



Comparative Study on Anxiety of Mother's having Children with Mental Retardation (Intellectual Disability)

By

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Abstract

The present study aims to compare the state and trait anxiety of mothers having boy and girl child with intellectual disability (mental retardation). For this purpose, 30 mothers were selected as sample (15=mothers of boys with mental retardation, 15 = mothers of girls with mental retardation) from middle class families of urban area. Educational status of the mothers was between Higher secondary to Graduation. Individual interview was taken from the mothers by using bengali adaptation STAI (State and Trait Anxiety Inventory by Speilberger, Gorsuch and Lushane (1970)). The results revealed that mothers of girl child with retardation showed higher STATE anxiety than that of mothers of boy child with mental retardation (mean of mothers of girl =54.33, boy=45.2, t test of mean is 0.01073 which is significant). In trait anxiety, the mothers of girl child with MR is also having the higher anxiety than that of the mothers of boys (mean of mothers of girls=22.6, mother of boys=18.53, t test of mean =0.12131which is significant).

From the findings of the study, it was concluded that the anxiety level of mothers having girl child with mental retardation is high in comparison to the mothers having boys child with mental retardation.

1.1 Introduction

Definition: Internationally the definition of Intellectual disability (mental retardation) has moved away

from medical model to rehabilitative model. Current trend is to describe the condition by using functional and educational terms rather than clinical terms. Definitions are listed chronologically to demonstrate the variations in describing condition of Intellectual disability (mental retardation).

a. Definition of Intellectual disability (mental retardation) - American Association of Intellectual disability (mental retardation) (AAMR) –1983:

As per American Association on Mental Deficiency, also previously known as American Association on Intellectual disability (mental retardation) – Men

_ Functional Academics

_ Leisure

_ Work

b. Definition of American Association of Intellectual disability (mental retardation) (AAMR) - 2002

Definition reads “Intellectual disability (mental retardation) is a disability characterized by significant limitations, both in intellectual functioning and in adaptive behavior, as expressed in conceptual, social and practical adaptive skills, the disability originating before the age of 18 years.

The complete and accurate understanding of Intellectual disability (mental retardation) implies that a particular state of functioning, which begins in childhood, having many dimensions and affected positively by individualized supports. As a model of functioning, it includes the context and environment within which the person functions and ecological approach that reflects the interaction of the individual with the environment. The outcomes of interaction are with regard to independence, relationships, societal contributions, participation in school and community and to personal well-being.

c. Definition of Intellectual Disability – (2009 American Association on Intellectual and Developmental Disabilities (AAIDD) – it was earlier known as AAMR, USA):

Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

Intellectual Functioning—also called intelligence—refers to general mental capacity, such as learning, reasoning, problem solving and so on. One criterion to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 or as high as 75 indicates a limitation in intellectual functioning. Standardized tests can also determine limitations in adaptive behavior, which comprises three skill types:

Conceptual Skills

- _ Receptive and expressive Language
- _ Literacy – Reading and writing
- _ Number concepts Money and time
- _ Self-direction.

Social Skills

- _ Interpersonal skills
- _ Responsibility
- _ Self-esteem
- _ Gullibility (likelihood of being tricked/manipulated)
- _ Naïveté (i.e., innocence or wariness)
- _ Problem solving
- _ Ability to follow rules/obey laws
- _ Avoid being victimized.

Practical Skills

- _ Activities of daily living (personal care - eating, dressing, mobility and toileting)
- _ Instrumental Activities of daily living (Schedules/routines) – preparing meals, taking medication, using telephone, managing money, using transportation and completing housekeeping activities
- _ Healthcare
- _ Occupational skills
- _ Maintain safe environment

The terms intellectual disability (mental retardation) and mentally retarded were invented in the middle of the 20th century to replace the previous set of terms, which were deemed to have become offensive. By the end of the 20th century, these terms ~~they~~ have come to be widely seen as disparaging and politically incorrect and in need of replacement. The term intellectual disability or intellectually challenged is now preferred by most advocates in most English-speaking countries. The AAIDD have defined intellectual disability to mean the same thing as intellectual disability (mental retardation). Currently, the term intellectual disability (mental retardation) is used by the World Health

[Organization](#) in the [ICD-10](#) codes, which has a section titled "Intellectual disability (mental retardation)" (codes F70–F79). In the future, the ICD-11 is expected to replace the term mental retardation with intellectual disability, and the [DSM-5](#) has replaced it with intellectual disability (intellectual developmental disorder). Because of its specificity and lack of confusion with other conditions, mental retardation is still sometimes used in professional medical settings around the world, such as formal scientific research and health insurance paperwork.

Many children with mild retardation are not identified until they enter school and sometimes not until the second or third grade, when more difficult academic work is required. Most students with mild intellectual disability (mental retardation), master academic skills up to about the sixth-grade level and are able to learn the job skills well enough to support themselves independently or semi- independently. Some adults who have been identified with mild intellectual disability (mental retardation) develop excellent social and communication skills and once they leave school are no longer recognized as having a disability.

Children with moderate retardation show significant delays in development during their preschool years. As they grow older, discrepancies in overall intellectual development and adaptive functioning generally grow wider between these children and age mates without disabilities. People with moderate intellectual disability (mental retardation) are more likely to have health and behavior problems than are individuals with mild retardation.

Clinical / Medical Characteristics:

Children with Intellectual disability (mental retardation) usually look like any other children but some may have

Distinct features like –

- _ Small or Large head
- _ Small stature
- _ Protruding Tongue
- _ Blunt features
- _ Drooling
- _ Cannot walk with good co- ordination.

