Attitudes of the mildly mentally retarded children's parents toward their children's handicap
Dammam – Saudi Arabia

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الغرض الرئيسى من هذه الدراسة هو التعرف على الاتجاهات لدى أبوي الأطفال المتخلفين عقلياً تجاه مرض أطفالهم.

تسعة وستون من والدي هؤلاء الأطفال المتخلفين عقلياً بدرجة بسيطة (مجموعة الأطفال المتخلفين عقلياً). ومجموعة مساوية مماثلة لأبوي أطفال أسوياء (مجموعة ضابطة) تمت مقابلتهم. وتم ملء استبيان مخصص لهذا الغرض. اتجاهات أبوي مجموعة الأطفال المتخلفين عقلياً كانت في هيئة لوم النفس والذي وجد أن أمهات الأطفال المتخلفين عقلياً يعانون منه بدرجة أكبر من الآباء حيث كان الفرق ذا دلالة احصائية. الرفض والشعور بالنقص كان موجودا لدى والدي الأطفال المتخلفين عقلياً. ولكن الفرق لم يكن ذا دلالة احصائية.

ومع هذا فإن هذا التأثير يعد أقل مما نشر في الأدبيات الطبية في المجتمعات الغربية. عدم السعي للتحقق من أسباب التخلف العقلي لدى الأطفال فى هذه الدراسة بلغ أكثر من الربع من مجموع العينة المستهدفه. والدى الأطفال المتخلفين عقلياً طالبوا بزيادة الخدمات المقدمة بواسطة المؤسسات الحكومية المختصة.

The objectives of this case-control study was to identify the attitudes of parents of mentally retarded children towards the illness of their children. Sixty-nine parents of mildly mentally retarded male children (MR group) and a similar number of matched parents of normal male children (Control Group) were interviewed using a questionnaire.

The parents of the MR group had feelings of guilt and self-blame which was significantly higher in mothers than in fathers. Feeling of rejection and inferiority were reported by the parents with no significant difference between fathers and mothers. All of the rates, however, were found to be less than those reported from western societies. Failure of families to investigate causes of mental retardation was found in more than a quarter of all the study groups. Parents of the MR group asked for more services to be provided by the appropriate governmental agencies.

Key Words: *Attitudes, Parents, Children and Mental Retardation.*

INTRODUCTION

All over the world, the combination of inadequate services provided to the mentally retarded children and their families, and the shift in care from the institutions to the community, has resulted in placing an extra burden on families[1-4]. It is still unknown how the attitudes of parents of the mentally retarded children toward their children's handicap in our community differ from that of the western communities. Through this investigation we will enrich our knowledge concerning this problem which is overlooked for socio-cultural reasons and has not been accorded priority amongst health and other problems[5]. It is hoped that the study will also help in the proper planning,

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organization and the more effective provision of the services needed.

SUBJECTS AND METHODS

The study population consisted of 72 male children aged 5–15 years attending a school for the educationally subnormal/mental (ESN/M) in Dammam City, Saudi Arabia, and their parents. The same number of normal children, attending regular schools, and their parents were randomly selected as controls. Matching was based on age, residence, nationality and the socio-economic class of the family. For undisclosed reasons, three parents (4.2%) from the MR group declined to participate. All parents of the remaining 138 children were invited by letter to take part in the study.

The letter also included questions on variables necessary for matching the controls.

Data analysis was performed using the SPSS/PC+ Statistical Package. Chi-square test was used to compare variables among and between groups.

Table 1
Criteria for Socio-economic Class Stratification

	Score
1. Education of father or Item "A"	
Secondary and University	7
Preparatory and primary	3
Illiterate	1
2. Occupation of father or Item "B"	
Professional or commercial	7
Semi-professional	3
Low type of job or unemployed	1
3. Family income (Saudi Riyals) per month or Item "C"	
10,000 or more	7
5,000 to less than 10,000	3
Less than 5,000	1

Level 1 : Upper Socio-economic Class
: A+B+C = 21

Level 2 : Middle Socio-economic Class
: A+B+C = 9 - 20

Level 3 : Low Socio-economic Class
: A+B+C = 3 - 8

ESN/M schools care for children who failed to progress satisfactorily in normal schools. The mean I.Q. score of the children of the study group was 57.4. Geographically, the ESN/M school involved pupils from the cities of Dammam, Sehat, Qatif, Al-hasa and a few other villages. However, in view of certain constraints it was decided to confine the study to only the children living in Dammam, Qatif and Sehat.

