A STUDY ON PSYCHOLOGICAL STRESS AND COPING STRATEGIES OF CARE GIVERS OF MENTAL RETARDATION.

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Abstract
The study was entitled with the psychological stress and coping strategies of care givers of children with mental retardation. The objectives were, to understand the socio-demographic profile of the respondents, to find out the level of stress among the care givers of mentally retarded children, to investigate the coping strategies adopted by the respondents, to study the affirmative relationship of the care givers with their children, and to identify the care giving involvement initiated by the respondents to bring up their mentally retarded child. The researcher adopted lottery method for sampling, and sizes of the respondents were 65. The respondents were the care givers of children with mental retardation were studying in Shanthi Nilayam school for mentally retarded in Kayakumari district. The data was collected on the basis of self prepared interview schedule. Distribution of level of coping strategies of care givers, the care givers stress, coping, affirmative relationship and care giving involvement is analyzed in this study.

Keywords: Stress, Coping, Affirmative, Retardation and Care giver.

INTRODUCTION
There is a general agreement that a person with mental retardation must have significantly sub average intellectual functioning; an impairment resulting from an injury, disease or abnormality that existed before age 18; and an impairment in adaptive abilities. Mental Retardation(MR) is divided into four degrees namely severity, mild, moderate, severe and profound mental retardation.

Mental Retardation
According to the American Psychological Association (APA) on mental retardation, quoted in the policy guidance for psychosocial rehabilitation of persons affected by mental disability, mental retardation refers to substantial significantly sub average abilities in cognitive functioning, accompanied by deficits in adaptive skills.

Incidence and Prevalence
Incidence and prevalence are statistical measures of the number of people with a particular condition. The incident of mental retardation refers to the number of new cases that occur within a particular period. Prevalence is often expressed as a percentage. Experts generally agree that people with mental retardation make up approximately 2.5 percent to 3 percent of the total population.

By far, most people with mental retardation are mildly affected, and therefore most of the diagnostic decisions about whether retardation takes place within this group. But accurate identification with this population is extremely problematic. When someone is more severely affected, there is little disagreement about whether mental retardation exists. With mildly affected people, however, conflicting diagnoses are much more likely.

Unfortunately for all of these reasons our estimate of those with retardation are only the estimates still , these figures must serve as the basis for many funding decision and for much programmers planning.

The Prevalence of Mental Retardation
According to the world health report (2001) it is estimated that the overall prevalence of mental retardation is between 1% and 3%. It is more prevalent in developing countries because of higher incidence of injuries and deprivation of oxygen at birth and early childhood brain infections. Statistics of South Africa states that the number of mentally handicapped people was 206 415 in the census.

Characteristics of Mental Retardation.
Psychiatric disorders are also common in people who have retardation, affecting as many as 20 percent to 35 percent of that population. In addition, there is some suggestion that people with particular MR-related syndromes may be more likely of evidence to psychopathology. Besides psychiatric conditions, people with MR may have a higher incidence of behavior problems, including aggression, withdrawal, and other inappropriate behaviors. Because of the frequency of health and psychiatric problems, the determination of needed supports involves careful assessment of these factors for each person.

**Signs and Symptoms**

The signs and symptoms of mental retardation are related to behavioral aspects. Most people with mental retardation do not look like they have any type of intellectual disability, especially if the disability is caused by environmental factors such as malnutrition or lead poisoning. The so-called “typical appearance” ascribed to people with mental retardation is only present in a minority of cases, all of which involve syndrome mental retardation.

Children with mental retardation may learn to sit up, to crawl, or to walk later than other children, or they may learn to talk later. Both adults and children with retardation may also exhibit some or all of the following characteristics.

