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Psychosocial problems of mother bringing up their mentally retarded children

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Abstract

Raising a child who is mentally challenged requires emotional strength 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 caregivers is critical to maintaining balance in the home. One or both parents may feel as though they somehow caused the child to be disabled, whether from genetics, alcohol use, stress, or other logical or illogical reasons. This guilt can harm the parent's emotional health if it is not dealt with. Some parents struggle with "why" and experience a spiritual crisis or blame the other parent.

Keywords: Mental Retardation, Causes and Prevention of Mental Retardation.

Introduction

The World Health Organization defines it as a condition of arrested or incomplete development of the mind which is characterized by impairment in motor and social skills and language ability. The degree of impairment varies from one child to another and also depends on the degree of mental retardation. Many children with mental retardation might also have coexisting conditions like autism, Down's syndrome, cerebral palsy, Attention Deficit Hyperactivity Disorder (ADHD) and epilepsy (fits) which need further attention and care. The more severe the mental retardation, the more help the child needs to look after himself/herself. Usually, when a child is mentally retarded, the family's complete focus is on the child and how to help him/her to the best possible extent. However, as caregivers to this child, the family members (the parents, siblings, grandparents or other relatives) go through a significant amount of stress and anguish themselves in the process of raising such a child. Hrithik's parents are a typical example of such a family.

Definition

Mental retardation (MR) is a condition diagnosed before age 18, usually in infancy or prior to birth, that includes below-average general intellectual function, and a lack of the skills necessary for daily living. When onset occurs at age 18 or after, it is called dementia, which can coexist with an MR diagnosis. Intelligence level as determined by individual standard assessment is below 70, and the ability to adapt to the demands of normal life is impaired. This is important because it distinguishes a diagnosis of MR from individuals with low IQ scores who are able to adapt to the demands of everyday life. Education, job training, support from family, and individual characteristics such as motivation and personality can all contribute to the ability of individuals with MR to adapt. Other behavioral traits associated with MR (but not deemed criteria for an MR diagnosis) include aggression, dependency, impulsivity, passivity, self-injury, stubbornness, low self-esteem, and low frustration tolerance. Some may also exhibit mood disorders such as psychotic disorders and attention difficulties, though others are pleasant, otherwise healthy individuals. Sometimes physical traits, like shortness in stature and malformation of facial elements, can set individuals with MR apart, while others may have a normal appearance.

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Mental retardation is caused by many factors; many of these are known, but others remain unidentified (The Arc, 2005). The link between the identification of specific causes of mental retardation and the development and implementation of preventive measures is clear. When a cause is identified, ways to prevent the debilitating effects of cognitive disabilities have often followed soon after. But it takes action for solutions actually to prevent or reduce the impact of the condition.

Causes

According to The Arc, a parent organization advocating for individuals with mental retardation, several hundred causes of mental retardation have been discovered, but for about one-third of those affected the cause is unknown (The Arc, 2005). Of those known causes, three conditions are the most common reasons for mental retardation:

1. Down syndrome
2. Fragile X syndrome
3. Fetal alcohol syndrome

Many different systems for organizing the causes of mental retardation can be applied. Sometimes they are divided into four groups: socioeconomic and environmental factors, injuries, infections and toxins, and biological causes. AAMR divide them instead into three groups by time of onset—that is, by when the event or cause first occurred (AAMR, 2002):

1. Prenatal: causes that occur before birth
2. Perinatal: causes that occur during the birth process
3. Postnatal: causes that happen after birth or during childhood

Prenatal causes exert their effects before birth. Examples include genetic and heredity, toxins taken by the pregnant mother, disease, and neural tube defects. Genetics and heredity include conditions such as fragile X syndrome and Down syndrome, as well as phenylketonuria (PKU). Prenatal toxins include alcohol, tobacco, and drug exposure resulting from the behavior of the mother during pregnancy. Diseases and infection, such as HIV/AIDS, can devastate an unborn baby. Neural tube disorders, such as anencephaly (where most of the child's brain is missing at birth) and spinal bifida (incomplete closure of the spinal column), are also prenatal causes of mental retardation.

