

A Study of Depression And Anxiety Among Parents of Normal Children and M. R. Children

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ABSTRACT

The present study was conducted to find out the anxiety and depression level of parents (Father) who have M.R Child. For this, 60 samples were selected as incidental technique method of data collection from Hazaribag and Ranchi district of Jharkhand. PDS, Sinha comprehensive anxiety test and Beck depression inventory were administered on the selected samples. Then data wren collected, tabulated and analysed with the help of N, M, SD and t-ration. For this finding it was discovered that there are no impact on depression and there are significant impact on anxiety level.

Keywords: *Anxiety, Depression, Mental Retardation.*

Introduction

Depression is a state of low mood and aversion to activity. It can affect a person's thoughts, behavior, motivation, feelings and sense of well-being. It may feature sadness, difficulty in thinking and concentration and a significant increase in appetite and time spent sleeping, and people experiencing depression may have feelings of dejection, hopelessness and sometimes, suicidal thoughts. It can either be short term or long term (Zwart, et al. (2018)). Depression is the largest burden of non-fatal disease in the world. Due to its high prevalence, high level of associated disability and young age of onset. It may be a recurrent disorder. Most people who provide to health care service with depression present in general practice. Other community providers, such as counselling services, employment assistance service and spiritual support services may also have a critical role in the identification and management

of depression. Depression affects about 6% of the general population.

Anxiety

Anxiety is an emotion characterized by an unpleasant state of inner turmoil, often accompanied by nervous behaviour such as pacing back and forth, somatic complaints, and rumination (Seligman ME, Walker EF, Rosenhan). High parental anxiety correlates with children's emotional distress in the hospital, especially during invasive procedures.

Mental Retarded (MR)

Intellectual disability (ID), also known as general learning disability (Colin 2013) and mental retardation (Clare (2010), Daily, Ardinger Holmes (2010) is a generalized neurodevelopment disorder characterized by significantly impaired intellectual and adaptive functioning. It is defined by an IQ under 70, in addition to deficits in two or more

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adaptive behaviours that affect every day, general living.

Once focused almost entirely on cognition, the definition now includes both a component relating to mental functioning and one relating to an individual's functional skills in their daily environment. As a result of this focus on the person's abilities in practice, a person with an unusually low IQ may still not be considered to have intellectual disability. Intellectual disability is subdivided into syndromic intellectual disability, in which intellectual deficits associated with other medical and behavioral signs and symptoms are present, and non-syndromic intellectual disability, in which intellectual deficits appear without other abnormalities. Down syndrome and fragile X-syndrome are examples of syndromic intellectual disabilities. Intellectual disability affects about 2–3% of the general population. Seventy-five to ninety percent of the affected people have mild intellectual disability. Non-syndromic, or idiopathic cases account for 30–50% of these cases. About a quarter of cases are caused by a genetic disorder, (Daily, Ardinger, Holmes 2010) and about 5% of cases are inherited from a person's parents. Cases of unknown cause affect about 95 million people as of 2013^[update]. (Global Burden of Disease Study 2013). Mental retardation is a life-long condition. It cannot be cured. But persons with mental retardation possess the ability to be trained to become independent with systematic and planned support. Mental retardation is not a mental illness. Mental illness can be cured. Person with mental illness have normal development but suffer from psychological disturbance which needs systemic treatment, sometimes even medication. Whereas mental retardation is a conditional when child's mental development is not matching with his physical development.

There are many superstitions about Mental retardation. These beliefs are not based on facts include :

- a. Mental retardation is due to "Karma" or fate.
- b. Mental retardation is caused by solar eclipse.
- c. Some believe that a person with Mental retardation is an "Avtaar".

Major feature of Mental retardation is characterized by delay in overall development. So they need systematic training for learning activities of daily living and other essential adaptive skills. For this they need specific support to be trained at different levels corresponding to their degrees of mental retardation. It affects the overall development of the child. Such as delay in acquiring language, social and self care skills, ability to understand and comprehend are less or delayed; reopens are slow and may have associated problems in hearing or vision. Some of them have reported history or seizures of fits that require continuous of long-term best form of management. For these, children are systematic and regular monitoring of training support for becoming self-reliant toward appropriate rehabilitation.