1) Delay in oral language development
2) Deficits in memory skills
3) Difficulty in learning social rules
4) Difficulties with problem solving skills
5) Delay in the development of adaptive behaviors such as self-help or self-care skills
6) Lack of social inhibitors

Children with mental retardation learn more slowly than a typical child. Children may take longer to learn languages, develop social skills and take care of their personal needs, such as dressing or eating. Learning will take them longer, require more reputation, and skills may need to be adopted to be their learning level. Nevertheless, virtually every child is able to learn developed and become a participating member of the community.

In earlier childhood, mild mental retardation (IQ 50-69, a cognitive ability about half two-third of standard) may not be obvious, and may not be identified until children begin school. Even when poor academic performance is recognized, it may take expert assignment to distinguish mild mental retardation from learning disability or emotional / behavior disorders. People with mild MR are capable of learning reading and mathematical skills, such as cooking or using the local mass transit system. As individuals with mild mental retardation reach adulthood, many learn to live independently and maintain gainful employment.

Moderate mental retardation (IQ 35-49) is nearly always apparent within the first years of life. Speech delays are particularly common signs of moderate MR. People with moderate mental retardation need considerable supports in school, at home, and in the community in order to participate fully. A person with severe or profound mental retardation will need more intensive support and supervision his or her entire life. They may learn some activities of daily living. Some will require full-time care by an attendant.

**Coping skills for life**

Good coping means active problems solving that has:  
1) **Optimism** or an expectation that positive change is possible  
2) **Practicality** about the kinds of solutions that are feasible  
3) **Flexibility** in approach to any problems  
4) **Resourcefulness** in finding support or additional information that helps with good coping you do not feel helpless or hopeless.

**Statements of Coping Principles**

1. Recognize that no thought or feeling is wrong in itself, it is what we do with it really counts.
2. Become aware of the way your body feels as tension begins to build up remind yourself to calm down.
3. Recognize that you don’t have to go through this alone. Don’t hesitate to seek information or counseling if questions or concerns arise. Help is available from a wide range of sources.
4. Work to improve communications with your family friends and physician.
5. If you are experiencing fatigue or feeling overwhelmed, consider redistributing or reducing your responsibilities for a period of time.
6. Recognize that family and friends have to deal with their feelings too. They may be helpful or unhelpful to you. They are, however, probably doing the best they know how.

7. Your physician is your partner. Your part of the partnership is to accept responsibilities for reporting honestly how you are feeling, inquiring about the concern you have, and doing your best to deal with the adjustments you must make.

8. Do things each day that are nurturing to you. These may include fun activities, relaxation, time alone and exercise.

9. You can work to solve some of the problems that are causing your stress.

10. Accept that guilt and worry about things you cannot change are useless and energy-draining.

11. Give yourself credit for whatever level of coping you are achieving. Remember, there is no “instant fix” for stress.

12. Develop love and respect for yourself as each one of us is a potential person with our strength and confidence.

Statement of the problem

Raising a child with a mental challenge may be more expensive than raising a typical child. The expenses can arise from a medical care, private education, tutoring, adoptive learning equipment or specialized transportation. So, care giving a mentally challenged can be very stressful. Care givers feel sad or moody, crying more often having a low energy level, having trouble in sleeping, in eating or eating too much lost in interest in their hobbies, feeling angry, stigma and discrimination cause additional stress to the care givers. They are more sensitive to the acceptance or rejection of their child by others in India. The mothers are often blamed by the paternal grandparents or the father for giving birth to a child with mental retardation. Financial constrains, worries about the future, sexual abuse, or exploitation were found to be an important factor to produce stress among care givers of mentally retarded children. Having a child with mental retardation in the family demands a lot of adjustments and coping on the part of care givers. Care givers who are successful in coping with having a mentally retarded child are able to effectively mobilize their internal and external resources to deal with the special needs of their child. Hence the researchers decided to take up the study with entitled “A study on psychological stress and coping strategies of care givers of mental retardation”.

Objectives of the study

The main objectives of the study is to assess the psychological stress and coping ability of care givers of mentally retarded children

Specific objectives

- To understand the socio-demographic profile of the respondents.
- To find out the level of stress among the care givers of mentally retarded children.
- To investigate the coping strategies adopted by the respondents.
- To study the affirmative relationship of the care givers with their children.

