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Influence of Coping Strategies on Depression among Parents Living With Mentally Retarded Children (Down Syndrome)

Mgbenkemdi E.H[1], Omeje Obiageli [2] & Eze S. G. N [3]
Department of psychology [(1&2)] Enugu state university of science and Technology (ESUT)
Department of Health and Physical Education [(3)] Enugu state university of science and Technology (ESUT)

Abstract: *This study investigated the influence of coping strategies, on depression among parents living with mentally retarded children. One hundred and eight (108) comprising 61 parents of mentally retarded children (Down syndrome) and 47 parents of non-retarded children between the ages 28-54 drawn from population of parents with mentally retarded children attending school at the Therapeutic Day Care Center (T. D. C. C.) Abakpa in Enugu; Evami special school independence layout Enugu and UNTH Ituku Ozalla (OPD section) were used for the study using criterion sampling technique. Moos, Cronkite and Finney (1990) 28- item coping strategies scale, and Radloff (1977) 20-item depression scale were administered. Cross-sectional survey design was used. One Way ANOVA F- test revealed that parents with normal children presented more depressive symptoms than parents with mentally retarded children, F (1, 106) = 16.23, P< .05. One way ANOVA F-test as statistical test also revealed no significant influence of coping strategies, F (1, 57) = 080, P> .05 on depression among parents with mentally retarded children. On the basis of these findings, it was been concluded that coping strategies were not determinants of depression among these parents with mentally retarded children. The results were discussed in relation to relevant literature.*

Keywords: *Coping strategies, depression, Parents, Living and Mentally Retarded Children (Down syndrome).*

I. INTRODUCTION

All parents would understand and quickly agree that parenting is a weighty responsibility. However, even though such is demanding, it is also rewarding. It is demanding if done correctly and it is rewarding if done right. Parenting is the process of promoting and supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood (Mgbenkemdi, 2014). Parenting refers to the activity of raising a child rather than the biological relationship.

Parenthood is the state of being a parent, or one who is either a father or mother. A parent is responsible for the well-being, education and care for a child while the child is a minor, or under the age of 18. The parent has a moral, social and legal obligation to the child under his care. This means that the parent is legally obligated to provide food, shelter, clothing, safety, health care and an education for the child until the child's 18th birthday. Parents are also charged with the socialization of the child, making sure that the child has social and communication skills necessary to interact successfully in society. The parent is legally responsible for meeting his obligations to the child and for any actions that the child takes while underage. For instance, if a child commits a crime, such as stealing, the parents are considered as culpable in the eyes of the law as if they had perpetrated the incident. If a parent is found to be neglecting or abusing a child, the state government can revoke parental rights. A parent can also give up his parental rights legally by passing them along to someone else as part of a legal adoption of the child.

Failure of the parents to meet these specific needs can have wide ranging and long lasting negative effects on the child. The following outline provides eight essential responsibilities that parents must adhere to in order to foster their child's physical and/or emotional well-being, (Theisen, 2017):

Provide an environment that is safe. Keep your child free from physical, sexual, and emotional abuse. Keep unsafe objects locked up or out of reach of your child. Get to know your child's caregivers (get references or background checks).correct any potential dangers around the house. Take safety precautions: use smoke and carbon monoxide detectors, lock doors at night, and always wear seat belts etc.

Provide your child with basic needs. Water, plenty of nutritious foods, shelter, a warm bed with sheets, blankets, and a pillow, Medical care as needed/ Medicine when ill. Clothing that is appropriate for the weather conditions and space (a place where he or she can go to be alone).

Provide your child with self-esteem needs. Accept your child's uniqueness and respect his or her individuality. Encourage (don't push) your child to participate in a club, activity, or sport. Notice and encourage your child's achievements and pro-social behavior. Encourage proper hygiene (to look good is to feel good, or so they say!). Set expectations for your child that is realistic and age appropriate. Use your child's misbehavior as a time to teach, not to criticize or ridicule. Teach your child morals and values, honesty, respect, responsibility, compassion, patience, forgiveness and generosity. Develop mutual respect with your child. Use

respectful language. Respect his or her feelings. Respect his or her opinions. Respect his or her privacy. Respect her individuality.

Involve yourself in your child's education. Communicate regularly with your child's teacher(s).make sure that your child is completing his or her homework each night. Assist your child with his or her homework, but don't do the homework. Talk to your child each day about school (what is being studied, any interesting events etc.). Recognize and acknowledge your child's academic achievements. Get to know your child. Spend quality time together. Be approachable to your child. Ask questions. Communicate. Communicate. Communicate.