Individuals with severe and profound intellectual disability (mental retardation) are almost always identified at birth or shortly afterward. Most of these infants have significant central nervous system damage, and many have additional disabilities and/or health conditions. Although IQ scores can

serve as the basis for differentiating severe and profound retardation from one another, the difference is primarily one of functional impairment.

Cognitive Functioning

Deficits in cognitive functioning and learning styles characteristic of individuals with intellectual disability (mental retardation) include poor memory, slow learning rates, attention problems, difficulty generalizing what they have learned, and lack of motivation.

Memory

Students with intellectual disability (mental retardation) have difficulty remembering information. As would be expected, the more severe the cognitive impairment, the greater the deficits in memory. In particular, research has found that students with intellectual disability (mental retardation) have trouble retaining information in short-term memory (Bray, Fletcher, & Turner, 1997). Short-term memory, or working memory, is the ability to recall and use information that was encountered just a few seconds to a couple of hours earlier—for example, remembering a specific sequence of job tasks an employer stated just a few minutes earlier. Merrill (1990) reports that students with intellectual disability (mental retardation) require more time than their nondisabled peers to automatically recall information and therefore have more difficulty handling larger amounts of cognitive information at one time. Early researchers suggested that once persons with intellectual disability (mental retardation) learned a specific item of information sufficiently to commit it to long-term memory—information recalled after a period of days or weeks—they retained that information about as well as persons without retardation (Belmont, 1966; Ellis, 1963).

More recent research on memory abilities of persons with intellectual disability (mental retardation) has focused on teaching meta-cognitive or executive control strategies, such as rehearsing and organizing information into related sets, which many children without disabilities learn to do naturally (Bebko & Luhaorg, 1998). Students with intellectual disability (mental retardation) do not tend to use such strategies spontaneously but can be taught to do so with improved performance on memory-related and problem-solving tasks as an outcome of such strategy instruction (Hughes & Rusch, 1989; Merrill, 1990).

Learning Rate

The rate at which individuals with intellectual disability (mental retardation) acquire new knowledge and skills is well below that of typically developing children. A frequently used measure of learning rate is trials to criterion—the number of practice or instructional trials needed before a student can respond correctly without prompts or assistance. For example, while just 2 or 3 trials with feedback may be required for a typically developing child to learn to discriminate between two geometric forms,

a child with intellectual disability (mental retardation) may need 20 to 30 or more trials to learn the same discrimination.

Because students with intellectual disability (mental retardation) learn more slowly, some educators have assumed that instruction should be slowed down to match their lower rate of learning. Research has shown, however, that students with intellectual disability (mental retardation) benefit from opportunities to learn to “go fast” (Miller, Hall, & Heward, 1995).

Attention

The ability to attend to critical features of a task (e.g., to the outline of geometric shapes instead of dimensions such as their color or position on the page) is a characteristic of efficient learners. Students with intellectual disability (mental retardation) often have trouble attending to relevant features of a learning task and instead may focus on distracting irrelevant stimuli. In addition, individuals with intellectual disability (mental retardation) often have difficulty sustaining attention to learning tasks (Zeaman & House, 1979). These attention problems compound and contribute to a student’s difficulties in acquiring, remembering, and generalizing new knowledge and skills.

Effective instructional design for students with intellectual disability (mental retardation) must systematically control for the presence and saliency of critical stimulus dimensions as well as the presence and effects of distracting stimuli. After initially directing a student’s attention to the most relevant feature of a simplified task and reinforcing correct responses, the complexity and difficulty of the task can gradually be increased. A student’s selective and sustained attention to relevant stimuli will improve as he experiences success for doing so.

Generalization of Learning

Students with disabilities, especially those with intellectual disability (mental retardation), often have trouble using their new knowledge and skills in settings or situations that differ from the context in which they first learned those skills. Such transfer or generalization of learning occurs without explicit programming for many children without disabilities but may not be evident in students with intellectual disability (mental retardation) without specific programming to facilitate it. Researchers and educators are no longer satisfied by demonstrations that individuals with intellectual disability (mental retardation) can initially acquire new knowledge or skills. One of the most important and challenging areas of contemporary research in special education is the search for strategies and tactics for promoting the generalization and maintenance of learning by individuals with intellectual disability (mental retardation). Some of the findings of that research are described later in this chapter and throughout this text.

Motivation

Some students with intellectual disability (mental retardation) exhibit an apparent lack of interest in learning or problem-solving tasks (Switzky, 1997). Some individuals with intellectual disability (mental retardation) develop learned helplessness, a condition in which a person who has experienced repeated failure comes to expect failure regardless of his or her efforts. In an attempt to minimize or offset failure, the person may set extremely low expectations for himself and not appear to try very hard. When faced with a difficult task or problem, some individuals with intellectual disability (mental retardation) may quickly give up and turn to or wait for others to help them. Some acquire a problem-solving approach called outer-directedness, in which they seem to distrust their own responses to situations and rely on others for assistance and solutions.

Rather than an inherent characteristic of intellectual disability (mental retardation), the apparent lack of motivation may be the product of frequent failure and prompt dependency acquired as the result of other people's doing things for them. After successful experiences, individuals with intellectual disability (mental retardation) do not differ from persons without intellectual disability (mental retardation) on measures of outer-directedness (Bybee & Zigler, 1998). The current emphasis on teaching self-determination skills to students with intellectual disability (mental retardation) is critical in helping them to become self-reliant problem solvers who act upon their world rather than passively wait to be acted upon (Wehmeyer, Martin, & Sands, 1998).