Information was collected by pre-trained interviewers using pre-tested and precoded questionnaires through pre-arranged home visits to parents. If the family was unavailable at the first call, another was arranged. The information obtained included: personal data of the parents; maternal medical history (pre-natal, natal and post-natal), milestones of the development of the child and its associated handicaps as well as the social history (family income, level of education, occupation of the head of the family). The parent's knowledge, attitudes, and behaviour towards their children's mental handicap were also investigated.

SOCIO-ECONOMIC STRATIFICATION

In view of the absence of local criteria for the categorisation of socio-economic classes, families were divided into three strata (upper, middle and low classes) according to the criteria shown in Table (1). To make the selection of controls more precise , this final score was also considered for the purpose of matching.

RESULTS

A. COMPARISON WITHIN MR GROUP

1. General Observations:

Less than one third (27.5%) of the families in the MR group failed to take their children to any hospital for an investigation of the cause of the retardation and all gave no reasons for their in action. A small proportion (4.7%) of the mothers in the MR group admitted that older mature or married siblings of the affected child harboured fears of having mentally retarded children in the future.

Table 2

Comparison between parents of MR Group

VARIABLE	FATHERS NO. (%)	MOTHERS NO. (%)	P–VALUE
Marked Behavioral Improvement of MR Child	54 (78.3%)	49 (71.0%)	N. S.*
Partial Behavioral Improvement of MR Child	11 (15.9%)	13 (19.0%)	N. S.
Adequacy of the Institute for the Eastern Province	56 (81.2%)	60 (87.0%)	N. S.
Feeling of Inferiority	7 (10.8%)	14 (20.9%)	N. S.
Feeling of Guilt	2 (3.0%)	11 (16.4%)	0.0226
Wished Child had Never Been Born	5 (7.5%)	7 (10.0%)	N. S.
Wished Death of MR Child at sometime	3 (4.5%)	6 (8.7%)	N. S.

*N. S. = Not significant

2. Parent's Comparisons:

Table 2 summarizes the results of this section. Forty nine mothers (71%) and 54 (78.3%) fathers of the MR group believed that their children had shown marked improvement in the degree of intelligence and behavior, while 13 mothers (19%) and 11 fathers (15.9%) believed that the improvement was minimal. Eighty seven percent of mothers and 81.2% of fathers in the MR group believed that the Institute at Dammam, where their children study, is inadequate to care for the entire Eastern Province (P = 0.48). Exactly 20.9% of the mothers and 10.8% of the fathers in the MR group felt inferior to other people because of their mentally retarded child. However, the difference was not statistically significant (P = 0.176). More mothers (16.4%) than fathers (3.0%) in the MR group felt guilty and blamed themselves for the birth of the retarded child (P = 0.0226). One tenth of the mothers and 7.5% of the fathers in the MR group wished that the child had never been born (P = 0.8). Similarly, more mothers (8.7%) than fathers (4.5%) had wished for the death of their handicapped child at some time, (P = 0.26). Twenty-six percent of the mothers and 20.2% of the fathers wished that their affected children be kept permanently in an institution (P = 0.545).

3. Comparisons among socio-economic classes

Significantly more families in the middle Socio-economic class (85.7%) than in the low socio–economic class (58.8%) managed to investigate the cause of retardation in their children (P = 0.0257). More mothers in the MR group from the lower socio-economic class (38.2%) than mothers from the middle socio-economic class (14.35%) (P = 0.046) welcomed the idea of keeping their children permanently in an institution.

B. COMPARISON BETWEEN MR AND CONTROL GROUPS

More mothers but not fathers in the MR group than in the control group felt the government should assume greater responsibility for the care of their children. (P = 0.0164). Mothers in both groups felt that they had given adequate care to their children since birth (P = 0.105) and their religious beliefs had not changed (P = 0.24). There was insufficient

evidence to prove that as compared with that of the control group (P = 0.17) mothers of the MR group were over-protective.