Perinatal causes occur during the birthing process. They include birth injuries due to oxygen deprivation (anoxia or asphyxia), umbilical cord accidents, obstetrical trauma, and head trauma. They also include low birth weight.

Postnatal causes occur after birth. The environment is a major factor in many of these situations. Child abuse and neglect, environmental toxins, and accidents are examples of postnatal causes. An additional reason for being identified as having mental retardation is societal biases, particularly toward diverse students.

Genetic Causes

Today, more than 500 genetic causes associated with mental retardation, many of them rare biological conditions, have been identified (The Arc, 2001). For example, fragile X syndrome is an inherited disability caused by a mutation on the X chromosome, and it was identified in 1991. It is now recognized as the most commonly known inherited cause of mental retardation, affecting about 1 in 4,000 males and 1 in 8,000 females (Crawford, Acuna, & Sherman, 2001). A

common associated condition is recurrent otitis media (middle ear infection) with resulting hearing and language problems. Cognitive disabilities can be severe. Many of these individuals are challenged by limited attention span, hyperactivity, stereotypic behaviors (such as hand flapping or hand biting), and an inability to relate to others in typical ways.

Another example of a genetic cause for mental retardation due to a chromosomal abnormality is Down syndrome (a chromosomal disorder wherein the individual has too few or too many chromosomes). The nucleus of each human cell normally contains 23 pairs of chromosomes (a total of 46). In the most common type of Down syndrome, trisomy 21, the 21st set of chromosomes contains three chromosomes rather than the normal pair. Certain identifiable physical characteristics, such as an extra flap of skin over the innermost corner of the eye (an epicanthic fold), are usually present in cases of Down syndrome. The degree of mental retardation varies, depending in part on how soon the disability is identified, the adequacy of the supporting medical care, and the timing of the early intervention. ~e great majority of people with Down syndrome have a high incidence of medical problems (National Down Syndrome Society [NDSS], 2005).

Toxins

Poisons that lurk in the environment, toxins, are both prenatal and postnatal causes of mental retardation, as well as of other disabilities. Many believe that the increased rates of attention deficit hyperactivity disorder, learning disabilities, and even autism are due to some interplay of genetics, environmental factors, and social factors (Office of Special Education Programs, 2000; Schettler *et al.*, 2000). Clearly, exposures to toxins harm children and are a real source of disabilities. Here are two reasons why toxins deserve special attention:

1. Toxic exposures are preventable.
2. Toxins abound in our environment.

One well-recognized cause of birth defects is fetal alcohol syndrome (FAS), which is strongly linked to mental retardation and results from the mother's drinking alcohol during pregnancy. FAS are recognized by Congress as the most common known cause of mental retardation. It costs the U.S. taxpayers 5.4 billion dollars in 2003 alone, and the costs in quality of life to the individuals affected and their families are immeasurable (U.S. Senate Appropriations Committee, 2004). The average IQ of people with FAS is 79, very close to the cutoff score for mental retardation (Bauer, 1999). This means that almost half of those with FAS qualify for special education because of cognitive disabilities. This group's average adaptive behavior score is 61, indicating a strong need for supports. These data explain why some 58 percent of individuals with FAS have mental retardation and why some 94 percent require supplemental assistance at school. Unfortunately, most of these people are not free of other problems in the areas of attention, verbal learning, and self-control. Estimates are that some 5,000 babies with FAS are born each year. An additional 50,000 show fewer symptoms and have what is considered the less serious condition fetal alcohol effects (FAE), which, like FAS, is caused by mothers drinking alcohol during pregnancy.

Toxins around in our environment. All kinds of hazardous wastes are hidden in neighborhoods and communities. One

toxin that causes mental retardation is lead. Two major sources of lead poisoning can be pinpointed. One is exhaust fumes from leaded gasoline, which is no longer sold in the United States. The other source is lead-based paint, which is no longer manufactured. Unfortunately, however, it remains on the walls of older apartments and houses. Children can get lead poisoning from a paint source by breathing lead directly from the air or by eating paint chips.