Adaptive Behavior

By definition children with intellectual disability (mental retardation) have substantial deficits in adaptive behaviour. These limitations can take many forms and tend to occur across domains of functioning. Limitations in self-care skills and social relationships as well as behavioral excesses are common characteristics of individuals with intellectual disability (mental retardation).

Self-Care and Daily Living Skills

Individuals with intellectual disability (mental retardation) who require extensive supports must often be taught basic self-care skills such as dressing, eating, and hygiene. Direct instruction and environmental supports such as added prompts and simplified routines are necessary to ensure that deficits in these adaptive areas do not come to seriously limit one's quality of life. Most children with milder forms of intellectual disability (mental retardation) learn how to take care of their basic needs, but they often require training in self-management skills to achieve the levels of performance necessary for eventual independent living.

Social Development

Making and sustaining friendships and personal relationships present significant challenges for many persons with intellectual disability (mental retardation). Limited cognitive processing skills, poor language development, and unusual or inappropriate behaviors can seriously impede interacting with

others. It is difficult at best for someone who is not a professional educator or staff person to want to spend the time necessary to get to know a person who stands too close, interrupts frequently, does not maintain eye contact, and strays from the conversational topic. Teaching students with intellectual disability (mental retardation) appropriate social and interpersonal skills is one of the most important functions of special education.

Behavioral Excesses and Challenging Behavior

Students with intellectual disability (mental retardation) are more likely to exhibit behavior problems than are children without disabilities. Difficulties accepting criticism, limited self-control, and bizarre and inappropriate behaviors such as aggression or self-injury are often observed in children with intellectual disability (mental retardation). Some of the genetic syndromes associated with intellectual disability (mental retardation) tend to include abnormal behavior (e.g., children with Prader-Willi syndrome often engage in self-injurious or obsessive-compulsive behavior). In general, the more severe the retardation, the higher the incidence of behavior problems. Individuals with intellectual disability (mental retardation) and psychiatric conditions requiring mental health supports are known as “dual diagnosis” cases. Data from one report showed that approximately 10% of all persons with intellectual disability (mental retardation) served by the state of California were dually diagnosed (Borthwick-Duffy & Eyman, 1990). Although there are comprehensive guidelines available for treating psychiatric and behavioral problems of persons with intellectual disability (mental retardation) (Rush & Francis, 2000), much more research is needed on how best to support this population.

Positive Attributes

Descriptions of the intellectual functioning and adaptive behavior of individuals with intellectual disability (mental retardation) focus on limitations and deficits and paint a picture of a monolithic group of people whose most important characteristics revolve around the absence of desirable traits. But individuals with intellectual disability (mental retardation) are a huge and disparate group composed of people with highly individual personalities (Smith & Mitchell, 2001b). Many children and adults with intellectual disability (mental retardation) display tenacity and curiosity in learning, get along well with others, and are positive influences on those around them (Reiss & Reiss, 2004; Smith, 2000).

Anxiety is a normal human emotion that everyone experiences at times. Many people feel anxious, or nervous, when faced with a problem at work, before taking a test, or making an important decision. [Anxiety disorders](#), however, are different. They can cause such distress that it interferes with a person's ability to lead a normal life.

An anxiety disorder is a serious [mental illness](#). For people with [anxiety disorders](#), worry and fear are constant and overwhelming, and can be crippling.

Anxiety

Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth, [somatic complaints](#) and rumination. It is the subjectively unpleasant feelings of dread over anticipated events, such as [the feeling of imminent death](#). Anxiety is not the same as [fear](#), which is a response to a real or perceived immediate threat; whereas anxiety is the expectation of future threat. Anxiety is a feeling of fear, worry, and uneasiness, usually generalized and unfocused as an [overreaction](#) to a situation that is only subjectively seen as menacing. It is often accompanied by muscular tension, restlessness, fatigue and problems in concentration. Anxiety can be appropriate, but when experienced regularly the individual may suffer from an [anxiety disorder](#).

People facing anxiety may withdraw from situations which have provoked anxiety in the past. There are different types of anxiety. Existential anxiety can occur when a person faces [angst](#), an [existential crisis](#), or [nihilistic](#) feelings. People can also face [test anxiety](#), [mathematical anxiety](#), [stage fright](#) or [somatic anxiety](#). Another type of anxiety, [stranger anxiety](#) and [social anxiety](#) are caused when people are apprehensive around strangers or other people in general. Anxiety can be either a short term 'state' or a long term "trait". Anxiety disorders are a group of [mental disorders](#) characterized by feelings of anxiety and fear whereas trait anxiety is a worry about future events, close to the concept of [neuroticism](#). Anxiety disorders are partly genetic but may also be due to drug use including alcohol and [caffeine](#), as well as withdrawal from certain drugs. They often occur with other mental disorders, particularly [major depressive disorder](#), [bipolar disorder](#), certain [personality disorders](#), and [eating disorders](#). Common treatment options include lifestyle changes, [therapy](#), and medications. Speiberger (1976), defined that state anxiety is a reaction omitting of unpleasant consciously perceived feeling of tension an apprehension with associated activation or arousal of autonomic nervous system . The State Anxiety requests people to describe how they feel right now and increase in response to situational stress and declines under relaxed condition.

State anxiety (S-anxiety) can be defined as fear, nervousness, discomfort, etc. and the arousal of the [autonomic nervous system](#) induced by different situations that are perceived as dangerous. This type of anxiety refers more to how a person is feeling at the time of a perceived threat and is considered temporary.

Examples: A child feels anxious when confronted by a large, strange animal. A person feels anxious to get on an airplane and fly somewhere for the first time

Trait anxiety (T-anxiety) can be defined as feelings of stress, worry, discomfort, etc. that one experiences on a day to day basis. This is usually perceived as how people feel across typical situations that everyone experiences on a daily basis.