Review of literature

Parents of these children often report lack of parenting efficacy Kersh, (2006), poor mental health (Herring et al., 2006) and problems in marital adjustment (Simmernan et al., 2001). Several researchers have found that the 'mental health' of the parents influences the quality of care children with impairments receive and affect the family environment of these children (Midence and Neill, 1996). Preoccupation with guilt, blame or reduced self-esteem may divert parental attention from salient aspects of child rearing such as nutrition, recreation, education and household organization. Financial strain of providing

medical and quality care to these children may add to parental stress. Various other stressors may include lack of control on the situations arising out of presence of such a child at home such as hurt egos, negative attitudes, isolation, anger, embarrassment, grief, and safety of these children (Haven, 2005). Presence of a child with impairment may also cause rift in the marital relationship. Difficulty in finding appropriate and affordable child care may affect the mother's decision about working outside home. It may influence her decisions related to her own as well as education /training of her other children. Even decision related to having additional children may be affected by the presence of an impaired child at home. Several studies have shown that there is a high level of marital discord, divorce or separation in families having children with impairments (Hodapp, and Harris 1995). Taanila, Syrjala, Kokkonen, & Jarvelin, (Taanila et al., 2002) have reported stress in families of children with impairment as a major cause of divorce.

Research by Dahlquist, Power, Cox, & Fernbach (1994) found that, compared to parents with lower anxiety, highly anxious parents of young children were less reassuring to their children prior to a medical procedure and were more agitated and less responsive to their children during the procedure. This likely communicated anxiety to the child and caused distress. They found that parental anxiety caused observed distress in older children as well. Wells & Schwebel (1987) found that, compared with high-stress mothers, moderately stressed mothers were more cooperative during an initial child medical exam, and their children recovered more rapidly. Prenatal anxiety has also been shown to influence children's post-hospital behaviour and recovery. Melnyk and Feinstein (2001) found that mothers who were more anxious during their child's hospitalization reported that their child had

more negative post-hospital behavior changes. Small and Melnyk (2006) built on this research and found that maternal anxiety was the single most significant predictor of children's negative behavioral changes, like aggression and hyperactivity, three and six months following hospitalization. In a study of children undergoing routine tonsillectomies, Skipper and Leonard (1968) found that mothers who experienced high stress while their children were hospitalized reported that following hospitalization, their children had disturbed sleep, excessive crying, greater difficulty eating, drinking, and relating to others, and regression in behaviour, like bedwetting and thumb sucking.

More research still needs to be done on the complex relationship between parental anxiety and child anxiety in the hospital setting. Additionally, the effects of paternal anxiety and sibling anxiety on a hospitalized child need to be further explored. While there are gaps in the research, parents should take away from the current body of knowledge that it is important to remain calm around their child, model appropriate coping behaviour, and practice self-care in order to manage anxiety and stress. There is trained hospital staff, like child life specialists, who can help parents understand procedures and learn coping skills. The studies by Melnyk and Feinstein (2001) and Dahlquist et al. (1994) suggest that teaching parents how to coach their children through medical procedures and about what behaviour changes to expect in their children, respectively, results in reduced parental anxiety. If a parent is feeling anxious about their child's upcoming hospital visit or during their child's hospitalization, they should not hesitate to practice self care and/or reach out to hospital staff for help it could make all the difference for their child.

Everyone has feeling of anxiety of same point in their lives whether it is preparing for a job interview or bringing up a child and other

through too. It is normal to experiencing anxiety in everyday situations. However persistent and excessive anxiety can cause more serious mental health problems. Anxiety is one of the most common mental health problems in every country in the world.

Most of people get through passing moments of anxiety with no lasting effect. But chronic anxiety can affect concentration; have a damaging effect on relationships and other effect too.

Impairment of children has been shown to lead to parental sense of devaluation and self-blame, impaired physical functioning, tiredness or exhaustion (Hedov, 2000), (Emerson, and Hatton 2003). Nearly two-thirds of the couples having a child with impairment have been found to be clinically depressed (Bitsika and Sharpley 2004). Studies endorse the fact that providing a high level of care to children with impairments affects the psychological health of the parents. The unpredictable nature and course of development of children with impairment has been shown to cause tremendous anxiety in parents. Thus, Parental mental health problems such as depression and anxiety limit the role of parents in the management of the child's impairment (Bartlett et al. 2004). Child maladaptive behaviour has been associated with increased burden and stress on the parents. Several researchers have reported a relationship between low adaptive functioning in children with impairment and elevated parental anxiety, (Saloviita, Itaalinna and Leinonen, 2003, Hall and Graff 2011). Some researchers report that half of the parents of children with impairments show severe anxiety (Gray, 2002). Spielberger et al., (1997) opines that parents of children with impairment generally show proneness to be nervous, worried and be highly reactive to perceived stress. Reactions to the perception of the situation form the extent of anxiety experienced

by the parents. If parents perceive a situation there are significant limitations to the current evidence available about depression. The concept of depression itself is problematic. It is a very broad and heterogeneous category, which may in some cases limit validity for effective treatment planning in primary care.