Low Birth Weight

Low birth weight is a major risk factor for disabilities and is definitely associated, with poverty and with little or no access to prenatal care (Children's Defense Fund. [CDF], 2004). Medical advances of the 1980s have greatly increased the likelihood that infants born weighing less than 2 pounds will survive. These premature, very small infants make up less than 1.4 percent of all newborns and are at great risk for disabilities, including mental retardation (Allen, 2002). However, babies born between 3 and 5 pounds also are at greater risk for disabilities than many doctors and parents believe. Babies with moderately low birth weight represent 5 to 7 percent of all births, but they represent 18 to 37 percent of children with cerebral palsy and 7 to 12 percent of children with cerebral palsy who also have mental retardation. Whereas about 5 percent of White babies have moderately low birth weight, between 10 and 12 percent of African American babies are born early and have low birth weight.

Child Abuse and Neglect

Abused children have lower IQs and reduced response rates to cognitive stimuli (CDF, 2001, 2004). In one of the few studies of its kind, Canadian researchers compared abused children with those not abused, and the results of abuse became clear (Youth Record, 1995). The verbal IQ scores were very different between the two groups of otherwise matched peers: The abused children had an average total IQ score of 88, whereas the average overall IQ of their non-abused peers was 101; and the more abuse, the lower the IQ score. The link between child abuse and impaired intellectual functioning is now definite, but the reasons for the damage are not known. Rather than resulting from brain damage, the disruption in language development caused by the abusive situation may be the source of permanent and profound effects on language ability and cognition. Or the abuse may itself be a result of the frustration often associated with raising children with disabilities. Remember, the connection between neglect and mental retardation has long been recognized and is part of the early history and documentation of this field.

Discrimination and Bias

It is important to remember that many subjective reasons account for students' placement in special education. There is little doubt that poverty and its risk factors are clearly linked to disabilities (CDF, 2004; National Research Council, 2002). It is also true that culturally and linguistically diverse children are overrepresented in some categories of special education (Hosp & Reschly, 2002, 2003; U.S. Department of Education, 2005a). This situation is particularly true for Black students, who are almost three times more likely to be identified as having mental retardation than their White peers (National Alliance of Black School Educators & ILIAD Project, 2002). Specifically, a definite relationship exists between poverty

and three other factors: ethnicity, gender, and mental retardation (Oswald *et al.*, 2001). However, this relationship may be somewhat different from what one might initially suspect: The risk factors of poverty (limited access to health care, poor living conditions) do not entirely explain this disproportionate representation.

Prevention of Mental Retardation For Pregnant Women

- Obtain early prenatal medical care.
- Obtain early prenatal medical care.
- Maintain good health.
- Avoid alcohol, drugs, and tobacco.
- Obtain good nutrition.
- Prevent premature births.
- Take precautions against injuries and accidents.
- Avoid sexually transmitted diseases.

For Children

- Guarantee universal infant screening.
- Ensure proper nutrition.
- Use automobile seatbelts, safety seats, and cycle helmets.
- Place household chemicals out of reach.
- Provide immunizations.
- Prevent or treat infections.
- Have quick and easy access to health care.
- Guarantee proper medical care for all children.

For Society

- Eliminate the risks of child poverty.
- Make early intervention programs universally available.
- Provide parent education and support.
- Protect children from abuse and neglect.
- Remove environmental toxins.
- Provide family planning services.
- Provide public education about prevention techniques.
- Vaccinate all children.

(Excerpt from Introduction to Special Education: Making a Difference, by D.D. Smith, 2007) edition, p. 286-292.