Examples: A child is socially anxious in all situations and always a little on edge throughout their childhood and into adulthood. A person is anxious in an array of different normal situations such as going to the grocery store and going to work the majority of the time where others are usually not.

1.2 STATEMENT OF THE PROBLEM:

Having mentally retarded child brings about different hardness for child and his/her family.

In our society daughters are always treated as a burden to her family. All the family members specially the mothers are always being anxious about the safety and security of the girl child. When the girl child is born with intellectual disability (mental retardation) then the anxiety goes at its apex because the thought of the safety of the child is a big question for their mothers. In case of normal girl child, mother can aware them about such pre-caution and preventive measures, which help them to be safe in the society, but in case of girl child with retardation, it is not always possible to make them understand about their own safety and security. So the study is to find out the comparison of anxiety level of mothers having girl and boy child with intellectual disability (mental retardation).

2.1 REVIEW OF LITERATURE:

Raj Kumari Gupta*, Harpreet Kaur 2002 has studied "STRESS AMONG PARENTS OF CHILDREN WITH INTELLECTUAL DISABILITY": The present study examines stress among parents of children with intellectual disability (mental retardation). 102 parents formed the sample of this study, 30 of whom had children without disability. A stress assessment test with internal validity of 0.608 was utilized. This test has two parts: physical and mental, former with 19 items and latter with 21 items. T test was applied to check differences in stress, gender differences, and differences in mental and physical stress. Results show that, most parents of children with intellectual disability (mental retardation) experience stress, physical and mental stress are significantly correlated. Gender differences in stress experienced occur only in the mental area, and parents have higher mental stress score. [L. Resends](#) and Scarp has studied (2011) Parental Anxiety/Depression of developmental disability. Study reveals that Parents of children with a developmental disability have been shown to experience increase in stress, depression, and anxiety, which are also associated with child behavior problems related to. Lit developmental disability erasure-examining potential mechanisms that underlie the relationship of child behavior problems and parental anxiety/depression in this population are scarce. The current study sought to examine the roles of parenting stress and parenting self-efficacy as mediators between child behavior problems and parental anxiety/depression. Using a sample of 134 mothers, these potential mediators were tested. Hypotheses were supported, indicating that parenting stress mediated the relationship between

child behavior problems and decreased parenting self-efficacy, and decreased parenting self-efficacy in turn partially mediated the relationship between parenting stress and increased depression.

Another study of Krorien 2008, to investigate the relationship among anxiety and depression with quality of life in mothers with disabled children.

Methods: The study was performed at three rehabilitation centres in Ankara. One hundred and seven disabled children's mothers were included in the study. Beck Depression Inventory (BDI), State Trait Anxiety Inventory (STAI) and Nottingham Health Profile's Part -1 (NHP) were used to assess depression, anxiety and quality of life of mothers. The assessments were performed during children's treatment in rehabilitation centres.

Results: The mean score on the BDI was 14.22, SD: 13.03, SAI was 41.95, SD: 6.55 and TAI was 47.27, SD: 7.94. There was a significant correlation between BDI and TAI($r: 0.348, p:0.01$) and all subscales of NHP (emotional reaction-ER $r: 0.622$, energy level-EL $r: 0.416$, pain $r: 0.463$, sleep $r:$

0.429, physical mobility-PM r: 0.422, social isolation-SI r: 0.587, p0.01). There was a significant correlation between TAI and ER (r: 0.271, p0.01) EL (r: 0.206, p0.05) sleep (r: 0.252, p0.01) of NHP. There was a significant correlation between mother's education level and TAI (r:-0.209,p:0.05). There was a significant correlation between mother's education level and NHP pain scale (r:-0.240, p0.05).

Conclusions: The findings of this study indicated that mothers with disabled children have anxiety and depression. Increased depression and anxiety level **badly** affected mother's quality of life. The effective rehabilitation programs should provide sufficient opportunities for repeated follow- up interviews which offer not only information on the children's disabilities but also psychological support for the mothers.

Sangita A.J. & Joshi M.S. (2000) **have** studied Depression Level of Mothers having Children with Disability. The study reveals *The Child's* disability stresses the mothers the most and this stress shows itself in the form of depression which in turn affect the mothers. The main objective of the study **is was** to evaluate the depression level of mothers having a child with disability. Samples of 100 mothers having children with disability were selected. Out of these 50 were working and 50 were non-working, belonging to nuclear and joint families. The tool used for the study was standardized Beck Depression Inventory. Overall the results indicated **d** that depression level **is was** higher among mothers with disabled daughter belonging to nuclear families. The findings **to of** nuclear families are more depressed than their counterparts.

Fazaila Sabih, Wahid Bakhsh Sajid (2006) **was** studied to assess the level of parenting stress and associating factors of stress in parents rearing children with intellectual disability (mental retardation). **Materials and Methods:** The sample included 60 parents (30 fathers, 30 mothers) of 30 children with diagnosis of MR. The sample was taken from different hospitals and institutions of intellectual disability (mental retardation) in Islamabad, Rawalpindi and Wah Cantt, Pakistan from 2005-2006. Stress in parents was measured through parental stress scale (PSS). **Results:** PSS score of fathers was 46.63 ± 7.99 and mothers **was** 50.03 ± 9.60 (p 0.01). Score for parents of children 4-9 years age was 50.38 ± 7.93 and for parents of children 10-18 years age **was** 47.13 ± 10.26 (p 0.01). Score for parents of boys was 46.81 ± 8.39 and for parents of girls **was** 50.00 ± 9.34 (p0.01).