Above all else, remember that your child is unique and you know him better than anyone else.

However, some of the responsibilities also include: to inculcate the norms and values of the society, child education etc. In the family the child imbibes the traditional values such as good morals, sense of identity, respect for life, respect for elders, honesty etc. The family provides the child with affection, sense of belonging, and validation. Every area of a child's life is affected by the family. In order for the family to meet a child's psychological needs, its members must be nurturing, convey mutual respect, provide for intimacy, and engage in bonding and attachment (Waller, 2006).

However, a child's upbringing is a consequence of the child-rearing philosophy, the specific practices they employ, and the nature of their own and child's personality. Denga and Denga (1998) opined that the way parents bring up their children can influence their adult behaviours. The home environment is important in developing the personality of the child. There is face-to-face interaction in the family which determines the character and personality make-up of the child. Parent's child rearing style may influence the child's social competence.

The phenomena of child rearing and duties /or responsibilities of parents towards their children as stated above also includes those of the mentally retarded children. All parents wish for a healthy baby, but some parents though not by their choice are gifted with mentally retarded children. The usual reactions of parents to the handicapping condition of their child are first of all denial. This leads the parents to kind of force the child to doing things ordinary normal children should do, when the child fails to achieve this, the parents react with anger which may be against the child or care givers. The second stage is Anger. When the first stage of denial cannot be maintained any longer by these parents, it is replaced by feelings of anger, rage, envy and resentment. The parents having expressed anger and then noticed that anger could not help matters would move beyond the anger to problem-solving strategies in order to cope with the situation that caused the feeling. The next reaction is bargaining, that is a process of explaining the condition in a milder, more acceptable manner and searching for responsibilities of rehabilitation if the child has not been destroyed up to this stage. Despite this new strategy, the handicapping condition still persists and the parents become depressed. The depression may then finally lead to the acceptance of the disability (Kubler-Rose, 1969). Some are able to cope up with such a situation and some experience a psychological stress. Parenting a mentally retarded child is not an easy task (Peshawaria & Ganguli 1995). Parents having a mentally retarded child experience a variety of psychological stress related to the children's disability. Parents especially mothers need every help and encouragement possible in their different task, which is indeed, easier for them while the child is still a baby (Peshawaria & Ganguli 1995). Psychological stress refers to pressures on an individual that are in some way perceived as excessive or intolerable, and also to the psychological and physical changes in response to those pressures i.e., the pattern of specific and non-specific responses an individual makes to the stimulus events that disturb his/her equilibrium and that exceed their ability to cope (Zimbardo, 2009). People differ not only in the life events they experience but also in their vulnerability to them. A person's vulnerability to psychological stress is influenced by his or her temperament, coping skills and the available social support. Vulnerability increases the likelihood of maladaptive responses to psychological stress.

The birth of a retarded child at home is likely to be one of the most traumatic events experienced in a family. Parents and other children in the family must undergo changes to adapt to the presence of intellectually disabled member. Most parents expect that their children will be attractive, smart, graceful, athletic, and loving. Parents of a handicapped child not only mourn the loss of unfulfilled expectations but often seem to face enormous strain on their psychological and economic resources. There is abundant evidence that parents of Down syndrome undergo more than the average amount of psychological stress. There is no universal parental reaction to the added psychological stress of raising a retarded child. A number of factors can influence reaction and adjustment, including the severity of the retardation. Family adaptation is also influenced by the parent's prior psychological makeup, availability and quality of professional services, marital interaction, religious beliefs, attitudes; family sized and structure. The amount of support the parents receive from friends, relatives and professionals, self determination and intellectual functioning of the parents (Featherstone, 1980).

In addition, the presence of a child with mental retardation in the family creates additional needs, whether the family is able to meet the needs or not is dependent on number of factors like nature of the event, the family resources and its perceptions of the event. Unmet needs, tangible or intangible however create

psychological stress (Rees, 1976). Research has indicated that families, who are successful in coping with mentally retarded children, are able to mobilize their internal and external means of support to deal effectively with the special needs of their children. Resources that act as facilitators to effective coping can be of two types: internal coping strategies (i.e., coping through passive appraisal, reforming, spiritual and religious support) and external coping strategies (e.g. social support from other parents who have already overcome the shock and stigma of having such disabled children). The elements of such social support include encouragement, assistance, feedback and pragmatic in the completion of tasks important in daily life (Houser, Seligman & Milton, 1991). In addition, support and help from extended family members like grandparents also act as significant facilitators to coping. Moreover, attitude to events is significant in coping with change when faced with problems to remain stable. That is the principle of cognitive consistency. We seek consistency in our beliefs and attitudes in any situation where two cognitions are inconsistent. According to Festinger (1957), cognitive dissonance theory suggests that we have an inner drive to hold all our attitudes and beliefs in harmony and avoid disharmony or dissonance.

