate’ (M=124.5) and majority of the subjects (73%) had ‘Low Pain’/‘Very Low Pain’ after Positive Therapy and there was a significant reduction in the mean pain of the sample from ‘High’ (M=45.51) before Positive Therapy to ‘Low’ (M=23.5) after Positive Therapy.

In a study by Divya and Hemalatha, (2007) on, ‘Management of Job Stress in IT professionals through Positive Therapy’, 50 IT professionals from Hewlett Packard, Bangalore, Karnataka, were screened using Case Study Schedule (Hemalatha, 2003) and Occupational Stress Index (Srivastava and Singh, 1981). By purposive sampling, 32
subjects (23 males and 9 females) were selected. They were in the age range of 24-38 years. The sample was divided into 3 batches of 10 to 11 in each batch and was given Positive Therapy for one hour per session. Five sessions were given on 5 consecutive days. Two weeks after the therapy, the subjects were reassessed using Case Study Re-assessment Schedule and Occupational Stress Index. Initially, the entire sample (100%) had ‘High’ job stress. The main sources of job stress were work and procrastination. The symptoms of stress reported by most of the sample were insomnia, loss of concentration and anxiety. The negative emotions experienced were fear, worries, anger and anxiety. But after the administration of Positive Therapy, most of the subjects (81%) had ‘Low’ job stress. There was a statistically significant reduction in the mean job stress of the sample from ‘High’ (M=181) to ‘Low’ (M=92). There was an enormous reduction in the number of subjects experiencing symptoms and negative emotions due to stress. Initially, coping strategies were used to the minimum extent, which improved after they underwent Positive Therapy. In short, there was a great influence of Positive Therapy in reducing the job stress, symptoms and negative emotions of the selected IT professionals.

Rajakumari and Hemalatha (2006) conducted a study on ‘Management of Stress in Nurses through Positive Therapy’. Out of 60 registered female nurses, in the age range of 22-33 years, from Ramakrishna Hospital, Coimbatore, Tamil Nadu, 30 were assigned to experimental group and 30 to control group. They were assessed using Stress Questionnaire (Latha, 1984). Initially, stress was high in both the groups (165 and 160 respectively). After the administration of the Positive Therapy for 10 sessions in 5 weeks,
there was a significant reduction in the mean stress (125) of the experimental group, where as there was a slight increase in the mean stress of the control group (171).

Umamaheshwari and Hemalatha (2006) conducted a study on ‘Management of Stress in Bank Employees through Positive Therapy’. From Bank of Baroda, Coimbatore, 30 officers and clerical staff, were selected. There were 18 males and 12 females in the age range of 26-56 years. Using Stress Inventory, Revised (Hemalatha and Nandini, 2005), it was found that 60% had ‘High’ stress and 3% had ‘Very High’ stress. The remaining 37% had ‘Moderate’ stress. Positive Therapy was used as the psychological intervention for 6 sessions, for 2 weeks, on alternate days. Results showed that after the administration of Positive therapy 47% had ‘Low’ stress, 50% had ‘Moderate’ stress and only 3% had ‘High’ stress. The mean stress, which was ‘High’ (11.50), reduced to ‘Low’ (4) after Positive Therapy.

In the study, ‘Management of Stress in Accident Patients through Positive Therapy’ by Prashanthi and Hemalatha (2006), 30 accident patients (20 males and 10 females), in the age range of 20-80 years from Rex Ortho Hospital, Coimbatore, were assessed using Stress Inventory Revised (Hemalatha and Nandini, 2005). Initially, the sample had either ‘High’ (50%) or ‘Moderate’ (50%) stress. Positive Therapy was given for one hour, on alternative days for 2 weeks. After the administration of the Positive Therapy, 43% did not have stress; 40% had ‘Low’ stress and remaining 17% had ‘Moderate’ stress.

‘Management of Stress and Enhancement of General Well-being in recovered Alcoholics through Positive Therapy’ was conducted by Suchitra and Hemalatha (2006). Forty six recovered male alcoholics, from Bangalore 37 with ‘High’ stress and 9 with
‘Moderate’ stress were selected for the study. They were in the age range of 24 to 47 years. After the administration of Positive therapy for 10 sessions in 2 weeks, stress had reduced remarkably in most of the subjects. The mean stress, which was ‘High’ (17.20) initially, had reduced to ‘Low’ (4) after Positive Therapy. The General Well-being had also improved in most of the subjects, indicating the beneficial effects of Positive Therapy.

