

PSYCHOLOGICAL MORBIDITY OF PARENTS OF MENTALLY RETARDED CHILDREN

HEMANT CHANDORKAR & BRIG. P.K. CHAKRABORTY

ABSTRACT

The magnitude of the problem of mental retardation in our country hardly needs any exaggeration. The psychological burden that these parents carry has been varied. The present study was undertaken to delineate the psychological problems of parents of mentally retarded children and to establish whether these problems were more prevalent in the parents of mentally retarded children than in the parents of normal children. The material comprised of three groups of subjects: The first group comprised of parents of twenty students of a school for mentally handicapped children; the second group comprised of parents of ten mentally retarded children who were not institutionalised or attended any special school for mentally retarded in the past; the third group comprised of parents of twenty normal school going children. 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. The commonest psychiatric disorder was Dysthymia followed by Generalised Anxiety Disorder and Moderate Depression.

Key words: Psychological morbidity, mental retardation, general health questionnaire (GHQ)

The magnitude of the problem of mental retardation in our country hardly needs any exaggeration. There are an estimated 126.17 million mentally handicapped person in our country as per the 1991 census (Manorama, 1995). The psychological burden that these parents carry has also been described by various workers in the field of mental retardation (Noland, 1972). The guilt of having born such child, the social stigma that attaches themselves on the family, the shame of a retarded child misbehaving in public and the frustration and helplessness felt at not being able to "cure" the child, have all been described at length.

Few studies dealing with the psychological morbidity in parents of mentally handicapped have surfaced. Cummings (1976) has noted that compared with fathers of healthy children, those with a mentally retarded child expresses more depression, lower self esteem and sense of parental incompetence within. Wilkin (1979) on

the other hand has found no simple pattern of parental response to handicapped child.

Keeping this in mind the present study was undertaken to delineate the psychological problems of parents of mentally retarded children and to establish whether this psychological morbidity was more prevalent in the parents of mentally retarded than in parents of normal children.

MATERIAL AND METHOD

The material for this study was collected in the form of three groups of subjects.

Group A: This group comprised of the parents of twenty students of a school for mentally handicapped children. The following criteria were used:

- (a) the child was the only one handicapped in the family.
- (b) No other physical handicaps or major illness

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in the child for the past two years.

(c) Age of the child between 4-14 years.

(d) The child was attending the school for mentally handicapped for atleast one year continuously and regularly.

Group B : This group comprised of parents of 10 children who were brought to the same school for mentally retarded for admission and who satisfied the criteria (a),(b),(c) &(d). However these children were never institutionalised or attended any special school for the mentally retarded in the past.

Group C : This group comprised of parents of twenty normal school going children, between the age of 4-14 years. The following criteria were applied for selection into group.

There were no physically or mentally handicapped children in the family. Thus, a total of 100 (50 fathers and 50 mothers) individuals took part in this study.

Socio-demographic criteria in each group was met by using the "National Sociodemographic Data Performa", devised by the Indian Council of Medical Reserach Project(1980)" Standardised Analysis of Diagnostic and Socio-demographic data at the National level.

Each parent was interviewed and evaluated separately, parents were then administered General Health Questionnaire. Scoring was done on the "Screening mode" of the questionnaire in which a score of '0' was given for the first two categories of answers and a score of '1' for those whose answers were in the next two categories. Those parents who scored a total tally of 13 or more, were considered to have psychological morbidity and were given a complete psychiatric examination. An ICD-10 (1992) diagnosis was given to each case.

RESULTS

The distribution of the General Health Questionnaire (GHQ) scores in the three groups is described in Table-1.

Mother in group A and group B have more psychological morbidity as compared to fathers on GHQ score, whereas in group C there is

TABLE 1
DISTRIBUTION OF GHQ SCORES IN THE THESE GROUPS

GHQ Score	Group A (N=20)		Group B (N=10)		Group C (N=20)	
	F	M	F	M	F	M
Upto 12	19	16	8	4	19	19
13 or more	1	4	2	6	1	1

Group A : Father Vs Mother - $X^2=4.90$, $p<0.05$

Group B : Father Vs Mother - $X^2=8.15$, $p<.01$

Group C : Father Vs Mother - $X^2=0.00$, NS

Father of Gr. A Vs Father of Gr. C - $X^2=0.00$, NS

Mother of Gr. A Vs Mother of Gr. C - $X^2=4.90$, $p<0.05$

Father of Gr. A Vs Father of Gr. B - $X^2=4.68$, $p<0.05$

Mother of Gr. A Vs Mother of Gr. B - $X^2=8.53$, $p<0.01$

Father of Gr. B Vs Father of Gr. C - $X^2=4.68$, $p<0.05$

Mother of Gr. B Vs Mother of Gr. C - $X^2=10.35$, $p<0.01$

identical distribution of morbidity for mother and father. When, mothers and fathers of group A were compared with group C, it was observed that significantly more mothers were sick in group A then group C ($X^2=4.90$, $p<.05$). Identical distribution of morbidity in fathers was seen in group A and group C. When fathers and mothers of group B were compared with fathers and mothers of group A and group C, then the analysis revealed that mothers of group B were significantly having more morbidity than mothers of group A ($X^2=8.53$, $p<.01$) and mothers of group C ($X^2=10.35$, $p<0.01$). Similarly fathers of group B were having significantly more morbidity than fathers of group A ($X^2=4.68$, $p<.01$) and fathers of group C ($X^2=4.68$, $p<.05$).