The presence of a Down syndrome is a source of strain for the members of the family, particularly, for the parents. The interaction of a mentally retarded child with his family is both more intense and more prolonged than if he were normal. As a result his or her parents need a great deal of help. The child's condition can range from mild to profound; the family's stability and its ability to handle problems can range from weak to strong. Mental retardation according to American Association of Mental Retardation (2010), is a disability characterized by significant limitations in intellectual functioning and adaptive behaviour as experienced in conceptual, social and adaptive skills. It is a condition of limited mental ability in which an individual has a low intelligence quotient (IQ), usually below 70 on a normal intelligence test, and has difficulty adapting to everyday life. According to Brown and Zinkus (1979) mental retardation is defined in terms of the intellectual and adaptive capacity of an individual when compared with others of his/her age. Brown and Zinkus (1979) view mental retardation as a developmental problem from childhood to adulthood. World Health Organization (1985) stated that before an individual could be classified as mentally retarded, both the intellectual functioning and adaptive behavior must be impaired.

Therefore, mental retardation simply means impaired intellectual or learning capacity and adaptive behaviour. These disabilities are not only found in adults but also among children before the age of 18.

II. CAUSES AND SYMPTOMS

Low IQ scores and limitation in adaptive skills are the hallmarks of mental retardation. The child may be very shy, withdrawn, fearful, and dull or over-friendly has no fear of strangers or is too afraid of strangers. He could be quite often also aggressive, irritable, hyperactive restless, self-injury, and mood disorders are sometimes associated with the disability (Serpel, 1989). The severity of the symptoms and the age at which they first appear depend on the cause. Children who are mentally retarded reach developmental milestones significantly later than expected, if at all. If retardation is caused by chromosomal or other genetic disorders, it is often apparent from infancy. If retardation is caused by childhood illness or injuries, learning and adaptive skills that were once easy may suddenly become difficult or impossible to master. In about 35 percent of cases, the cause of mental retardation cannot be found. Biological and environmental factors that can cause mental retardation include genetics, prenatal illness and issues, childhood illnesses and injuries, and environmental factors (American Association of Mental Retardation, 2010)

Genetics

About 5 percent of mental retardation is caused by hereditary factors. Mental retardation may be caused by an inherited abnormality of the genes, such as fragile X syndrome. Fragile X, a defect in the chromosome that determines sex, is the most common inherited cause of mental retardation. Single gene defects such as Phenylketonuria (PKU) and other inborn errors of metabolism may also cause mental retardation if they are not found and treated early. An accident or mutation in genetic development may also cause retardation. Examples of such accidents are development of an extra chromosome 18 (trisomy 18) and Down syndrome. Down syndrome is caused by an abnormality in the development of chromosome 21. It is the most common genetic cause of mental retardation (APA, 2008).

Prenatal illness and issues

Fetal alcohol syndrome affects one in 6000 children in the United States. It is caused by excessive alcohol intake in the first twelve weeks (trimester) of pregnancy. Some studies have shown that even moderate alcohol use during pregnancy may cause learning disabilities in children. Drug abuse and cigarette smoking during pregnancy have also been linked to mental retardation (APA, 2008).

Maternal infections and illness such as glandular disorders, rubella, toxoplasmosis, and cytomegalovirus infection may cause retardation. When the mother has high blood pressure (hypertension) or

blood poison (toxemia), the flow of oxygen to the fetus may be reduced, causing brain damage and mental retardation. Birth defects that cause physical deformities of the head, brain, and central nervous system frequently cause mental retardation. Neural tube defect, for example, is a birth defect in which the neural tube that forms the spinal cord does not close completely. This defect may cause children to develop an accumulation of cerebrospinal fluid in the brain (hydrocephalus). By putting pressure on the brain, hydrocephalus can cause learning impairment.

Childhood illness and injuries

Hyperthyroidism, whooping cough, chicken pox, measles, and Hib disease (a bacterial infection) may cause mental retardation if they are not treated adequately. An infection of the membrane covering the brain (meningitis) or an inflammation of the brain itself (encephalitis) causes swelling that in turn may cause brain damage and mental retardation. Traumatic brain injury caused by a blow or a violent shake to the head may also cause brain damage and mental retardation in children.