Latha and Rohini (2006) conducted a study on ‘Management of Stress in Wives of Alcoholics through Positive Therapy’, in which, 35 wives of alcoholic patients from Krishna Rehabilitation Centre for Alcoholics, Coimbatore, Tamil Nadu, served as the sample. The sample was in the age range of 30-50 years. Results revealed that initially, 51% had high stress. But after the administration of Positive Therapy for 2 weeks, for 6 sessions of one hour each, on alternate days, there was a significant reduction in the mean stress from ‘High’ (M=19.09) to ‘Low’ (M=4.09).

Yogatha and Gayatridevi (2006) conducted a study on ‘Management of stress in stress-induced diabetes through Positive Therapy’. The subjects were 50 diabetes patients (15 males and 35 females) in the age range of 25-65 years, from SKY Spiritual Trust, Coimbatore. Using Stress Questionnaire (Latha, 1984), it was found that the entire sample had ‘High’ level of stress. The subjects were provided with Positive Therapy for one hour per session, three times a week, for one month. Results showed that Positive Therapy had helped to reduce the mean stress from ‘High’ (143.76) to ‘Low’ (27.38). It was amazing that 90% of the sample had ‘Very Low’ stress and the remaining 10% had ‘Low’ stress.
Kavitha and Hemalatha (2005) conducted a study on ‘Management of Stress and Enhancement of General Well-being in Haemodialysis Patients through Positive Therapy’. Thirty six haemodialysis patients from K.G Hospital, Coimbatore, in the age range of 20-65 years, served as the sample. Initially, the entire sample had ‘High’/‘Very High’ stress (22.55). Positive Therapy was administered for one hour per session, on alternate days for two weeks, involving 6 sessions. Results revealed that after the administration of Positive Therapy, the mean stress of the sample came down to ‘Low’ level (6.22).

Praveena and Hemalatha (2004) conducted a study on ‘Assessment and management of stress in working women through Positive Therapy’. Out of 100 women from the selected small-scale industries in Coimbatore, Tamil Nadu, 60 women who had ‘Very High’/‘High’ stress, aged between 17 and 50 years were selected for the research. Out of them, 30 were assigned to the experimental group and 30 to the control group. Positive Therapy was given in smaller groups of 10 members in a group, for one hour per session; 6 sessions were given over a period of three weeks. Results indicated that Positive Therapy had helped to bring down the mean stress of the experimental group from ‘High’ (22.5) to ‘Moderate’ (10.5) levels. There was a significant difference in the mean stress before and after treatment. The mean stress of the control group had increased slightly in the retest and continued to be ‘High’ (22.20 to 23.80).

Dhara and Hemalatha (2003) conducted a study on ‘Management of Stress in Primary School Teachers through Positive Therapy’. Out of 60 female teachers selected, in the age range of 25-36 years, from Mani Feeder’s School and Vivekalaya School in Coimbatore, Tamil Nadu, 30 were assigned to experimental group and 30 to control
group. Initially, mean stress was ‘High’ in both the groups. Positive Therapy was given in two groups of 15 subjects in each group for 6 sessions on alternate days; the duration of each session was 40 minutes. Results revealed that Positive Therapy had helped in bringing down the mean stress significantly to ‘Low’ level in the experimental group, whereas in the control group, the mean stress continued to be ‘High’.

Preetha and Hemalatha (2002) conducted a study on, ‘Management of Stress in IT Professionals through Positive Therapy’. Sixty Information Technology (IT) professionals (30 males and 30 females) were selected by purposive sampling from 4 IT companies in Bangalore, Karnataka. Their age ranged between 23-36 years. Case Study Schedule (Hemalatha, 2000), Stress Questionnaire (Latha, 1984) and Glazer Stress Control Life Style Questionnaire (2000) were administered on the entire sample. Then 30 subjects were assigned to the experimental group and 30 to the control group (15 males and 15 females in each group). The subjects in the 2 groups were matched in age, sex, education, designation and level of stress. Positive Therapy was given to the subjects in the experimental group for 7 days and they were asked to practice Relaxation Therapy and Exercises daily at home. After 3 weeks, all the subjects were reassessed using the same tools. The major cause of stress in IT professionals was found to be occupational, particularly, work over-load. The symptoms experienced by most of them were headache and irritability. Most of the sample had poor health habits such as lack of physical activity, smoking, excessive coffee consumption, frequent late nights and alcohol consumption. Positive Therapy had proved to be effective in reducing the level of stress, as well as the symptoms of the sample in the experimental group, whereas the mean stress and the symptoms remained unaltered in the control group.
The literature reviewed clearly shows that a number of researches have been conducted on Positive Therapy and Stress, proving the efficacy of Positive Therapy in the management of stress.

