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A FOLLOW-UP STUDY OF MENTAL RETARDATION FOCUSSING ON PARENTAL ATTITUDES

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SUMMARY

The investigation studies the perception and attitudes of parents towards their mentally retarded child. Thirty such children were followed up after one year of initial contact and the parents were interviewed. Parents of higher education had a more scientific perception. Most parents had unrealistic hopes and expectations, feelings of shame, guilt and self blame were predominant. Rejection, hostility neglect of child and other negative attitudes were significantly more often seen in younger parents, urbanites and those with higher education. The negative attitudes were more towards a child with additional psychiatric problems. This information could be of great advantage in managing families with a retarded child.

Parental attitudes towards a mentally handicapped child are of paramount importance, not only because majority of such children are looked after at their homes, but also because on these depend the efficiency and adequacy or otherwise of the training measures to be adopted by the parents (Akhtar and Verma, 1972). Kanner (1961) has said that parents do not have the same attitudes towards each of their children, as indeed they cannot. The fact that attitudes are not static presents the greatest aid to therapy. Most parents can be helped to express, recognise and eventually modify their attitudes for the mutual benefit of themselves and their children (Kanner, 1966). Wrong parental attitudes do interfere with the child's learning. Unrealistic and self defeating attitudes lead on to distorted family interactions which greatly hampers the already slow learning processes of the child and may at times precipitate severe emotional problems in both the parties (Akhtar and Varma, 1972). Parental attitudes and reactions also determine the treatment seeking pattern of these parents (Chaturvedi and Malhotra, 1982) and mainly arise out of the sense of frustration in carrying out the parental role of nurture (Zuckerberg *et al*., 1968). Rastogi (1981), on the other hand, reported considerable amount of favourable parental attitudes accompanied with feelings of guilt, pessimism and sometimes hostility.

An attempt has been made here to study the parental perception. Knowledge and attitudes towards mental retardation during follow-up and to examine its relationship with clinical and sociodemographic variables.

MATERIALS AND METHODS:

The sample consisted of 45 parents of the Mentally Retarded Children, living upto 50 Kms. around the institute, who attended the special mental retardation clinic of PGIMER, Chandigarh one year prior to the study. These parents have been given special attention, counselling and guidance. Contact with parents was established by sending a letter explaining the need of re evaluation and making home visits. A semi-

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structured interview proforma was designed to ascertain the following information: 1. Identification data of the child and the key person involved in child care. 2. Their perception of the condition. 3. Attitudes towards the child. Questions were framed to elicit rejection, over protection, shame, guilt, etc., Questions on parental attitudes were based on Kanner's (1966) description of various attitudes and the resultant handling of the child (Appendix). The parents were encouraged to explain their feelings and verbalise their attitudes without any hesitation. The magnitude of presence of negative attitudes and its correlation with various clinical and demographic variables were analysed. Parents having more than 3 manifestations of unhealthy attitudes were identified as parent with negative attitudes (Table 5).

RESULTS:

30 parents responded to letters and home visits. Tables 1 and 2 describe the characteristics of the children and socio-demographic background of their parents. Table 3 shows the parental perception; 60% parents considered mental retardation as an illness mainly of mental type. Parents of higher education status had a better perception as compared to those who were illiterate ($p < .05$) and considered it as a form of mental illness, though they percieved it as a severe disorder.

Though majority thought the cause to be organic damage of defect in the brain, some parents (30%) especially those from rural areas doubted dietary deficiency as a major contributory factor. Other factors implicated were neglect during pregnancy or delivery by

TABLE 1. *Distribution of children*

TOTAL NO: 30

Age	Sex	Education	Intelligence (ICD-9)
Less Thun			
5 years—1	Male 18	Illiterate 12	Mild Retardation 15
5-10 years—15	Females 12	Primary 15	Moderate Retardation 7
Above			
10 years—14		Middle School 3	Severe/Profound Retardation 8

TABLE 2. *Distribution of parents*

Background	Education	Income per month
Rural 10	Illiterate 10	Upto Rs. 400 .. 9
Urban 20	Under Matric 10	Rs. 400-1000 .. 15
	Matric & above 10	More than Rs. 1000/- 6

TABLE 3. *Perception of mental retardation*

	Background			Education			
	Rural (10)	Urban (20)	Significance	Illiterate (10)	Under Matric (10)	Above Matric (10)	Significance
Perception:							
Problem	6	6	NS	5	6	1	$p<.05$
Illness	4	14		5	4	9	
Type:							
Mental	5	16	NS	7	6	8	N.S.
Physical	1	2		1	1	1	
Not sure	4	2		2	3	1	
Severity:							
Mild	5	8	NS	7	4	2	$p<.05$
Severe	5	12		3	6	8	

23% of parents, and supernatural forces (16.7%) (Table 4).

ATTITUDES TOWARDS MENTAL RETARDATION: (TABLE 5)

Rejecting attitudes was the commonest. Many parents had strong feelings of shame (70%), blamed past sins (75%) had guilt feelings and blamed themselves (50%) for being the cause of mental retardation. Of the rejection manifestations commonest were overt hostility and neglect of the child; 86% parents got irritated over trivial issues and 63% would punish their retarded children frequently. But, only a few (27%) tried to avoid their child or send him away from home to various institutes or special care centres.

Perfectionistic attitudes were also commonly seen. 90% parents used excessive force, strictness and persuasion while dealing with the retarded child. 73% parents were nagging and frequently finding faults in whatever the child did.