Challenges the Families Face

1. Acceptance: When a doctor gives the parents the news that their child is mentally retarded and will never be completely normal, it is too painful for most parents to face. Many parents, like in Hrithik's case, spend years in denial, trying to find some solution or cure to this problem. They might go from one hospital to another, try alternative forms of medicine or look to religion for a miracle. But mental retardation is not a disease and there are no medicines to cure it. It is a syndrome which is caused by genetic factors (chromosomal abnormalities like in Down's Syndrome), hereditary causes (due to marriage between close relatives, previous incidences of mental retardation in the family) or due to brain damage of some sort. As hard as it is to accept, once parents realize that their child is mentally retarded and will always remain so, their expectations of the child will readjust accordingly. They can move on to taking the necessary steps to help the child make the most of his potential by going addressing his special needs through special education, vocational training etc.

2. Self-blame: The parents wonder if they did something wrong, during the course of the pregnancy or after birth, while taking care of the child. They wonder if God is punishing them for their sins.

3. Stigma: Many parents might feel that a mentally retarded child is something to be ashamed of and cannot be allowed out of the house. Neighbors, relatives or others might make cruel remarks about the child and parents might feel isolated and without support.

4. Helplessness: Many parents don't know how to get help for their child once he/she has been diagnosed with mental retardation. The sense of helplessness comes both from a lack of understanding about mental retardation and a lack of information about the resources available for mentally retarded individuals. It might also arise from insensitive handling of the case by the mental health professional, who might not have enough time to talk to each family at length about their experience.

5. Behavior problems: Many parents find it difficult to handle behavior problems like screaming, crying, inability to concentrate, aggressiveness, stubbornness etc that a child with mental retardation might have. For parents, especially mothers, who have to take care of household tasks and work apart from taking care of the child, patience can wear thin. Getting angry with the child or hitting him/her also does not help very much. Often, the child might not understand how disruptive his/her behavior is to others and why they get angry.

6. Unrealistic expectations: Many times, parents of mentally retarded children are dissatisfied with the slow progress their child is making in learning new things. They push harder to force the child to learn quicker and try to be on par with other children. However, the child can only learn to the best of his/her ability and no more. If he/she has the mental age of a 8 yr old, he/she cannot be expected to undertake a normal vocation which requires complicated mental processes. When parents have unrealistic expectations of what their child can achieve, it leads to disappointment not only for them but also in the child who does not understand what he/she is doing wrong.

7. Worry about the future: One of the main concerns of parents with mentally retarded children is about how their children will be taken care of when they die. They feel that no one else can take care of their child with same love and care that they have and they are scared about how their child will manage to survive in the world.

8. Marital/family problems: Having a child who is mentally retarded places greater strain on a family than otherwise. Due to the extra tasks that have to be done to take care of the child, parents feel overworked, stressed out and unhappy. The marital relationship can become strained if the parents have different approaches in dealing with the child or if one parent has to take care of the child all the time. Sometimes, mothers might feel they are not getting enough support from their husband in taking care of the child. Fathers might feel that the mothers are unnecessarily worried and overprotective of the child. Other family members can complicate matters depending on how they react to the child.

All these reactions that a family experiences are completely normal. It takes time, support and accurate information to understand and accept what their child is. Even after coming to terms with the fact that mental retardation is incurable, it is very difficult to give up hope that someday something will make their child normal. This hope is what might keep

most parents going. As long as this hope does not lead to demanding too much of the child, it is perfectly ok. There are professionals like psychiatrists, clinical psychologists, occupational therapists and counselors who can help you if you are going through a similar experience. For more information on special education schools and vocational training centre, you can contact the National Institute of Mental Handicap, Secunderabad or visit their website. For further information or counseling for the families of mentally retarded individuals, contact us at talkitover.

Kinds of Support for Caregivers

Respite Care

Respite care gives caregivers a break from their caring responsibilities. It helps relieve stress and maintain their own health. Sometimes, friends and family members may be able to help caregivers, but help is also available from outside organizations. Home care businesses can provide paid care providers to assist the caregiver or allow them to take a break, although these are not free. Charities and community organizations can sometimes provide volunteer helpers for caregivers. Outside the home, day centers and residential care can both help support caregivers. Insurance, charity grants and state aid can all help with the cost of this kind of care.