Operational Definitions

Stress

Any interference which disturbs the functioning of the organism at any level and which produces a situation which is natural for the organism to avoid.

Coping strategy

Coping skills are those skills that we use to offset disadvantages in day to day life. Coping skills can be seen as a sort of adaptation, such as the finally tuned hearing that many visually impaired people develop.

Care giver

One who provides basic care for a person who has mental retardation and or developmental disabilities.

Mental retardation

The person who has to have both significantly low IQ and considerable problems in adapting to everyday life.

Hypothesis

1) Higher the stress, lower the coping strategies of care givers.
2) Higher the stress, higher the interest and efforts of care givers in
child caring.

3) Higher the caregiver stress, lower the love and affection towards child.

REVIEW OF LITERATURE

The review of the literature is carried out to know about the existing practices of treating the variables in the present research and helps to fasten the research process. To acquaint with the current knowledge in the area of study and to understand the research methodology, the investigator reviewed the related literature.

Awadalla H.I. et.al (2010), three tools were used in his study on determinants of maternal adoption to mentally disabled children in El Minia, Egypt. They assessed maternal adoption and the relationship between maternal socio demographic factors and adaptation as well as examining maternal distress. All 100 mothers with children aged 6 – 18 years attending the school where recruited in the study. Three tools were used, demographic data sheet, adaptation scale to assess the nature of mother’s interaction and patterns of psychosocial adaptation and depression scale to detect the presence of psychiatric disorders among the mothers. They found out, about two-thirds of mothers had high level of psychopathology. They might experience greater demands upon their personal resources and consequently were more distressed and maladapted.

Yueh – Ching Chou, et.al (2010), Studied on older and younger family care givers of adults with intellectual disability: factors associated with future plans. The sample size was 315 caregivers who were 55 years or older and who cared for adults with intellectual disability and 472 similar care givers who were under 55 years of age. The results indicated that the older caregivers compared with younger ones reported a lower quality of life, loss family support, a more negative perception of having a family member with intellectual disability, the greater worries about the future care arrangements of the adult with intellectual disability

Lucy Boyd (2011), reported that raising a child who is mentally challenged requires emotional and flexibility. The child has special needs in addition to the regular needs of all children, and parents can find themselves overwhelmed by various medical, care giving and educational responsibilities. Whether the special needs of the child are minimal or complex, the parents are inevitably affected. Support from family, friends, the community or paid care givers is critical to maintaining balance in the home. They often struggle with guilt. This guilt can harm the parent’s emotional health if it is not adult with. Most parents have aspirations for their child from the time of her birth and can experience severe disappointment that she will not be president, a physician, an actor or whatever they had in mind. Parents feel embarrassed or ashamed that their child is mentally disabled. The additional responsibilities can take a physical toll on a parent, leading to exhaustion. The American Academy of Family physicians relates that these issues can cause significant caregiver stress. Raising a child with a mental challenge may be more expensive than raising a typical child. These expenses can arise from medical equipment and supplies, medical care, care giving expenses, private education, tutoring and adaptive learning equipment or specialized transportation.

Aesha John (2012), assessed stress among mothers of young children with intellectual disabilities in urban India and examined the extent to which child functioning and maternal coping predict maternal stress. Through qualitative analysis, the study identified negative and positive dimension of Indian mothers’ care giving experiences. Mothers completed parenting stress Index – Short form, and children’s teachers completed vineland – II teachers rating form. Maternal responses to a semi – structured interview were rated to assess maternal coping and content analyzed to derive qualitative themes. The researcher was found that three – fourth of the sample obtained a clinically significant stress score and maternal coping emerged as a robust predictor of stress for mothers of boys with intellectual disabilities. Qualitative analysis indicated positive and negative maternal experiences related to self, child, family and community.