TABLE 4. *Causes of Mental Retardation*

Cause	Number of Respondent	Percentage
Brain damage	18	60.0
Neglect during pregnancy	7	23.3
Dietary deficiency	9 (6 from Rural Areas)	30.0
Supernatural forces	5	16.7
Others	8	26.7
Do not know	5	16.7

(Please Note: Parents have implicated more than one etiological factor)

TABLE 5. *Attitudes towards Mentally Retarded Child*

Commonest reactions	(% of parents)
Feelings of Shame	70%
Guilt and Self blame	50%
Blame past sins	70%
Common Attitudes (As per Konner, 1966)	
Rejection manifestations:	
(overt hostility, neglect)	
Get easily irritated	86%
Punishing frequently	63%
Avoidance behaviour	27%
Perfectionistic attitudes:	
Excessive strictness	83%
Persuasion, force	90%
Frequent fault finding	73%
Compensatory overprotection:	
and over involvement	67%

Parents with more than 3 of above feelings or attitudes: 20(67%).

Compensatory overprotection and increased attention was seen in 2/3 of the cases. Parents would not allow the children to do anything on their own and supervise them continuously. 20 parents had more than 3 unhealthy attitudes and feelings. Table 6 shows the correlations between clinical and demographic variables and negative attitude.

Such unhealthy negative attitudes were significantly more ($p < .05$) in younger parents and those from high socio-economic status ($p < .05$). These attitudes were more often seen towards children who had severe retardation (88%). Parents who had high education and those from urban habitat more often displayed unhealthy attitudes. Such attitudes were more often towards male children and in those who remained illiterate though it was equally distributed in all age groups. However, these findings were not statistically significant.

The negative attitudes were significantly more towards child with psychiatric problems, and were not so towards children with epilepsy.

DISCUSSION:

The study thus highlights the great extent of negative and unhealthy attitudes in the parents. Parents interpret the birth of a retarded child differently (Poggs, 1961). Parents from rural areas had poor understanding, considering it as a short-lasting and temporary problem and were not sure of the nature of the problem. Educated parents and those from urban background, definitely had a more scientific perception of the condition and its cause. In accordance with the prevailing belief systems, parents,

TABLE 6. *Parental negative attitudes and clinical and socio-demographic variables*

	Total No. of Parents	Parents with negative attitudes (n=20)	Parents denying negative attitudes (n=10)	X^2	P
Degree of Retardation:					
Mild	15	8	7	3.12	NS
Moderate	7	5	2		
Severe	8	7	1		
Age of Parent:					
Below 30 years	3	3	0	6.48	p<.05
31-45 years	20	15	5		
Above 45 years	7	2	5		
Literacy:					
Illiterate	10	6	4	4.16	NS
Under Matric	10	5	5		
Over Matric	10	9	1		
Economic Status:					
Income upto Rs. 400/- PM	9	3	6	6.45	p<.05
Rs. 400-1000 PM	15	12	3		
Over 1000/-	6	5	1		
Background:					
Rural	10	5	5	1.73	NS
Urban	20	15	5		
Associated Psychiatric Problem:					
Present	21	17	4	6.43	p<.05
Absent	9	3	6		
Epilepsy:					
Yes	8	7	1	2.14	NS
No	22	13	9		

usually from rural background, tended to implicate role of dietary deficiency, supernatural forces and neglect during pregnancy as causative or contributory factors.

Their unrealistic expection that sooner or later the child would start functioning like any other person of normal intelligence probably arises from their excessive hopefulness and a conscious or unconscious wish that the child be perfect. Feelings of guilt and shame could be arising out of their poor perception of illness, poor social, academic performance by the child or as a psychological reaction, but this would eventually hamper the proper handling of the child. Such attitudes have been reported in other studies, as well (Condell, 1966; Harper,

1968; Rastogi, 1981). Feelings of guilt and rejecting attitudes have also been reported by other investigators (Zuk, 1959; Worchel and Worchel, 1963; Walsh, 1968).

Frustration, irritability and punitiveness was evident in the parent frequently probably resulting from the child's mistakes and shortcomings. They attempt to use excessive force and persuasion while making them learn, not realising the limited learning capacity of the child and not having the patience to teach them gradually. Inadequate knowledge and the unrealistic expectations may result in such feelings. On the other hand they try to be overcautious and give more than wanted attention to them By this order children could be neglected and this may lead to increased family problems. These vain attempts increase their frustration. In their effort to be extra careful about their child they deprive him the chances to learn on his own.

Surprisingly, unhealthy and negative attitudes are more in educated, urbanites and those belonging to higher socioeconomic status. This is probably arising due to the failure of their child to perform as other children in the modern competitive society. They are 'let down' by their retarded child and this they take as a personal defeat, therefore despite their better understanding of the illness they tend to reject the disadvantaged child. Younger parents have more negative attitudes probably due to the increased burden in so early a life or due to their limited experience. Rastogi (1981) reported more negative attitudes exhibited by mothers. In this study, however, both parents were not examined individually.

Children who were more severely retarded, with Psychiatric problems and uneducable were also difficult to train and most parents lost hope regarding their development and because of increased difficulty in their handling aroused more negative feelings in their parents. Certain of these aspects are inter-related as children with psychiatric problems are more severely retarded and have associated physical problems (Chaturvedi and Malhotra, 1983).

CONCLUSION:

The extent of negative parental attitudes, erroneous perception and unrealistic expections is such that it necessitates specialised handling by various psychotherapeutic and counselling measures. These should be handled in order to improve upon the retarded child's functioning and reducing the stressful family situation.

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