Environmental factors

Ignored or neglected infants who are not provided with the mental and physical stimulation required for normal development may suffer irreversible learning impairments. Children who live in poverty and suffer from malnutrition, unhealthy living conditions, and improper or inadequate medical care are at a higher risk. Exposure to lead can also cause mental retardation. Many children develop lead poisoning by eating the flaking lead-base paint often found in older buildings. If mental retardation is suspected, a comprehensive physical examination and medical history should be done immediately to discover any organic cause of symptoms. Conditions such as hyperthyroidism and PKU are treatable. If these conditions are discovered early, the progression or retardation can be stopped and, in some cases, partially reversed. If a neurological cause such as brain injury is suspected, the child may be referred to a neurologist or neuropsychologist for testing.

The symptoms of mental retardation are usually evident by a child's first or second year. In the case of Down syndrome, which involves distinctive physical characteristics, a diagnosis can usually be made shortly after birth. Mentally retarded children lag behind their peers in developmental milestones such as smiling, sitting up, walking, and talking. They often demonstrate lower than normal levels of interest in their environment and responsiveness to others, and they are slower than other children in reacting to visual or auditory stimulation. By the time a child reaches the age of two or three, retardation can be determined using physical and psychological tests. Testing is important at this age if a child shows signs of possible retardation because alternate causes, such as impaired hearing may be found and treated.

Classes of Mental Retardation

The American Association on Mental Deficiency (2010) identifies the following specific degree of mental retardation.

IQ score	Diagnosis	Functioning
55-70	Mild Mental Retardation	May live independently
40-55	Moderate Mental Retardation	Group home living
25-40	Severe mental retardation	Limited communications skills
< 25	Profound mental retardation	Needs constant care

Source: (AAMD 2010)

Mild Mental Retardation: Approximately 85% of the mentally retarded population is in the mildly retarded category. Their I.Q scores range from 50 – 70, and they can often acquire academic skills and communication skills during preschool years. They have minimal impairment in sensory motor areas. They can become fairly self-sufficient and in some cases, live independently with the community and social support, but may need guidance and assistance when under social and economic stress.

Moderate Mental Retardation: About 10% of the mentally retarded population is considered moderately retarded. These people have I.Q scores ranging from 35-55. They can carry out work and self care tasks with moderate supervision. They typically acquire communication skills in childhood and are able to live and function successfully within the community in such supervised environments as group homes.

Severe Mental Retardation: About 3-4% of the mentally retarded populations are severely retarded. They have I.Q scores of 20-40. They are characterized by poor motor development, acquisition of little or no communicative speech during the preschool period. They can learn some survival words like 'food', 'man'; 'drink' by sight-reading. As adults they may perform simple tasks under close supervision.

Profound Mental Retardation: Only 1-2% of the mentally retarded population is classified as profoundly retarded. These individuals have I.Q Scores under 20-25. They display minimal capacity for sensory motor functioning. They require total supervision in an individualized relationship. We shall consider the different types of mental retardation based on physical characteristics.

III. TYPES OF MENTAL RETARDATION

The garden variety type or familial type: In all physical regards, these individuals look like everyone else, yet when faced with intellectual tasks they become confused and perform at below average level. They do not suffer severe intellectual deficiency. Most persons in this group come from families in which retardation is common, and they belong to the either moderate or mild categories of mental retardation.

Microcephalus: This means small head. It is characterized by a cone shaped head with a circumference of less than 17 inches in adulthood, in contrast to a normal figure of 22 inches. The small size results in some parts of the brain missing or not growing, hence the mental retardation. Microcephalics vary intellectually from moderate to profound retardation.

Hydrocephalus: This is characterized by a globular enlargement of the cranium resulting from the accumulation of abnormal amounts of Cerebro-spinal fluid within the ventricles due to hereditary traits. Both face and body remain normal in size giving the upper part of the head a grotesque appearance or extra-ordinary large head.

Cretinism: This is mental retardation as a result of iodine deficiency from thyroid gland in the brain. This could be as a result of deficiency in iodine intake during pregnancy. The cretin has learning defect and totally arrested sexual development. Normal growth is stunted except for a disproportionately large head. If this deficiency is detected early, replacement therapy may prevent cretinism.