DISCUSSION

Different investigators[7-9] have suggested different diagnostic classifications and evaluation of the child with mental retardation. Lamont and Dennis in 1988[10] and Lamont et al in 1986[11] recommended chromosomal analysis for all mildly mentally retarded children irrespective of the presence or absence of any dysmorphic features. It should be mentioned that during the pre-entry medical examination to the institute, none of the above-mentioned methods of evaluation were adopted. In our study, self-blame (feeling of guilt) was the only variable which was found to be significantly higher in mothers compared to fathers of the MR group. Gath in 1977[12] reported two fathers of Mongol children with impotence who described their feeling of inferiority and being " less of a man" for not producing a normal child. Childs in 1985[13] reported that 90% of his sample of parents of retarded children felt inferior and less worthy when they were told about the condition of their children and that this feeling was present soon after delivery of an affected child. Self blame was found in 95% of mothers reviewed by Childs[13]

Rejection of mentally handicapped children was studied by Molsa and Molsa in 1985[14]. They found that in general 13% of mothers and 20% of fathers rejected the child. They also found that if parents were prepared for possibility of a handicap, it was easier to adapt to the situation, while if it was totally unexpected, 50% failed to adapt and rejected the child.

Childs[13] reported thoughts of rejection in 40% of his sample. The finding of our study that the rejection was more prevalent in mothers than fathers of mentally retarded children supported the findings of some investigators like Cook in 1963[15] and Ricci in 1970[16]. However it is at variance with that of Fletcher[17], who in 1947 found that acceptance of a defective newborn was more usual in mothers than fathers.

In our study, no evidence was found to suggest that over-protection was more in mothers of the MR group compared with their controls. Cook[15] reported that mothers of handicapped children were more protective. However, there was no control group in that study. Dingman et al in 1963[18] without using a control group found that differences in attitude were related to maternal education primarily. This was not indicated by Cook in 1963[15].

Our results showed that though there was a statistically significant (P = 0.037) higher level of education of mothers in the control group as compared to the MR group there was statistically no significant difference (P = 0.17) between the two groups with regard to their being over-protective. Similarly, the average number of years of maternal education was greater in the middle than in the lower socio-economic classes of the MR group (P< 0.001). However, with regard to over-protection, there was no statistically significant difference (P = 0.91) between mothers in the same two socio-economic classes. It should be mentioned that differences in period of study populations, sample sizes and methodologies adopted may have resulted in conflicting results concerning the attitudes of parents towards the mental retardation in their children. It should also be stated that in a Muslim community, such as ours, the stronger belief in God and adherence to Islamic teachings may explain such lower rates of self blame, feeling of inferiority and rejection as compared to rates from other communities. A majority of the parents of the MR group preferred to keep their children at home rather than have them kept permanently in institutions. However, the basis for the desire of more mothers in the low-socio-economic class as compared to those in the middle socio-economic class to keep their children permanently in institutions could be financial. This is supported by the fact that more fathers from low socio-economic class admitted

to being burdened financially by the birth of an affected child than their counterparts from the middle socio-economic class did. This is in contrast to Ayer's finding[19] where all the mothers of mentally handicapped children in his sample wanted to keep their handicapped children at home for as long as possible, so as to provide a normal home environment for them . However, there was no socio-economic stratification of Ayer's study sample.

In conclusion, it should be noted that the attitudes of parents towards their children's mental handicap is multifaceted. Wilkin who was quoted by Byrne and Cunningham[20] has shown that both the parents' attitudes towards mental retardation and their ability to cope are largely affected not by single factors, such as sex of the child, degree of handicap, age of the child, socio-economic condition of the family, age of the parents, etc., but rather by a combination of some or all these and other factors. These other factors include the availability of supportive resources from outside the family and social support from within the family of the affected child, and the attitudes of the family prior to the birth of the affected child. The management of mentally retarded children and their families should be a team effort. Community based outreach programs involving family physicians, community nurses, social workers, school teachers and psychologists should be encouraged. Other specialists such as pediatricians, psychiatrists, neurologists and genetic counselors should always have a place . There is a great need for more intersectorial coordination among the available agencies currently providing services to the mentally retarded children and their families.

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