Ramesh Upadhyayer, G and N.B Havalappanavar, N.B (2008) studied various coping strategies using by the fathers and mothers of 628 mentally challenged individuals are assessed using the coping check list by Rao. K. Subhakrishna and Prabhu. Simple random samplings are used for the study. It was observed that, except on religious faith and denial blame, on all other five strategies the mean is more for fathers because mothers use more of religion faith and denial blame strategies compared to fathers.

Sindhu Micheal (2010) conducted a study on efforts on Vipassana on stress among care givers of children with special needs at, Vidyasudha Sru, Porur and Chennai. The samples size
was 40 and design used was one group pre – test – post – test. The results showed that in pre – test, 90% respondents had moderate level of stress and 10% had mild level of stress, after the intervention of Vipassana, 82.5% had moderate level of stress and 17.5% had mild level of stress. The study concluded that Vipassana meditation has an important role in reducing stress.

**RESEARCH DESIGN**

The researcher has attempted to assess the level of stress and coping strategy among the care givers of mentally retarded children. The study represents the description of stress level and coping strategy among the respondents.

**Variables**

**Independent variables**

The independent variables are Age, Gender, Educational qualification, Religion, Type of the family, Family income, Occupational status, Size of the family, Type of marriage, Number of children, Information about the mental retardation.

**Dependent variables**

Psychological stress, Coping strategies of care givers of mentally retarded children.

**Universe and sampling**

Universe of the study comprises about 180 children with mentally retardation are studying in that school. Among this 65 care givers of mentally retarded children were selected by lottery method.

**Inclusion criteria**

1) Caregivers who may be father or mother.
2) Caregivers who are willing to participate in the study.
3) Caregivers who can read or write Tamil.

**Exclusion criteria**

1) Respondents who have memory difficulties.
2) Respondents who reports having mental illness, and severe neurological disease.
3) Caregivers who are not staying with the children with mental retardation.

**Pilot study**

A pilot study was done by the researcher in Shanthi Nilayam which is a special school for mentally retarded. In order to gets information regarding the number of children who are studying and details about the school. It was known that averages of 180 students are studying there.

**Tools of data collection**

Socio demographic sheet and Self prepared interview schedule.

**Pre- testing**

Pre-test was done to check their relevance of interview schedule prepared by the researcher with record to the present study. The researcher has done the pre-testing with an informants and this helped to ensure that the questions were conveyed to the respondents with its actual meaning.

**Sources of data**

A major source of data was primary and the researcher has collected information directly from the respondents with the help of an interview schedule.

**Statistical method**

Statistical methods were used for the analysis of the data. The analysis was done using and statistical package for the social sciences (SPSS ). The test used for the analysis of the data was correlation.

**ANALYSIS OF DATA**

This chapter presents the analysis and interpretation of the data collected in the form of results and the findings of the study. The results of the analysis are presented in separate tables and the observations of the findings are presented.

**Table(1) Distribution of respondents by Gender**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Gender</th>
<th>Frequency</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>20</td>
<td>30.8</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>45</td>
<td>69.2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>65</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In the above table(1) observed that more than half of the respondents were female and almost quarter of the respondents were male. This may be due to high female sex ratio to male in Kanyakumari district.(1010:1000). The above distribution supports Marsh view (1992) that all family members are affected by the presence of disability; however the mental retardation of child undoubtedly poses special challenges for mothers. Fathers may be
placed in a peripheral role that offers validation and support.