Aims

The present research was done with following aims :

1. To measure the anxiety and depression of parents having mental retarded child.
2. To measure the anxiety and depression of parents having Normal Child.

Hypothesis

H₁ Parent having mental retarded child will have higher than normal anxiety child's parent.

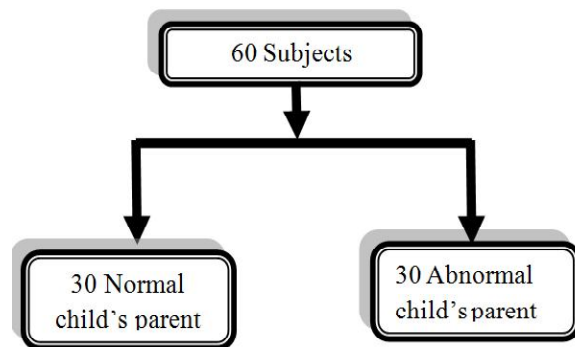
H₂ Parent having mental retarded child, will have higher depression than normal Child's parent.

Methodology

4.1 : Sample : 60 samples (normal and M.R. child's parent) were selected as sample.

4.2 : Method of Sample selection : Incidental sampling technique was used.

4.3 : Sample Distribution : 60 Subjects



4.4 : Sample Area : 30 Normal and 30 Abnormal child's Parent subjects were selected form Hazaribag and Ranchi district of Jharkhand.

4.5 Tools used: The following tools have been used in the present research :

(a) Personal Data Sheet (PDS) : It has been formulated by researcher itself for collecting some socio-demographic variable of the parents. Such as age, education, religion, place of residence, occupation, family type, family member and family income.

(b) Sinha Comprehensive Anxiety Test : This test was constructed by A.K.P. Sinha and L.N.K. Sinha. It consists of 90 items.

(c) Beck Depression Inventory : The beck depression inventory created by Aaron T.

Beck, it has 21 question, multiple choice, self report inventory.

Test Administration

The study was completed in one session. Personal Data Sheet, anxiety test and depression inventory were administrated on the subjects.

Statistical Analysis

After procurement of data, data were, scored, tabulated and analysed the help of N,M,SD and t-ratio.

Table No I :
Comparison between normal child's parents and M.R. child's parent in the term of depression

Variable	Normal child's parent (father)			Abnormal child's parent (father)			t	P
	N	M	SD	N	M	SD		
Anxiety	30	22.05	5.43	30	25.06	6.07	1.58	NS*

NS* (Not significant at any level)

According to table no 2 the N,M and SD of normal child's parents subjects on depression are 30, 22.05 and 5.43 respectively, while the N,M and SD of MR child's parents subjects on depression are 30, 25.06 and 6.07 respectively. The t-ratio between these two groups is 1.58, which is not significant at any

level. So, the hypotheses made in this regard is rejected. Therefore, it can be said that there are no difference between normal child's parents and M.R child's parent on depression. It means MR child parents and normal child's parent are no differ.

Table No II :
Comparison between normal child's parents and M. R. child's parent in the term of Anxiety

Variable	Normal child's parent (father)			Abnormal child's parent (father)			t	P
	N	M	SD	N	M	SD		
Depression	30	38.34	5.90	30	50.51	8.72	2.86	<0.01

According to table no. 3 the N,M and SD of normal child's parents subjects on are

30, 38.34 and 5.90 respectively, while the N,M and SD of MR child's parents subjects on are

30, 50.51 and 8.72 respectively. The t-ratio between these two groups is 2.86, which is significant on level. So, the hypothesis made in this regard is accepted. There for it can be said that there are significant difference between both groups. It means parents of M.R child have more depression than parents of normal children.

Findings

1. There is no significant difference between parents of normal child and M.R child on depression.
2. There are significant difference between parents of normal child and M.R child on anxiety. It means M.R child's parents have more anxiety than normal parent.

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