Financial Support

Being a caregiver can be financially draining. A full-time caregiver cannot work outside the home, and may well have to bear costs associated with caregiving. In particular, caregivers may be faced with significant medical costs for those they care for. The National Families Caregiver Support Program provides financial support for those caring for relatives aged 60 or older, and for grandparents caring for grandchildren with physical or mental disabilities. Grandparents caring for grandchildren can also receive support through the Temporary Assistance for Needy Families program. Other financial support is available through charities and local programs.

Emotional Support

Caregivers benefit from receiving emotional, social and psychological support. Without such support, many caregivers begin to feel isolated and unhappy. Support can come from a number of different sources. Family members and friends can be a useful source of support, although it is not available to everyone. Online support groups and discussion boards provide an easy-to-access and informal support network. Support groups can provide regular, local human contact. Often, they are aimed at particular medical conditions, meaning they can provide specialized support. For caregivers who find themselves emotionally overwhelmed by their responsibilities, support from professional mental health services may be beneficial.

Medical Support

Caregivers often have little medical knowledge themselves, and rely on support from medical professionals to carry out their role. If medical insurance does not cover the costs to the caregiver of accessing medical support, then support may be available through Medicare. Once funding has been found for medical support, it is important that caregivers engage with medical professionals to access as much support as they can. They should communicate with them and take an active role to gain knowledge and care giving advice.

Support & Help for Families with Intellectually Disabled Children

E. Zupanick, Psy. D. Raising a child with an intellectual disability can be a daunting and exhausting task. There are many appointments to keep. Finding and funding the needed support services can easily overwhelm families. Family members must cope with the daily stress of seeing their child struggle. Furthermore, family members must cope with all this, knowing these difficulties will last a lifetime. Finally, family members experience a range of troubling emotions. It is natural to feel grief, resentment, disappointment, and frustration. Sometimes these feelings can lead to feelings of guilt, hopelessness, and depression. It should come as no surprise that these families need their own supportive services.

1. Community supports: Within each person's community, there are a variety of programs and services. Many of these services are designed to assist people with disabilities. Some of these services are specifically intended for families and other caregivers. The particular array of services available in any given community varies widely. Support coordination specialists (case managers) ensure service recipients receive the proper mix of services. Contact your local county services office to locate these services.

2. Respite and emergency care services: Respite services are available in many communities. These services are available to caregivers of intellectually disabled citizens. Respite services give families a chance to take a break from their daily care responsibilities. It is very helpful and refreshing for family members to take some time off. Most respite programs are provided through national organizations. The most well known are The Arc and the Easter Seal Society. Services may also be available through schools, churches, and other non-profit groups. Families are usually allotted up to four weeks of free respite services each year.

3. Family Therapy and Support Groups: Parents of children with intellectual disabilities face many losses. The loss of their dreams, hopes, and aspirations for their child can cause great sorrow. Moreover, there remains a profound social stigma attached to intellectual disabilities. It can be an ongoing and difficult adjustment for families. They must learn to cope with a wide range of difficult emotions. Feelings of guilt, frustration, disappointment, uncertainty, worry, sadness, and grief are very common.

4. Advocacy and legal supports

Another powerful coping strategy is advocacy. Advocacy refers to actions that are taken on behalf of someone else to promote their welfare and rights. Thus, an advocate is someone who argues or pleads for another person's cause. Advocates serve as a voice for people with intellectual disabilities who cannot easily advocate for themselves. Family members can affect the quality of care a disabled person gets. They should participate in decisions about services and not be afraid to speak up if something doesn't sound right. The more families become actively involved, the less helpless they feel. When parents become involved in their children's care, their children are less likely to require institutionalization. They are also more likely to enjoy a higher quality of life.