Table(2) Distribution of responses for items in sources of stress

<table>
<thead>
<tr>
<th>Variables</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Sometimes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>34(52.3)</td>
<td>19(2 9.2)</td>
<td>12(18.5)</td>
</tr>
<tr>
<td>Happy with the child</td>
<td>39(60)</td>
<td>15(2 3.1)</td>
<td>11(16.9)</td>
</tr>
<tr>
<td>Afraid about the future</td>
<td>49(75.4)</td>
<td>8(12.3)</td>
<td>8(12.3)</td>
</tr>
<tr>
<td>Health has suffered</td>
<td>9(13.8)</td>
<td>44(6 7.7)</td>
<td>12(18.5)</td>
</tr>
<tr>
<td>Angry of the respondents</td>
<td>4(6.2)</td>
<td>41(6 3.1)</td>
<td>20(30.8)</td>
</tr>
<tr>
<td>Suffering of social life</td>
<td>13(20)</td>
<td>44(6 7.7)</td>
<td>8(12.3)</td>
</tr>
<tr>
<td>Financial problem</td>
<td>39(60)</td>
<td>16(2 4.6)</td>
<td>10(15.4)</td>
</tr>
<tr>
<td>Feeling of spending more money</td>
<td>33(50.8)</td>
<td>26(4 0.0)</td>
<td>6(9.2)</td>
</tr>
<tr>
<td>Worries of the respondents</td>
<td>47(72.3)</td>
<td>9(13. 8)</td>
<td>9(13.8)</td>
</tr>
<tr>
<td>Anxious/ irritability</td>
<td>12(18.5)</td>
<td>31(4 7.7)</td>
<td>22(33.8)</td>
</tr>
<tr>
<td>Ashamed/guilty feeling</td>
<td>6(9.2)</td>
<td>52(8 0.0)</td>
<td>7(10.8)</td>
</tr>
</tbody>
</table>

Table(3) Distribution of responses for items in coping strategies

<table>
<thead>
<tr>
<th>Statements</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Sometimes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping abilities of the respondents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive attitude</td>
<td>18(27. 7)</td>
<td>38(58. 5)</td>
<td>9(13.8)</td>
</tr>
<tr>
<td>Making right decision at right times</td>
<td>31(47. 7)</td>
<td>23(35. 4)</td>
<td>11(16.9)</td>
</tr>
<tr>
<td>Plan of action</td>
<td>22(33. 8)</td>
<td>29(44. 6)</td>
<td>14(21.5)</td>
</tr>
<tr>
<td>Seeking professional help</td>
<td>43(66. 2)</td>
<td>16(24. 6)</td>
<td>6(9.2)</td>
</tr>
<tr>
<td>Habit of going walk with the child</td>
<td>31(47.7)</td>
<td>20(30.8)</td>
<td>14(21.5)</td>
</tr>
<tr>
<td>Knowledge to improve child's life</td>
<td>41(63.1)</td>
<td>15(23.1)</td>
<td>9(13.8)</td>
</tr>
<tr>
<td>Habit of hearing music</td>
<td>32(49.2)</td>
<td>26(40)</td>
<td>7(10.8)</td>
</tr>
<tr>
<td>Giving equal importance as that of normal child</td>
<td>62(95.4)</td>
<td>1(1.5)</td>
<td>2(3.1)</td>
</tr>
<tr>
<td>Receive support from friends and relatives</td>
<td>17(26.2)</td>
<td>38(58.5)</td>
<td>10(15.4)</td>
</tr>
<tr>
<td>Listening skills</td>
<td>44(67.7)</td>
<td>15(23.1)</td>
<td>6(9.2)</td>
</tr>
<tr>
<td>Like to spend more time with the child</td>
<td>57(87.7)</td>
<td>2(3.1)</td>
<td>6(9.2)</td>
</tr>
</tbody>
</table>

Table(2) exhibits the distribution of responses from the caregivers to each of the 11 items in the sources of stress. As the table evidences, the major sources of caregiving stress as reported by the caregivers (percentages given in the brackets) are represented by the following items such as “afraid about the future” (75.4%), “worries of the respondents” (72.3%), “financial problem” and “happy with the child” (60%), “felt like a failure” (52.3%), and “feeling of spending more money” (50.8%). Conversely, the minor sources of stress as reported by the caregivers are represented in the following items such as “health has suffered” and “social life has suffered” (67.7%), and “angry of the respondents” (63.1%).