Down syndrome: About 95% of mongoloids are found to possess 47 chromosomes instead of the normal complement of 46. The remaining 5% exhibit other defects all of which are related to chromosomal disjunction. The brain is diffusely under developed and suggests the consequences of basic metabolic deficiency, leading to metabolic dysfunction with consequent brain damage leading to mental retardation (APA 2000). A mentally retarded child in a family is usually a source of distress factor for the parents (Kotopaulos, 2010). It often requires a reorientation and re-evaluation of family goals, responsibilities and relationships. Parenting a mentally retarded child is not an easy task (Peshawaria & Ganguli, 1995). King (2009) stated that parents living with a mentally retarded child experience a variety of psychological stress related to the child's disability.

The American's Disabilities Act defines mental retardation as any physical or mental impairment that substantially limits one or more major life activity. La Plante (2001) define a person with a disability as one who is unable to perform his or her major activity or is limited in the amount of activity. According to Wellner (1998) mental retardation occurs one in 10 Americans who had severe disabilities in 1994-95. In Kraus, Stoddard, & Gilmartin (1996) report, almost one out of every five people has a mental retardation. The discrepancy between reports might be due to the severity of the disability; however, the two statistics illustrate the increase in the number of individuals reporting a disability. For purpose of this work, the term mental retardation, disability, intellectual disability is utilized.

In the past, individuals with disabilities were formally considered liabilities, suffered inhumane treatment, and were often institutionalized away from society (Fewell, 1986). Society's attitude has changed dramatically in the past 30 years with public acknowledgement of the importance of caring for the mentally retarded and the constitutional rights for the retarded (Newman, 2003). Several trends such as advances in technology, medical care, mandated services, and mainstreaming the individuals with disabilities back into society rather than placing them in institutions have also helped the disabled live better lives and function in the community. Most childhood disabilities are referred to as developmental disabilities; defined as any physical or mental condition that may impair or limit a child's ability to develop cognitively, physically, and emotionally compared to other children (Pueshel & Bernier, 1988). The origin of a child's disability may be the result of a variety of conditions that can occur at any time such as childhood accidents, chronic illness, infections, or genetic disorders (Rose, 1987). Even with the advancement of medical technology, some causes of certain disabilities are still unknown (Rose 1987). Unlike obvious physical anomalies, which are usually noticed at birth many developmental disabilities are left undiagnosed until a child reaches school age. Identifying a developmental disability may be difficult for a parent if he or she is unaware of a child's developmental stages. According to Thompson (2000), children with disabilities need additional items such as special clothing, equipment, communication devices and bathroom aids all these affect the parents financially, emotionally, physically, and hence predict conflict and depression. Although children with disabilities may have additional

needs, despite their disabilities they are children first (Capper, 1996).

Yet, parents can never fully prepare themselves for the news that their child is different from other siblings (Pueshel & Bernier, 1988). Whether the diagnosis of disability is shortly after birth or later on in life, family dreams and expectations are affected (Rose, 1987). Parents may have to face immediate decision about their child's medical care and treatment (Thompson, 2000). Even though there are no universal reactions to the added stress of raising a child with disabilities (Kwai-Sang Yau and Li-Tsang, 1999) several researchers have noted that there are similar patterns or stages that the parents experience emotionally (Blacher, 2000). Some parents will experience a variety of intense emotions including initial shock, numbness, denial, fear, anxiety, anger and depression (Featherstone, 1980, Rose, 1987; Thompson, 2000). Many researchers studying the impact a child with intellectual disability has on a family especially the parents employ on ecological perspective, which looks at how the environment and the family affect one another (Bristol & Gallagher, 2006). The parents' feelings towards their child will influence their ability to cope and also have an effect on how the child and other family members react to the child's disability (Callanan, 1990).

Parents living with mentally retarded cope with the same responsibilities and pressures that other parents face; however, one reoccurring theme reported among these parents is the higher amounts of stress they experience and greater demands made by caring for a child with intellectual disabilities. The everyday tasks of feeding, toileting, traveling and communicating are much more physically and emotionally demanding for parents living with mentally retarded (Featherstone, 1980). This sense of stress may be associated with a child's characteristics, greater financial and care-giving demand, feelings of being unprepared for the tasks of parenting, and a sense of loneliness and isolation (Kazak & Willox, 1984). Therefore, parents who become more involved in their child's care may be stressed and need support and resources to enable them cope effectively and to avoid being depressed (Fewell, 1986).