5. Support for siblings of intellectually disabled: Siblings of children with intellectual disabilities need their own support. In recognition of these needs, The Arc has created the Sibling Support Project. It provides age-specific support and intellectual disability education. The Sibling Support Project trains local agencies to create projects that join sibling peers.

Statement of the Problem

Every mother dreams of having a child who's physical and mental characteristics are excellence. This may not be the case with children endowed with mental capacities much below of what is required of their age. Understanding the emotional upheavals that these mothers go through is not easy. They undergo a lot of stress and anxiety to care of their child in day today life. They also discriminated by the society, neighbors and relatives. Hence the researcher selected this topics to study the various problems faced by the parents of mentally retarded children.

Objectives

- I. To study the socio-economic back ground of the respondents.
- II. To study the coping pattern of mothers with regard to the upbringing of mentally retarded children
- III. To study the problems and difficulties of mothers in nurturing their mentally retarded children.
- IV. To study the anxiety level of parents over their children's future.
- V. To study the special education system for children with mental disability.

Universe

The Universe of the study was Santhosh Special School at Trichy -2

Census Method

There are 47 special children were enrolled boys (30) and girls (17).So, the researcher selected only 30 boys by using census method.

Age of the Respondent

S. No	Age	Respondents	Percentage
1	21-30	2	6.67
2	31-40	16	53.33
3	41-50	10	33.33
4	51-60	2	6.67
	Total	30	100

The table shows that the more than half of respondents (53.33%) belong to 31-40 age, 33.33% of respondents belongs to 41-50 age and the same of the percentage (6.67%) of the respondents belongs to 51-60 and 20-30 ages respectively.

Occupation of the Respondent

S. No	Particular	Respondents	Percentage
1	Government	6	20
2	Private	14	46.67
3	Business	3	10
4	Other	7	23.33
	Total	30	100

The above table shows that 46.67% of the respondents are private employees and 23.33% of the respondents belong to other occupation, 20% of the respondents are government employees and remaining 10% of the respondents are doing business

Monthly Income of the Respondent

S. No	Particular	Respondents	Percentage
1	5000	17	56.67
2	10000	9	30
3	15000	3	10
4	20000	1	3.33
Total		30	100

From the above table it is inferred that 56.67% of the respondents are getting monthly income up to 5000, 30% of the respondents are getting monthly income up to 10000, 10% the respondents are getting monthly income up to 15000 and 3.33% of the respondents are getting monthly income up to 20000.

Respondents of First Checking Of Child to Doctor after Suspicion

S. No	Particular	Respondent	Percentage
1	within 3-6 months	21	70
2	after one year	8	26.67
3	not any of the above	1	3.33
TOTAL		30	100

The above table shows that the respondent takes their child for first visit to doctor after suspecting MR features among their child. 70% of respondents took within 3-6 months, 26.67 respondents took after one year and 3.33% respondents reply not any of the above.

Diagnosis of the Doctor

S. No	Particulars	Respondents	Percentage
1	Medication will be helpful	5	17%
2	Nothing can be done	16	53%
3	Medication can be supportive from no worsening the situation	9	30%
Total		30	100%

From the table shows half of the (53%) of respondents said that they did not consulted the doctor to diagnose the problems of the child, 30% of respondents said that they consult the doctor to diagnose the problem of child,

Neighbour’s Reaction toward Respondent’s Child

S. No	Particulars	Respondents	Percentage
1	Very much encouraging	8	26.67
2	Does not respond as well as when you would have been along	7	23.33
3	Stop their activities and pay attention to child’s need	15	50
Total		30	100

The above table show that the 50% of respondents are says that their neighbors are stopped their activities and more concentrate on child’s need. Were 26.67% of respondents are very much encouraged on child growth and remaining 23.33% of respondents are does not responds as well as when the respondents would have been along.