The results thus obtained reveal that the major coping strategies as reported by the caregivers are represented (Table 3) by the following items such as “giving equal importance as that of normal child” (95.4%), “like to spend more time with the child” (87.7%), “listening skill” (67.7%), and “seeking professional help” (66.2%). Similarly, the above table shows that 58.5% of the caregivers not receiving support from friends and relatives.
Table(4) Distribution of responses to caregivers affirmative relationship with the child.

<table>
<thead>
<tr>
<th>Relationship with the child</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm and loving attitude</td>
<td>62(95.4)</td>
<td>1(1.5)</td>
<td>2(3.1)</td>
</tr>
<tr>
<td>Easy communication with the child</td>
<td>53(81.5)</td>
<td>7(10.8)</td>
<td>5(7.7)</td>
</tr>
<tr>
<td>Need around the child</td>
<td>32(49.2)</td>
<td>22(33.8)</td>
<td>11(16.9)</td>
</tr>
<tr>
<td>Child fear that losing interest of the respondents</td>
<td>8(12.3)</td>
<td>52(80)</td>
<td>5(7.7)</td>
</tr>
<tr>
<td>Child try to stay close with their caregivers</td>
<td>54(83.1)</td>
<td>5(7.7)</td>
<td>6(9.2)</td>
</tr>
<tr>
<td>Enjoyment about the closeness of their child</td>
<td>63(96.9)</td>
<td>1(1.5)</td>
<td>1(1.5)</td>
</tr>
<tr>
<td>Child turn for guidance</td>
<td>47(72.3)</td>
<td>7(10.8)</td>
<td>11(16.9)</td>
</tr>
<tr>
<td>Child like to spend away from the respondents</td>
<td>17(26.2)</td>
<td>44(67.7)</td>
<td>4(6.2)</td>
</tr>
<tr>
<td>Child like to visit friends without him</td>
<td>5(7.7)</td>
<td>51(78.5)</td>
<td>9(13.8)</td>
</tr>
<tr>
<td>Child expect to do everything he/she says</td>
<td>49(75.4)</td>
<td>9(13.8)</td>
<td>7(10.8)</td>
</tr>
<tr>
<td>Child answer back freely</td>
<td>36(55.4)</td>
<td>21(32.3)</td>
<td>8(12.3)</td>
</tr>
</tbody>
</table>

The responses(Table.4) given by the caregivers to every one of the items in affirmative relationship questionnaire. As seen from the above table, the items that were positively rated by majorities referred to “ready to talk whenever the child wants and "enjoyment about the closeness of the child” (96.9%), “warm and loving attitude” (95.4%), child try to stay close with the care giver” (83.1%) easy communication with the child” (81.5%), child’s expectation towards their care giver” (75.4%),and “child turn for guidance always” (72.3%).

Table(5) Distribution of responses to items in the caregivers involvement.

<table>
<thead>
<tr>
<th>The caregivers involvement</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular medical check-up</td>
<td>54(83.1)</td>
<td>4(6.2)</td>
<td>7(10.8)</td>
</tr>
<tr>
<td>Maintain health and hygiene</td>
<td>64(98.5)</td>
<td>15(23.1)</td>
<td>1(1.5)</td>
</tr>
<tr>
<td>Provide balanced diet</td>
<td>62(95.4)</td>
<td>2(3.1)</td>
<td>1(1.5)</td>
</tr>
<tr>
<td>Like to teach general knowledge</td>
<td>57(87.7)</td>
<td>4(6.2)</td>
<td>4(6.2)</td>
</tr>
<tr>
<td>Help the child to</td>
<td>48(73.8)</td>
<td>7(10.8)</td>
<td>10(15.4)</td>
</tr>
</tbody>
</table>

The above table represents(Table.5) that Among the total responses to the categories received the maximum care giving involvement are respectively “maintain health and hygiene” (98.5%), "provide balanced diet” (95.4%), “like to teach general knowledge” (87.7%), “regular medical check-up” (83.1%), “take the child to spiritual places” (81.5%), “motivate the child to get good habits” (75.4%), “help the child to participate competitions” and “go excursion with the child (73.8%).