Conclusion: There was significant stress in parents of MR children. Mothers experienced more stress than fathers. The level of stress was different in parents with the increasing age of the children. The implication is that mothers of GIRL children with MR are more prone to experience stress, thus requiring special attention from mental health professionals. (Rawal Med J;33:214-21)

Adana, Turkey; M.D. at Biostatistics, Cukurova University Faculty of Medicine, Balcal, June 2002 **showed that** parents of children with intellectual disability (mental retardation) experiences high level of emotional, financial and physical stress. There are multiple problems of having a mentally retarded

child in the family. The problems are mainly related to the social ridicule and social stigma. Feelings of depression are common, particularly when realization of the child's retardation is recent. Mothers of children with disability having higher perception of economic situation, income adequacy, parenting social support, and religious practices, have lower symptoms of depression it was found that in minority mothers, higher the religious coping, the lower the symptoms of depression.

The aim of this investigation was to study the Caregiver's Burden and social support in mother's of children with Intellectual disability (mental retardation) as compared to mother's of normal children. The sample for the study consisted of a group of 30 mothers of children with Intellectual disability (mental retardation) and control group which consisted of 30 mothers of normal children. The age range of the children was 3 to 15years and the age range of the mothers was 25 to 45years. Socio-demographic data sheet was prepared for the study. Caregiver's Burden Scale (CBS) and Berlin Social Support Scales (BSS) tools were used in this study. Mothers of children with Intellectual disability (mental retardation) showed significant difference on care givers burden than the mothers of normal children . Akhilesh Kumar Malhotra (2005) did a cross-sectional study to assess the disability impact on parents of children with intellectual disability (mental retardation) studying in two special schools of Delhi. A Parents of 100 mentally retarded children enrolled in these schools were interviewed. Univariate analysis was done using SPSS software to know causal relationship between severity of intellectual disability (mental retardation) and various domains of modified NIMH disability impact scale. Majority of parents had disability impact as a result of social restriction and loss of support from relatives, in laws, friends and neighbours. More than half of parents felt that their health suffered because of mentally retarded child. Majority of parent's didn't have disability impact in relation to physical care, career adjustment, financial problem, embarrassment, and negative effect on relationship with spouse, in laws, family members, friends and neighbours, negative effect on siblings and specific negative thought. Severity of intellectual disability (mental retardation) was found to be significantly related with physical care, loss of support and specific negative thought.

Vivian Khamis had done a study on psychological distress among parents of children with intellectual disability (mental retardation) in the United Arab Emirates. This study was designed to identify predictors of stress and psychological distress among parents of children with intellectual disability (mental retardation) in the United Arab Emirates. It examined the relative contributions of child characteristics, parents' socio demographics, and family environment to parental stress and psychological distress. Participants were parents of 225 mentally retarded children, of whom 113 were fathers and 112 were mothers. Measures of parental stress (QRS-F), psychiatric symptom index (PSI) and family environment scale (FES) were administered in an interview format. Hierarchical

multiple regression was used to predict parental stress and psychological distress. The results indicated that the model containing all three predictor blocks, child characteristics, parents' socio demographics, and family environment, accounted for 36.3% and 22.5% of parental stress and parent's psychiatric symptomatology variance, respectively. The age of the child was significantly associated with parent's feelings of distress and psychiatric symptom status, and parental stress was less when the child was older. Parents reported more psychiatric symptomatology when the child showed a high level of dysfunction. Father's work appeared to be a significant predictor of parental stress, indicating that for fathers who were not working, the level of stress was higher than fathers who were working. Lower socioeconomic level was associated with greater symptom rates of cognitive disturbance, depression, anxiety, and despair among parents. Among the family environment variables, only the personal growth dimension stood out as a predictor of parental stress. An orientation toward recreational and religious pursuits, high independence, and intellectual and recreational orientations were associated with lower levels of parental stress. On the other hand, parents in achievement-oriented families showed elevated levels of parental stress. Implications for prevention, and intervention as well as parent training and system-oriented counselling programs are discussed.

Mita Majumdar et al 2007 had done a study to evaluate ~~for the~~ anxiety and depression among parents of children with Intellectual disability (mental retardation) (MR). This was a prospective study conducted at a tertiary care hospital in Pakistan. Participants were 198 parents (99 fathers/99 mothers) of 100 children with the diagnosis of MR. The parents were assessed for anxiety and depression using DSM IV criteria. Informed consent was obtained. The study was approved by the Institutional Research Committee. Significantly high proportion (p -value = 0.024) of mothers (89%) had anxiety, depression or both anxiety and depression together as compared to fathers (77%). Among mothers, 35% met criteria for anxiety, 40% for depression and 13% for both anxiety and depression. Among fathers 42% had anxiety, 31% depression and 3% both anxiety and depression. There was a significant association (P value = 0.027) between gender of parent and individual psychiatric diagnosis of anxiety, depression and anxiety and depression together. A significant association (p value = < 0.043) was also found between mother's anxiety, depression or both and degree of intellectual disability (mental retardation) of their children. The study concluded that parents of children with MR are at higher risk for anxiety, depression or both, needing mental health assessment. There was correlation between mother's anxiety, depression or both and level of MR among children.