This pressure of taking care of the needs of the mentally retarded children could be considered stressful depending on the parents' personality dynamics. Thus the nature and effects of stressful life events on the parents depend heavily on the parents' perception hence events perceived as good are called eutress and they have beneficial or constructive effects on the individual. Those perceived as bad are called distress, and they have been shown to have debilitating effects on the individual (Cohen & Williamson, 1991). Whichever way the stressor is perceived, it has effects on the individual's physiological response system. Stress according to Rees (1976), has implications for adaptation and coping, hence it could be asserted that stress is not totally nasty. It has the potential of bringing out the best in us. Omoluabi (1995) noted that the total absence of stress in a person's life can lead to disastrous effects. Thus it could be posited that, without stress, the accompanying motivational strivings to accomplish life's ambition and conquer the environment may become illusive. Nweze (1995) observed that life may not be worth living at all in the absence of stress.

Studies have revealed that there is a significant cause-effect relationship between stress and illness. This relationship results from the activation of the autonomic nervous system and endocrine system as well as their effects on the immune system. The relationship invariably leads to degenerative disease conditions like chronic hypertension, heart diseases, strokes and kidney failure (Hubert, 1994). Psychologically, the stress response process is manifested by disorganization and exaggerated defense reactions, a break with reality, apathy and stupor (Coleman, 1976). Featherstone (2006) reports a sense of isolation, stress and loneliness that many parents experience with disabled children.

When a child is born with a disability, it brings deep sorrow and disappointment for the entire family especially the parents (APA 2008). This stress could have a negative impact on the parents, leading to anger, anxiety and depression (Bromley, Hare, Davison & Emerson, 2004).

Interestingly, Benson (2006) reported that parents living with mentally retarded children were at increased risk of poor mental health, not only because of the demands of caring for children with mental retardation, but also because of other stressors engendered or exacerbated by their children's disability. Baxter, Cummins & Polak (1995) concluded that in a longitudinal study of parental stress the time of diagnosis of mental retardation was the most stress inducing period for parents, followed by the time when the child entered school and when they presented transit from school to work. It could be deduced that parents present different levels of stress as their mentally retarded children pass through stages of development. Some of the stresses include:

1. Parents living with mentally retarded children have challenging behaviours indicated high levels of stress to the parents. According to Sharpley, Bitsika and Efremidis (1997) the permanency of the condition.
2. The lack of acceptance of behaviour associated with mentally retarded by the family members and the society.
3. The low levels of support provided.
4. The socio-economic burden of raising a mentally retarded child, including the negative impact on parent's career and/or income.
5. The future of their children especially the problems that may arise when the children reach adulthood.

6. The psychological characteristics of the parents such as perceived self –efficacy, locus of control and coping style.

Depression: This is a disorder of low mood state. It is also a drastic alteration in a person's mood resulting in the individual presenting a number of very unpleasant symptoms. These symptoms include, dissatisfactions with one's life, feeling very discouraged about the future, feeling hopeless and helpless, being unable to sleep (insomnia) diffuse anxiety, early morning awaking, poor appetite, loss of energy, inability to concentrate on any work or thought, and reduced motor activity. Depression is the emotion accompanying surrender (Ebigbo & Izuora, 1986). According to American Psychological Association (2008) depression is the expression of sadness, disappointment, loneliness, self- criticism, low-self concepts, guilt, shame, boredom, tiredness, lack of interests and lack of meaning in life etc. In psychotic cases, there may be delusions of persecution centering on sin, guilt and punishment, somatic delusions in which the person believes that part of his body is missing or non-functional and auditory hallucinations of a persecutory nature. Disordered and confused thinking may also be present. Sometimes serious thought that one would be better off dead could pervade the individual's thinking. Depression could be defined as a disorder of the mind that affects the physical, psychological and social functioning of an individual (Moos, 2008). Depression may either be characterized as temporal or permanent / chronic or transient.

Some depressed person usually rebound to their usual mood after sometime. This is called the temporary depression while some persons instead of rebounding to their normal mood, continues in that state for over a long time or for life if untreated. This is called chronic mania depression. It is observed that people experience mood swing hence operate between extreme low mood to over-excitement and are classified as manic depressive. This pathological condition has been shown to have many factors in its etiology.

Etiological factors:

Etiological factors may include, break up of intimate romantic relationship, loss of a loved one or highly prized job, disappointments in business or academic pursuits to genetic and biochemical factors. Parents who live with retarded children reported higher level of physical, emotional, psychological and financial demands (Suls & David, 2001). Parenting is one of the most challenging jobs an individual will ever do. Raising children can be stressful at times, but also very rewarding. Becoming the parent of the child who has mental retardation is a time of great stress and change (Thompsom, 2000). Parent's perception of having a child with a disability, the characteristics of the family, the parent's internal and external resources, and the child's characteristics are examples of factors that influence the amount of stress, and depression the parent's experiences. It is important that parents learn how to deal with their stress effectively in order to avoid negative psychological, emotional, and physical consequences. This experience of stress, and depression might depend upon the kind of coping strategies adopted by these parents.