Table(6)Correlation between the stress, coping, affirmative relationship and care giving involvement.

<table>
<thead>
<tr>
<th></th>
<th>Stress</th>
<th>Coping</th>
<th>Relationship</th>
<th>Interest and efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig.(2-tailed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td>1</td>
<td>-.272</td>
<td>.075</td>
<td>-.163</td>
</tr>
<tr>
<td>N</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig.(2-tailed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td>.028</td>
<td>.552</td>
<td>.194</td>
</tr>
<tr>
<td>N</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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The above correlation results indicate that there is a significant positive correlation between stress and coping, and also between stress and relationship, and also between stress and care giving involvement. There is also a significant positive correlation between coping and relationship, and also between coping and care giving involvement. There is a significant positive correlation between relationship and care giving involvement.
Correlation is significant at the 0.05 level (2-tailed),
** Correlation is significant at the 0.01 level (2-tailed).

The result of correlation(Table.6) between the stress, coping, affirmative relationship and care giving involvement. The correlation indicates that the statistically significant negative correlation between the stress and coping strategies. Hence hypothesis one is accepted (r = -.272*). There was a significant positive correlation in between the coping and affirmative relationship towards their child (r=0.355**) coping had positively correlated with care giving involvement (r = .541**).

Stress and care giving involvement were positively correlated (r=.541**). This supports the second hypothesis that there is a direct relationship between the psychological stress and care giving involvement. Psychological stress and affirmative relationship were positively correlated with each other. It indicates the third hypothesis that there is a negative relationship between the stress and affirmative relationships were negative correlation. Hence it rejects the third hypothesis.

**FINDINGS, CONCLUSION AND RECOMMENDATIONS**

**Major findings of the study**

Socio-demographic profile of the respondents
1) More than half of the respondents were female and almost quarter of the respondents were male.
2) Almost half of the respondents (47.7%) were in the age group of 31-40.
3) Quarter of the respondents (24.6%) were educated to school education.
4) Majority of the respondents (33.8%) have income level 11000-24000.
5) Majority of the respondents (53.8%) were labourers.
6) Majority (83.1%) of the respondents had arranged marriages.

**Distribution of responses for items in sources of stress**

The major sources of care giving stress as reported by the caregivers are represented by the following items such as “afraid about the future” (75.4%), “worries of the respondents” (72.3%), “financial problem and happy with the child” (60%), “felt like a failure” (52.3%) and “feeling of spending more money” (50.8%).

The major coping strategies as reported by the caregivers are represented by the following items such as “giving equal importance as that of normal child” (95.4%), “like to spend more time with the child” (87.7%), “listening skill” (67.7%) and “seeking professional help” (66.2%).

Majorities referred to “ready to talk whenever the child wants” and “enjoyment about the closeness of the child” (96.9%), “warm and loving attitude” (95.4%), child try to stay close with the care giver” (83.1%) “easy communication with the child” (81.5%), child’s expectation towards their care giver” (75.4%) and “child turn for guidance always” (72.3%).

The maximum care giving involvement are respectively “maintain health and hygiene” (98.5%) “provide balanced diet” (95.4%), “like to teach general knowledge” (87.7%), “regular medical check-up” (83.1%), “take the child to spiritual places” (81.5%), “motivate the child to get good habits” (75.4%), “help the child to participate competitions” and “go excursion with the child” (73.8%).

**Distribution of level of coping strategies of care givers**

The 10.7% of the caregivers were highly stressed and 15.3% had highest level of coping. It is found about 90.8% were showing more relationship with the child and 81.5% showed more level of care giving involvement. Mean relationship between the care givers stress, coping, affirmative relationship and care giving involvement.