**POSITIVE THERAPY AND DEPRESSION**

Rohini and Nikketh (2010) conducted a study on Management of Stress and Depression in Women facing violence through Positive Therapy. Forty seven women victims from Upahaar Social Service Organization, Dharapuram, Tamil Nadu were selected for the study through purposive sampling. The age range of the sample was 19-58 years. The tools used for the study was Case Study Schedule by Rohini (2009), Stress Inventory constructed and standardized by Hemalatha and Nandini (2005) and Beck’s Depression Inventory by Beck (1971). After the assessment, six sessions of Positive Therapy was given to the entire sample. They were reassessed after a week using Case Study Reassessment Schedule, Stress Inventory and Beck’s Depression Inventory.

Rajalakshmi and Hemalatha (2007) conducted a study on ‘Management of Depression and Enhancement of Well-being in Cancer Patients through Positive Therapy’. Thirty two cancer patients, 15 males and 17 females, in the age range of 25-65 years, from GKNM Hospital, Coimbatore, Tamil Nadu, were screened and were found to have high depression and low well-being. The entire sample was given 10 sessions of Positive Therapy in 2 weeks. Results showed that the mean depression of the sample had come down from ‘High’ (32.91) to ‘Low’ (11.25) and their well-being improved from ‘Low’ (5.3) to ‘High’ (15.31).

Gayathridevi and Gayathridevi (2007) had done a study on ‘Management of Depression in Depressive Patients through Positive Therapy’. Thirty depressive patients, in the age range of...
18-58 years, from Illicunavar Mental Health Clinic, Madurai, Tamil Nadu, were selected as the sample. The subjects were given 5 sessions of Positive Therapy. The results revealed that, after Positive Therapy, the mean depression had come down from 29.83 to 23.83.

Venkateswari and Rohini (2006) conducted a study on the ‘Management of Pain and Depression in Institutionalized Geriatric through Positive Therapy’. The sample consisted of 41 institutionalized geriatrics, 20 males and 21 females, in the age range of 60-80 years, from Coimbatore, Tamil Nadu. After the administration of Positive Therapy on the entire sample for 5 sessions on consecutive days, the mean pain reduced from 7.10 to 3.42 and the mean depression reduced from 21.10 to 12.37.

Sangeetha and Vijayalakshmi (2003) conducted a research on ‘Assessment and Management of Geriatric Depression through Positive Therapy’. Sixty subjects (30 males and 30 females) were selected from the ‘Home for the Aged’, Thindal, Erode, Tamil Nadu. The samples were in the age range of 60-80 years. The tools used were Case Study Schedule and Geriatric Depression Scale. Depression at a moderate level was a common feature among the entire sample before treatment. All the elderly subjects in the experimental group were given Positive Therapy designed by Hemalatha as an intervention to develop their coping skills for handling their problems and to enhance better mental health. After treatment, the mean depression of the subjects in the experimental group had reduced significantly from ‘moderate’ to ‘normal’ level, whereas the mean depression of the control group continued to be at moderate level. Positive Therapy helped them keep their body and mind relaxed and also they were able to sleep peacefully during night time without any negative cognitions, since Thought Stopping
helped them change their negative cognitions into positive ones thus, helping them, enjoy sound mental health.

Sivasankari and Rohini (2003) conducted a study on, ‘Post-partum depression and anxiety through Positive Therapy’. Sixty new mothers form Cosmopolitan Hospital and Gowreesha Hospital, Trivandrum, Kerala served as the sample. They were in the age range of 19-35 years. Case Study Schedule (Hemalatha, 2000), Zung’s Depression Questionnaire (1965) and Zung’s Anxiety Questionnaire (1971) were used. They were classified into 2 groups experimental and control. Positive Therapy was given individually to the subjects in the experimental group for 7 days, after which they were asked to practice Relaxation Therapy and the Exercises daily at home for 3 weeks. All the subjects were reassessed with the same tools after 3 weeks. Initially, 10% of the sample had severe depression and 20% had severe anxiety. After the treatment namely, Positive Therapy, there was a significant reduction in the mean depression as well as anxiety in the experimental group, clearly proving the efficacy of Positive Therapy in the management of post-partum depression and anxiety. No such difference was found in the control group between I test and retest.