Coping Strategies

Coping strategies according to Folkman (1984) is any effort we make to manage situations we have appraised as potentially harmful or stressful. It could also be defined as cognition and behaviours used by the individual in evaluating stressors that are either active or avoidant coping strategies aimed at decreasing the amount of stress (Folkman & Lazarus, 1980). Coping also involves engaging in response or set of responses that reduce external, stressful or negative events (McCrea, 1984). It is any activity or responses that are capable of reducing distressful psychological outcomes such as anxiety and depression and in this way modulates the individual's psychological reaction to stressful event (Folkman, Lazarus, Gruen & Delongis, 1986). Any activity in thought or deed which has as its goal the removal or modification of threat to identity could be regarded as coping strategy (Breakwell, 1986). Coping strategy could be seen as part and parcel of the arsenal of self-protective measures used by the individual concerned to remain healthy and functional even in the face of conflict (Omeje, 1998). Coping is the parent's attempt to manage or deal with the stressful situation.

Stress In Families Who Have Children With Mental Retardation.

One of the characteristics of stress is change. Adding a member to an existing family is a change that alters the families' social system. This change can be particularly stressful if the child has a disability (Kazak & Marvin, 1984). Families of children with intellectual disabilities are likely to experience changes in their daily routines, roles and expectations of their child in addition to the normal stresses of parenting (Crnic, Friederich & Greenberg 1983). Parents of children without a disability have the potential relief of sharing household responsibilities with their children. One stressor of parents who have children with intellectual disabilities is that they may continue to care for their child for extended periods of time, which can be physically, financially and emotionally draining (Tumbull & Behr, 1986; Winkler, 2010). Another stressor that is chronic for parents having a child with developmental delays is society's negative attitude toward their child. Even though society's

attitude toward mentally retarded child has gradually changed, but there are still some people who feel uncomfortable around these children and want to avoid contact with them (Winkler, 2010). Similarly, reflecting on personal experience and research, Featherstone, (1980) reports a sense of isolation and loneliness that many parents experience. The family's social and recreational patterns may be altered due to the added care needed by the child (Seligman, 1983). Parental stress may also be related to attempts to locate appropriate services and education for their child among the maze of human service agencies that often have confusing acronyms, and overlapping boundaries (Barley, & Simeonson, 2008). Rose, (1987) found that the children with mental retardation require twice as many health services as non-retarded children, resulting in higher medical expenses for families. Parent who have children with mental retardation have the added burden of finding special clothing, adaptive equipment, and making home modifications (Peuschel & Bernier, 1988). The child with developmental disabilities may of course require extra time for feeding, toileting, and taking the child to and from appointments (Fewell, 1986). Considering all these information, it is assumed that parents who have children with disabilities are at a higher risk for added stress because of the emotional imbalance and self - recrimination. They undergo a number of hardships such as altered relationship with friends, major changes in family activities, medical concerns, medical expense, specialized child care needs, time commitments and intra-family strains. All these factors influence the amount of stress experience by parents who have mentally retarded children and how they cope. Each child and his or her disability are unique. Parental reactions and interpretations of stress they experience are influenced by the child's behaviour and personality characteristics such as rate of child progress, responsiveness, temperament, repetitive behaviour patterns, and the presence of additional or unusual care-giving demands (Holroyd, 2013). Many parents with mentally retarded children may accept the condition of their disabled children effectively based on the way they record the rate of developmental success of their children, while some parents do not.

Coping involves psychological resources and coping skills that help to eliminate, modify, or manage a stressful event or crisis situation (McCubbin & Patterson, 1983). How parents respond to the stresses of raising their children with intellectual disabilities depend on a wide variety of factors influencing their ability to cope, such as their interpretation of their crisis events and the family's sources of support, resources and family structure (Bailey & Smith, 2003). The personality characteristics of the family members, their financial status, educational level, problem solving - skills and spirituality all influence parents ability to cope (Abbott & Meredith, 1986). Strong marital relationship and social support also help determine parental adjustment (Abbott & Meredith, 1986). Parents of retarded children sometimes need the services of professional in order to cope hence it is imperative that these professionals update their skill and knowledge follows the trend in changes that take place in medicine, adaptive behavior and equipment. Individuals who work with parents who have children with disabilities must understand how to assist the parents in coping with their stressors. In order to accomplish this, one must understand how the parents are currently coping and what is working for them. Because each family system is unique, each family may have coping strategies different from others. Recognizing the diversity of families, while respecting and understanding their differences is necessary; in order to help them cope effectively. Coping strategies has been classified into two namely: problem-focused coping strategy and emotion- focused coping strategy (Darwin, 1859).