Table 2 described the number of symptoms observed in parents (who had GHQ score of upto 12) which they had in the GHQ in the past 1-2 years and had subsided in the past 6 months. It was observed that more than half the parents had more than 4 symptoms two years ago. The two thirds of the parents (7 fathers and 5 mothers) could definitely and directly attribute the reduction in symptoms to progress made by their child in the school for the handicapped.

TABLE 2
NUMBER OF SYMPTOMS OF PARENTS IN GROUP A WITH GHQ SCORES OF 12 OR LESS

No. of symptoms	Group A	
	F	M
≥ 4 Symptoms	10	05
< 4 Symptoms	09	10

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TABLE 3
PSYCHIATRIC DIAGNOSIS IN STUDY GROUPS

Diagnostic category	Groups						Total
	A		B		C		
	F	M	F	M	F	M	
Moderate depression	0	1	0	1	0	1	3
Generalised anxiety disorder	0	2	1	1	1	0	5
Dysthymia	1	2	1	4	0	0	8
Hypochondriacal disorder	0	0	0	1	0	0	1
Total	1	5	2	7	1	1	17

Table 3 describes the distribution of psychiatric diagnosis in the study group. It was observed that the most common category was Dysthymia, being followed by Generalised Anxiety Disorder. Of the 3 cases of Moderate Depression, all were mothers. The one in group C had family history of the illness.

DISCUSSION

There is no literature to date about the prevalence of mental illness in parents of mentally retarded children for comparison with the results of this study. However, Roos (1963) while describing the parental reactions to retardation, elaborates that the parents may suffer from guilt, shame, loss of self esteem, depression in the form of grief reaction, as if the child is "chronically dead" and covert death wish.

There was a much higher prevalence of psychological morbidity in the mothers. This is correlated with the fact that more mothers than fathers were disturbed by the problems of rearing their handicapped child. This is because of the fact that mothers come in much closer contact with the child than the fathers. While comparing the parents of the special school students (Group A) with those of the control group C, it was noticed that the fathers in group A did not have any significantly higher psychological morbidity than their counterparts in the control group.

The mothers in group A had a significantly higher prevalence of psychological morbidity than those in group C. In addition a large proportion of

these had symptoms that subsided and more than half of them could directly attribute this reduction of symptoms to the progress made by their children at the school for the mentally handicapped (Table 2). In comparison with parents, whose children were attending the special school, both the fathers and mothers whose child never had specialised care (group B), had significantly higher psychological morbidity.

What emerges from all this, is that the fathers of mentally retarded children were affected psychologically by the problems they faced in rearing their handicapped children. Special help offered at this school for the mentally handicapped child, reduced the stress on the fathers to a more acceptable level, and the prevalence of psychological morbidity fell to a level not significantly higher than that seen in fathers of normal offspring.

The mothers of mentally retarded children are more affected than their spouses, by the problems of rearing the child. Those whose child had received no formal specialised help (group B) were very much more psychologically disturbed than those whose children were normal. Expert guidance of the child at school for the mentally handicapped ameliorated the problems faced by the mothers to an appreciable degree. The resultant reduction in psychological morbidity was however still not enough and were more than mothers of normal children.

When parents with GHQ scores of 13 or more underwent detailed psychiatric evaluation, it was revealed that 65% had depression (Table 3). Of the 11 depressed patients, 3 showed features diagnostic of moderate depression, 8 of the 11 patients with depressive symptoms, were diagnosed as dysthymia. 6 out of 8 were mothers.

These findings corroborate Olshansky's (1962) observations that parents of mentally handicapped children suffered from "chronic sorrow" throughout their lives. However, there was a lower prevalence of depression in parents of group A. Thus contradicting his statement. The other possible factors that reduced the prevalence of depression in these parents were the noticeable changes in the educational status,

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improved behaviour of the handicapped child with peer groups, the family and the neighbour through the facilities like ungraded classes, a sheltered workshop and a child guidance clinic.

In addition, the parents probably get some psychotherapeutic benefit from their frequent attendances at the child guidance clinic, Parent Teacher Association meetings and Parent's club discussion, all organised at the school. This is consistent with Olshansky's (1962) observation, that a non-psychiatric type of psychotherapy is very effective with such parents.

The next common illness encountered in these parents was Generalised Anxiety Disorder. 30% of the psychologically morbid parents had anxiety severe enough to warrant a clinical diagnosis of Generalised Anxiety Disorder.

Hypochondriacal disorder was manifested by mother of new applicant to the school.

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