Rabia Tabassum & Naeem Mohsin 2007, conducted a study to find out the relationship between depression and anxiety among parents of children with disabilities and to compare the parent's depression and anxiety with the type of disability among children. Sample was comprised of 80 parents among which 58.12% were mothers and 41.875% were fathers having one

or more disabled children with the age range of 4-18 years. Purposive sampling technique was used to select the sample. Depression Anxiety and Stress Scale, DASS (Lovibond & Lovibond, 1995) with 42 items was used. Pearson Product moment correlation was used to find the relation among depression, and anxiety. Independent sample t-test was used for comparison among parents having children with different disabilities. The results of this study showed that a highly significant positive correlation was found between depression and anxiety with ($r = .833, p < .01$) a significant difference found on depression subscale of DASS among parents with disabled boys than disabled girls with $t(158) = 2.301, p < 0$.

Dorgan et al (2010) conducted a comparative study to assess the psychological problems in terms of stress, depression and anxiety among parents of girl and boy children with intellectual disability (mental retardation). Sample was $n=230$ parents of girl child and $n=230$ parents of boy with child intellectual disability (mental retardation). The results of this study revealed that parents of girl child with intellectual disability (mental retardation), especially mothers are at greater risk to develop psychiatric/psychological problems (depression, stress and trait anxiety).

Upadhyay Shambhu & Singh Anju (2009) studied "Psychological problems and needs of parents in caring mentally retarded children: The impact of level of intellectual disability (mental retardation) of children". The result of the study shows that the level of psycho-social problems faced by the parents of mentally retarded children increases with the level of intellectual disability (mental retardation) of the child. Therefore, parents of moderately retarded children registered more problems, in all aspects, compared with parents having mildly retarded children. The parents of both retarded children expressed fulfillment of different needs. The mildly retarded children's parent needs were more of preventive and adjustment nature where as parent's of moderately retarded children were more concerned with life long adjustment and financial security, including government help, of their children.

Chandorkar Hemant & Chakraborty (2000) studied "Psychological Morbidity of Parents of mentally Retarded Children" and the results of the study conclusively proved that the parents of mentally retarded children had a higher prevalence of psychological morbidity than the parents of normal children.

2.2 SUMMERY OF REVIEW OF LITERATURE:

From the above studies it is clear that parents of children with intellectual disability (mental retardation) are having psychological disturbances such as anxiety, stress, and depression.

Chandorkar Hemant & Chakraborty (2000) studied "Psychological Morbidity of Parents of mentally Retarded Children" and the results of the study conclusively proved that the parents of mentally retarded children had a higher prevalence of psychological morbidity than the parents of normal children.

According to the study of Gupta and Kour 2002, parents specially mothers of mentally rerarded **children** are more anxious than parents of normal children.

Similarly Adana, 2002 reveals that mother's of mentally retarded are more likely to have psychological problems than that mother's of normal children.

Akhilesh Kumar Malhotra (2005) stated that parents didn't have disability impact in relation to physical care, career adjustment, financial problem, embarrassment, and negative effect on relationship with spouse, in laws, family members, friends and neighbours, negative effect on siblings **and** specific negative thought. Severity of intellectual disability (mental retardation) was found to be significantly related with physical care, loss of support **and** specific negative thought.

In a study conducted by Mita Majumdar (2007), significant association (p value = < 0.043) was also found between mother's anxiety, depression or both and degree of intellectual disability (mental retardation) of their children. The study **concluded that** parents of children with MR are at higher risk for anxiety, depression or both, needing mental health assessment. There was correlation between mother's anxiety, depression or both and level of MR among children.

Similar study **was** done by the Korien (2008) which stated that parents specially mothers are having more psychological disturbances than that of the fathers having mentally retarded child.

Study of Sangita A.J. & Joshi M.S. (2000) showed **that** anxiety and depression that mothers perceive **was** more serious in mothers of girls than in mothers of boys. Having a mentally retarded child in the family itself brings a stress to the mothers.

Similarly it **was** found from the study of Rabita Tabbasum & Naem Mohasin (2007), **that** there is a significant difference **between** depression subscale of DASS among parents with disabled boys than disabled girls. Parents of girl child with intellectual disability (mental retardation) are likely to have more depression.

According to **a study by** Fazaila Sabih **and** Wahid Bakhsh Sajid, (2006), parents of girl children are likely to have more stress than that of parents of boy child with intellectual disability (mental retardation).

Study **of by** Dorgan (2010) revealed that parents of girl child with intellectual disability (mental retardation), especially mothers are at greater risk to develop psychiatric/psychological problems (depression, stress and trait anxiety).

THEORITICAL FRAME WORK

3.1 RATIONALLE OF THE STUDY

Having Intellectual disability (mental retardation) brings about different hardness for the child and the mother. This condition commonly starts with shock, sometimes there are feelings of guilt, sorrow, and helplessness. When the children are diagnosed with developmental disability their parents specially mothers may experience psychological turmoil.

The most important question which comes in the mind of the mother is that who is going to take care of their child after them .The mothers will have to undertake too much stress because they are with their child in everyday life more than the fathers.

Today's society is not safe for girl child, and when the child is having intellectual disability (mental retardation), the risk increases itself. How to maintain privacy, personal hygiene and safety, the girl child learns from her mother. But when the mother is having girl MR child, it is very difficult for her to make her understand with all those above said issues. So the mothers are always having the same question in their mind that how to protect girl child with retardation and this kind of thoughts make them depressed and anxious.

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children with intellectual disability (mental retardation) having have some kind of psychological disturbances.

But there are very less study on comparison of anxiety of mothers of boy and girl children with disability.

So the purpose of the study is to find out that if there is any significant difference between the anxieties of mothers having boy or girl mentally retarded child.

3.2 Objectives of the study:

- To identify the state and trait anxiety of mothers having girl mentally retarded child
- To identify the state and trait anxiety of mothers having boy disabled child
- To compare the level of anxiety among the mothers having different kinds of gender.