The females had higher mean scores (4.97) on stress when compared to the males. The mean score is high for the age group of 31-40. They were higher scores (6.09, 6.0, 5.25) seen among the illiterates, primary, and high school education on stress. There were high mean score (6.5) seen in those who belong to the income level of 10000-50000 on stress. Labourer and agriculture had high mean score (6.5) on stress. Mean score is high for those who have children with severe and profound mental retardation (6.6, 5.03) on stress.

Mean score is high (6.35) for males when compared to females on coping. The respondents age group below 30 had high mean score (7.33) on coping when compared to other age groups. The group of respondents who have educated to high school and college have high mean score (7.83, 7.04) on coping. The care givers who have high level of income group having high mean score (7.33) on
coping. Professionals (8.5) and those who work in government sector (7) care givers have high mean score. The care givers with mild (6.23), moderate (6.44) children were scored high mean score on coping.

There were highest score seen among males (7.55) on affirmative relationship. The care givers who have the age group of above thirty (7.6) scored high mean score. There were highest mean score found in illiterate (8.5), middle school (8.18), high school (8.08) and higher secondary (8) on showing affirmative relationship. Those who have income level between 11000-24000 have high affirmative relationship, mean score (8.36). The care givers who were working in governmental sector scored (7.9) high mean score on affirmative relationship. The care givers of moderate (8.17) and profound (8) mental retarded child scored high mean scores.

The care givers age group in between 31-40 scored high mean score (7.77) on care giving involvement. The male care givers had high mean score (7.55) on care giving involvement. care givers who were educated to middle school (8.18),and high school (8) scores high mean score when compare to other caregivers. The care givers having the income level 11000-24000 scored (8.04) high mean score on care giving involvement. Professionals scored high mean score (8.5) on care giving involvement. The caregivers with moderate mental retarded children has high mean score (7.79) on care giving involvement.

Correlation between the stress, coping, affirmative relationship and care giving involvement. The correlation indicates that the statistically significant negative correlation between the stress and coping strategies. Hence hypothesis one is accepted. (r=-.272*).

There was a significant positive correlation in between the coping and affirmative relationship towards their child. (r=0.355**). Coping had positively correlated with care giving involvement (r=.541**). Stress and care giving involvement were positively correlated (r=.541**). This supports the second hypothesis that there is a direct relationship between the psychological stress and care giving involvement. Psychological stress and affirmative relationship were positively correlated with each other. It indicates the third hypothesis that there is a negative relationship between the stress and affirmative relationships were negative correlation. Hence it rejects the third hypothesis.

Conclusion

The present study is to assess the psychological stress and coping strategies of care givers of children with mental retardation. The results obtained from the research shows that 10.7% of the caregivers were highly stressed and 15.3% had highest level of coping. 90.8% were showing more relationship with the child and 81.5% showed more level of care giving involvement. The correlation was done to explore the relationship between stress, coping, affirmative relationship and care giving involvement. The correlation indicates that the statistically significant negative correlation between the stress and coping strategies. There was a significant positive correlation in between the coping and affirmative relationship towards their child. Coping had positively correlated with care giving involvement. Stress and care giving involvement were positively correlated. Psychological stress and affirmative relationship were positively correlated with each other. This study supports the review of literature.

Suggestions

1) Service providers should be capacitated on mental retardation.
2) Awareness should be done in the community about mental retardation, its causes, treatment, and how it can be prevented.
3) Provision of adequate information and skills to parents of child with mental retardation to enhance coping.
4) Siblings should be well informed about the condition of their disabled brothers or sisters.
5) Service providers should facilitate the establishment of community based care services. This is done in an attempt to support families in caring for their disability offspring.
6) Families need assistance in dealing with problems in larger society, e.g. stigma and isolation.
7) Families must be linked with available resources, for example, the department of social development for the application of social grants.
8) Families need access to medical and psychological services and social workers and therapist can provide a practice of assistance.
9) The disclosure of the challenged must be done soon after the birth of the child and follow-up visits be made by the service provider.

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References