POSITIVE THERAPY AND GENERAL WELL-BEING

The study on ‘Management of Anxiety and Enhancement of General Well-being in Coronary Heart Disease Patients through Positive Therapy’ was conducted by Thowheetha and Gayatridevi (2010). From Balaji Hospital, Coimbatore, 35 Coronary Heart Disease Patients were selected using Case Study Schedule (Hemalatha, 2008), Manifest Anxiety Inventory (M.A.I, Hemalatha, 2000) and WHO General Well-being 1998). Thirty five subjects were selected by purposive sampling method. They were in
the age range of 30-70 years. The subjects were given Positive Therapy evolved by Hemalatha (2004) is a package combining the Eastern Techniques of Yoga and Western Techniques of Cognitive Behaviour Therapy. Six sessions of Positive Therapy were given on alternative days for two weeks. After two weeks, the entire subjects were reassessed using Case Study Reassessment Schedule, Manifest Anxiety Inventory and WHO General Well-being. Initially, 89% of the sample had ‘High’ anxiety and 6% of the sample had ‘Very High’ anxiety and 51% of the sample had ‘Low’ level of well being. After Positive Therapy 54% of them had ‘Low’ Anxiety and the remaining 46% had ‘moderate’ anxiety and General Well-being, 77% of the sample improved to ‘Very High’ level and 27% of the subjects had ‘High’ level There was significant reduction in the anxiety from high to low level. The significant mean of general well-being is improved from low to high. The most common negative emotions faced by the samples were fear, worry, anger and anxiety. Positive therapy proved to be effective in reducing their negative emotions.

Pushpaveni and Gayatridevi (2010) conducted a study on ‘Management of Depression and Enhancement of General Well-being in Institutionalized Senior Citizens through Positive Therapy’. Forty Senior Citizens from Missionaries of Charity, Coimbatore, Tamil Nadu were selected for the study through Purposive Sampling Method. The age range of the sample was 60 and above. The tools used for the study were Case Study Schedule by Hemalatha (2009), Beck Depression Inventory by Beck (1971), WHO General Well-being Index (1998). After the assessment five sessions, Positive Therapy was given to the entire sample. They were reassessed after two weeks.
Management of Stress and Enhancement of General Well-being in Hypertension Patients through Positive Therapy was conducted by Chandrika and Gayatridevi (2010). From Government Hospital, Ooty, Tamil Nadu, One Hundred and Twenty Five (63 males, 62 females) were screened using Case Study Schedule (Hemalatha, 2009), Stress Inventory (Hemalatha and Nandini, 2005) and WHO General Well-being Index (1998). All the 125 were selected by Purposive Sampling. They were in the age range of 45-70 years. Eight Sessions of Positive Therapy was given in alternative days. Each session lasted for one hour. After two weeks the subjects were reassessed using the Case Study Reassessment Schedule and Stress Inventory. Initially 50% of the samples had ‘High’/Very High’ Level of Stress. None of them had ‘High’ / Very High’ after Positive Therapy. There was a significant reduction in the Mean Stress was ‘High’ before therapy for male was 20.44 and female was 19.67 and reduced to ‘Low’ for males (5.94) and for females (5.93) after Positive Therapy. General Well-being was ‘Low’ before and after treatment and it had drastic improvement in General Well-being (100%). There was a significant improvement in the mean stress from ‘Low’ for males (12.73) and females (13.52) before Therapy. Fourty percent of the samples had High Level of Hypertension before the treatment and 2% of samples had High Level of Hypertension. The symptoms reported by majority of the samples were nausea, blurred vision, sweating, headache, depression, giddiness, confusion, fatigue and short temper. The common negative emotions experienced by the samples were anger, worry and anxiety. The Poor Health Habits were Drinking and Sleep Less than 6 Hours. After Positive Therapy there was a
drastic reduction in the Symptoms, Negative Emotions and Poor Health Habit of the Samples.

CONCLUSION

The literature reviewed clearly indicates that a number of researches have been conducted on parents of Mentally Challenged revealing their higher levels of stress, depression and low general well-being. Researches on Positive Therapy have indicated its efficacy in the management of stress, depression and enhancement of general well-being.

The studies that had been reviewed gives a clear idea about stress, depression and well-being of the parents of mentally challenged. The studies have proven that rearing a child with intellectual disability is a very difficult and responsible task. The cause for parental stress with mentally challenged are difficulty in accepting, inability to understand and comprehend, difficulty in concept formation, problem behaviour, fear and worry about the health and future of the mentally challenged, unable to do their routine activities due to which they are dependent. The studies also showed that stress, depression and low well-being leads to physiological and psychological reactions such as aches and pains, fatigue, headache, joint pain, confusion, irritability, insomnia, pre-occupation of thoughts, tension, worry, anger and irritability.

With regard to intervention, various approaches to manage stress, depression and low well-being such as Training Programme for the Parents and Family to cope with their Stress, Relaxation Therapy, Yoga and other Group Psychotherapy, have been analysed.

The studies on Positive Therapy show that the strategies of Positive Therapy helped various sample to manage stress, depression and low well-being. The previous
research using Positive Therapy also shows that it was effective in helping the parents of mentally challenged to manage their stress and depression and to enhance their general well-being.

Therefore, in the present study, a genuine attempt is made to apply Positive Therapy on the selected parents of mentally challenged to help them to get rid of stress, depression and low well-being.