3.3 HYPOTHESIS

H1---
There will be no significant difference between the mothers having boy and girl MR children w.r.t state anxiety.

H2 ---
There will be no significant difference between the mothers having boy and girl MR children w.r.t trait anxiety.

H A P T E R I V M E T H O D O L O G Y

4.1 Sample

A Sample of 30 mothers having MR children of which 15 mothers having girl MR children and 15 mothers **having** boy MR children were taken for the study. All the mothers were **resident of** urban area **belonging** to the middleclass families. All were married and possess within nuclear and joint family. Their Educational status **was from** Higher Secondary to graduation

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**4.2 S
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of Data Collection

Under the permission of the authorities concern of the Howrah South Point, all the sample s were taken and data were collected from the mothers having MR children.

4.3 Tool

Data were collected from different groups of selected respondent for the verification of the respective null hypothesis by administrating the following instrument.

SELF EVALUATION STATE – TRAIT ANXIETY INVENTORY (STAI)

Bengali version of State Trait Anxiety inventory originally developed by Speilberger, Gorsuch and Lushane (1970) was used in the present study. This inventory consists of 40 items, 20 each for state and trait. This inventory is useful for the assessment of anxiety for the distinction of two aspects namely, State Anxiety and Trait Anxiety.

The State Anxiety requests people to describe how they feel right now and increase in response to situational stress and declines under relaxed condition.

The Trait Anxiety asks people to describe how they generally feel and reflex relatively stable individual reflexes.

The items are rated on a scale of 1-4 (not at all, somewhat, moderately so, very much so) there are direct and reversed item. For scoring we have to add the total score of direct item and indirect item and then subtract indirect score from the direct, now 50 will be added with the score.

4.4 Variables

In this project the independent variables are psychological factors such as state and trait anxiety. The dependent variables are mothers having boy and girl children with intellectual disability (mental retardation).

ANALYSIS OF DATA

AND

INTERPRETATION OF RESULTS

TABLE NO: 5.1

STATE ANXIETY

SCORES OF MOTHERS HAVING BOY MENTALLY RETARDED CHILDREN

SL.NO	SCORES	MEAN	SD
1	55		
2	32		
3	51		
4	49		
5	63		

6	54	45.2	13.44
7	54		
8	49		
9	42		
10	43		
11	50		
12	50		
13	41		
14	09		
15	30		

Distribution of the scores shows discrepancy which may fluctuating deviation (30-60) may or may not be existing high or low in anxiety

TABLE NO: 5.2

STATE ANXIETY

SCORES OF MOTHERS HAVING GIRL MENTALLY RETARDED CHILDREN

SL.NO	SCORES	MEAN	SD
1	60	54.33	3.33
2	56		
3	56		
4	59		
5	50		
6	57		
7	55		
8	51		
9	58		
10	54		
11	53		
12	54		
13	50		
14	50		
15	52		

Distribution of the scores shows that most of the distribution are towards higher rank *i.e.*, between (50-60) which may indicate that may be the sample *was* suffering from high level of State Anxiety.

Graphical representation of scores of mothers having boy retarded child and mothers having girl retarded child with reference to STATE ANXIETY

**TABLE NO: 5.3
TRAIT ANXIETY**

SCORES OF MOTHERS HAVING BOY MENTALLY RETARDED CHILDREN

SL.NO	SCORES	MEAN	SD
1	21	18.53	10.19
2	7		
3	26		
4	25		
5	21		
6	22		
7	30		
8	34		
9	3		
10	11		
11	25		
12	28		
13	4		
14	16		
15	5		

Distribution of the scores shows discrepancies which may fluctuating deviation (15-25) may or may not be existing lower rank in trait anxiety.

TABLE NO: 5.4

TRAIT ANXIETY

SCORES OF MOTHERS HAVING GIRL MENTALLY RETARDED CHILDREN

SL.NO	SCORES	MEAN	SD
1	22	22.6	8.35
2	15		
3	40		
4	27		
5	19		
6	22		
7	19		
8	37		
9	20		
10	20		
11	05		
12	28		
13	24		
14	20		
15	21		

Distribution of the scores showed that most of the distributions are not towards higher rank i.e., between (20-30) which may indicate that may be the sample was not suffering from high level of Trait Anxiety.

Graphical representation scores of mothers having boy retarded child and mothers having girl retarded child with reference to TRAIT ANXIETY

TABLE NO: 5.5

Shows the scores of mothers of BOY MENTALLY RETARDED CHILDREN AND mothers of GIRL MENTALLY RETARDED CHILDREN in relation to STATE ANXIETY

PSYCHOLOGICAL VARIABLES	CATEGORY OF MOTHERS	
	HAVING BOY MENTALLY RETARDED CHILDREN	HAVING GIRL MENTALLY RETARDED CHILDREN
STATE ANXIETY		
MEAN	45.2	54.33
SD	13.44	3.33
t-test	0.01073	

** Significant at .01 level

N=mothers of boy MR children =15 mothers of girl MR children =15

As to STATE ANXIETY TABLE NO-5.5, the mean score of mothers having boy MR CHILDREN was 45.2 and mean score of mothers having GIRL MR CHILDREN.....