Child’s Condition Affected Mother ‘S Way of Living

S. No	Particular	Respondents	Percentage
1	Unable to take up employment	1	3.33
2	Unable to socialize	6	20
3	Unable to pursue studies	3	10
4	Increased your faith in god	13	43.33
5	Developed a more realistic attitude towards life	7	23.33
Total		30	100

The above table shows the impact of the child condition on the respondent personal life, majority of the respondents (43.33%) accepted the fact that their child’s condition is a hurdle to take up employment. and respondents (20%) of children unable to socializing. (23.33%) of the respondents developed a more realistic attitude towards life (10%) percent of the respondents

Mother ‘S Attitude towards Mr Children

S. No	Particulars	Respondents	Percentage
1	It is painful	6	20
2	Causes embarrassment	3	10
3	Upsets family life	15	50
4	Increased dependency of the child	6	20
		30	100

The above table shows us the attitude of the respondents towards mentally retarded children. A little more than respondents (50%) upsets family life. and same respondents pitiful & increased dependency of the child (20%) and the (10%) respondents embarrassment to the family.

Findings, Suggestion, Conclusion

Majority of the respondents (53.33) come from the age group 31-40
 Majority of the respondents (50%) have done their secondary while only some
 Most of the respondent 56.67% Of the occupation
 Majority of the respondents (43.3%) have income
 Majority of the respondents (43.3%) have family size.
 Majority of the respondents 86.67% Of consanguineous marriage
 Majority of the respondents (73.33%) did not have an history of mental retardation in their family.
 Majority of the respondents (50%) identified the onset only after three months after birth.
 Majority of the respondents (70%) visited the doctor within three to six months of of the respondents (53.33%) nothing can be medication
 Majority of the 66.67% undergo medication.
 Majority of the respondents (56.67%). allopathic
 Majority of the respondents (56.67%) any other
 Majority of the respondents (83.33% of special education system of child,

Majority of the respondents (56.67% of three year and above special education school
Majority of the respondents 43.33% vehicle used to take child to special education identification.
Majority school Benefit of the going to special education school 93.33% of the respondents
36.67% of the feeling of parent when child got insults or ridicules by some one
Majority of respondents (86.67%) scaring of the child future
Majority of the respondents 76.67% of the cannot marry
Majority of the respondents 63.33% of the education
Majority of the respondent's 96.67% taking MR Child to out other then school
Less than Half of the respondents 43.33% place were MR Child taken out
Majority of the respondents 66.67% no different
The child received a lot of sympathy and special liking from outsiders when taken out (36.67%) respondents
Majority of the respondents 50% of very much encouraging
Majority of the respondents 33.33% they ignore and play with other children-insults your child by pushing
Majority of the respondents of 50% the spend for child 3-4 hours
Majority of the respondents 60% spending time with the child
Majority of the respondents 53.33% support from the husband
Majority of the respondent's problem facing social environment supportive for relatives
Majority of the respondents 40% all other activity
Majority of the respondents 36.67% relationship maintain the parent-child
Majority of the respondents 43.33% increased your faith in god
Majority of the respondents 50% towards mentally retarded child upsets family life

Suggestions

1. Parents should participate in the educational program planning process, and take part in developing children's individualized educational plans
2. Support groups can be formed by parents of mentally retarded children and suggest to implement special plans and schemes for them through the group.
3. Parents can be trained in behavior modification techniques, as most parents face the problem of day to day home management.
4. The mothers of mentally retarded children should be given training in self care skills, language stimulation and training in cognitive skills so that they can teach the child at home.
5. The mothers could be given an orientation on pre natal care.
6. The parents should take their child out as often as they can and socialize them to the outside environment for improving social skills.

Conclusion

The present day mothers of abnormal children seems to cope up with the stress of Bringing up a mentally retarded child with greater confidence and courage, unlike the mothers of olden days by using professional help in the area of counseling and special education. The factor that contributes to parental acceptance of a retarded child is the

parent's knowledge of mental retardation. For this reason many parent organizations are formed whose important function is the dissemination of information, regarding the management of their child. The researcher while undergoing data collection found that the mothers of retarded children undergo many problems and the significant being the economic Condition. Most of the respondents also receive no support from their husband and even if received it is very passive

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