Graphical representation of Mean and SD score of mothers having boy retarded child and mothers having girl retarded child with reference to STATE ANXIETY

TABLE NO: 5.6

Shows the scores of mothers of BOY MENTALLY RETARDED CHILDREN AND mothers of GIRL MENTALLY RETARDED CHILDREN in relation to TRAIT ANXIETY

PSYCHOLOGICAL VARIABLES	CATEGORY OF MOTHERS	
	HAVING BOY MENTALLY RETARDED CHILDREN	HAVING GIRL MENTALLY RETARDED CHILDREN
TRAIT ANXIETY		
MEAN	18.53	22.6
SD	10.19	8.35
t-test	0.12131	

** Significant at .01 level

N=mothers of boy MR children =15 mothers of girl MR children =15

As to STATE ANXIETY TABLE NO-5.6 the mean score of mothers having boy MR CHILDREN was 18.53 and mean score of mothers having GIRL MR CHILDREN was 22.6

Graphical representation of Mean and SD score of mothers having boy retarded child and mothers having girl retarded child with reference to TRAIT ANXIETY

DISCUSSION AND CONCLUSION

6.1 DISCUSSION:

As to STATE ANXIETY TABLE NO: 3.1 shows that mothers of boy retarded child and mothers of girl retarded child differs significantly w.r.t to STATE Anxiety. The mean score of mothers having girl retarded child was 54.33 which is greater than that of mean score of mothers having boy retarded child which was 45.2. Therefore the SD of mothers having boys was 13.44, whereas mothers having girls was 3.33, which shows that mothers having girl child will have more STATE Anxiety than the mothers of boy retarded child. The score of t test also shows that there is a difference between 2 mean score which is significant, so the hypothesis one is not accepted.

As to TRAIT ANXIETY TABLE NO: 3.2 shows that mean score of mothers having boy retarded child was 18.53 which is lesser than the mean score of mothers having girl retarded child-which was 22.6. SD of mothers having boy retarded child is-was 10.19, whereas mothers having boy child is was 8.35. Table 3.6 shows that the t test of this mean scores differs significantly ($t = 0.12131$). So it can be said that in the present situation, mothers of girl mentally retarded child have more trait anxiety compare to that of mothers of boy retarded child. Hence the hypothesis 2 is also not accepted.

6.2 CONCLUSION:

Anxiety refers to feelings of unease, worry, tension, and stress - It is usually accompanied by a situation that causes these feelings for example, a big test or interview. It can also be caused by anxiety disorders such as obsessive compulsive disorder or generalized anxiety disorder. The STAI tests two different types of anxiety, state and trait anxiety. State anxiety (S- anxiety) can be defined as fear, nervousness, discomfort, etc. and the arousal of the [autonomic nervous system](#) induced by different situations that are perceived as dangerous. This type of anxiety refers more to how a person is feeling at the time of a perceived threat and is considered temporary. Trait anxiety (T-anxiety) can be defined as feelings of stress, worry, discomfort, etc. that one experiences on a day to day basis. This is usually perceived as how people feel across typical situations that everyone experiences on a daily basis.

Finding of the study indicates that mothers of girl retarded children will have higher STATE and TRAIT Anxiety than that of the mothers of boy retarded child. There was a statistically significant relationship between maternal anxiety and sex of the mentally disabled child. This was

similar to what was found by Fazaila Sabih, Wahid Bakhsh Sajid where they found that the child's sex had an effect on mother's psychological wellbeing and adaptation in managing the case and that the mother had more confidence when the child was a boy. Similarly study of Sangita A.J. & Joshi M.S. (2000) shows anxiety and depression that mothers perceive was more serious in mothers of girls than in mothers of boys.

Having a mentally retarded child in the family itself brings a stress to the mothers.

The ratio of male and female disability in our country is 51:49.

Girls with disability in our society are treated as double handicapped, the first one is for being a girl and the second one is having the intellectual disability (mental retardation).

In the Indian scenario the mothers are the ultimate caregiver of their disabled children. We can say that the mentally retarded children is completely dependent on others especially on their mothers. They are also dependent on their mothers for their daily life activities and common hazard, safety and security. And when it comes in case of girls then the level of dependency and feeling of safety and security goes higher.

As to Trait anxiety there is also remarkable differences in anxiety proneness between these two groups of mothers. Mothers of girl child with intellectual disability (mental retardation) are likely to have more anxiety. Mothers of mentally retarded child mostly suffer from social isolation negligence. In our Indian culture, the girl child is always taken for granted. They are most negligible portion of the society from the very early age. They are treated badly, abused physically, mentally and sexually even in their own families. Mothers always gets worried of their girl children as they are treated as the social burden. When it comes to the child with disability, the worry of the mothers gets higher and higher. How to take care of their girl child with MR, how to manage them during their puberty, how to secure and protect them, etc., are all these kind of questions comes to the mother of girl child with MR and makes them much more anxious than that of mothers of boy child with MR.

6.3 LIMITATION OF THE STUDY:

The study had many limitations:

- Sample size was small.
- Educational standards were not same of the sample.
- All the mothers were not belonging to the same socio-cultural background
- It was not found if there was any psychotic disorders of mothers who were the sample
- It could be done with level of severity of children with disability.

- It could be done on two different age group of the children namely before and after puberty and then find which groups of mothers are having more anxiety

6.4 SUGGESTION FOR FURTHER STUDY

The finding of the study indicates that mothers of MR children have anxiety, which badly affects their quality of life.

We thought that effective rehabilitation program should provide with sufficient opportunities for repeated follow of interviews, which will not only help the children with disabilities, but also be a psychological support for the mothers.

An attain should therefore be made to adopt the preventive measures for the exercising control over the occurrence of Intellectual disability (mental retardation). So there is need of proper care of mother and child before the birth of the child. Provision of normal and stimulating environment after birth is needed, there are also needs for provision of public education and proper counseling of parents of disabled child.

The mother should never compare their child's achievement and abilities with those of their normal sibling or other children in home and neighbourhood. The children with retardation should have a provision of special education and training. Also there must be some advocate group to protect and secure their rights.

APPENDIX

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