Problem – Focused (Realistic Approach)

Problem focused is aimed at coping with the sources of distress. It involves an attempt to understand and define the problem and to work out possible solutions. Folkman and Lazarus (1980) opined that we are likely to use problem-focused coping strategies when we feel we can do something about the challenge or problem. This focus of coping has been shown to be adaptive.

Emotion Focused (Unrealistic Approach)

This is aimed at managing or reducing the stress or emotional distress that is or might be elicited by the stressor (Folkman & Lazarus, 1985). It involves physical exercise, meditation, expressing feelings and seeking support. There is no effort to confront the problem. It could be considered avoidance in nature and inner directed. Based on the distinction between these two foci of coping, contemporary instruments for measuring coping have been devised (Friedrich, Wilturner, & Cohen, 1985). Statistical analyses of data collected with these instruments show that problem focused and emotion focused strategies form the two most important dimensions onto which other subscales load. But depending upon which type of strategy that is used problem-focused coping strategies is found to be more effective than emotion-focused coping strategies (Bailey & Smith, 2003). In other words, it could be asserted that the type of coping strategies parents of retarded children adopt determine how they fair in their relationship (marital conflict) and well being (pathological symptoms). Thus, the

IV. PURPOSE OF STUDY

It has been postulated that coping strategies have influence on the depression among parents with mentally retarded children, the present study explored this in Igbo environment since available literature was based on Western culture, specifically the present study investigated the following:

1. To determine whether there will be a significant difference in depressive symptoms between parents of mentally retarded children and those with normal children.
2. To determine whether there will be a significant difference in depressive symptoms among parents of mentally retarded children who adopted problem- focused coping strategy and those who adopted emotion – focused coping strategy.
3. To determine whether there will be a significant difference between parents (of mentally retarded children and non-retarded children) who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy on depressive symptoms.

Statement of the Problem

Parents living with mentally retarded children have many challenges which if not properly managed lead to marital conflict and depression (Sharpley, Bitsika, & Efremidis, 1997). These challenges parents face in living with this category of children may lead to disruption of the family and affect husband and wife hence; they become depressed (Minuchin, 1974, Suls & David 2001).

However, the effect/ impact of these challenges (e.g. marital conflict & depression) faced by these parents living with mentally retarded children seems to depend on the kind of coping strategies adopted by these parents. Studies have shown that coping strategies, marital conflict affect depression among parents of children with mental retardation (e.g.). These studies were done in Western culture except (Isichie, 2010) hence, the present study. Thus, this study investigated the influence of coping strategies and marital conflict on depression among parents living with mentally retarded children in a Nigerian sample.

Therefore, this study addressed the following questions:-

1. Will there be a significant difference in depressive symptoms between parents of mentally retarded children and those with normal children.
2. Will there be a significant difference in depressive symptoms between parents of retarded children who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy.
3. Will there be a significant difference between parents (of mentally retarded children and non-retarded children) who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy on depressive symptoms.

Coping is difficult to operationalize, because it is a very ambiguous and complex concept. However some theories have been postulated hence the following were reviewed:

V. THEORETICAL FRAME WORK

Evolutionary and Behavioural Theory (Darwin, 1859)

The theory of evolution was proposed by Charles Darwin in (1859) to explain the origin of man. This theory was later connected with the principles of coping mechanisms. Darwin stated that with time, organisms including man originated and adapted to their environments. These adaptive behaviours depend on the genetic endowment such as hereditary variations and the influence of their environments. Genetic factors have creative effects on human growth and development. The environmental factors by natural selection eliminate the harmful or not very useful hereditary endowment, thus enabling those that are beneficial to develop and reproduce. So, heredity and environment interact to produce behaviours necessary for the organism to adjust and adapt to the stressful life events. And so, the evolution theory accounts for man's ability to cope with the stressful problems in the human life and development. Omeje (2000) stated that coping strategies adopted by an individual depends on hereditary factors or natural endowment as well as on the exigencies of his environment. These will enable the individual to use effective adaptation strategies and do away with ineffective ones. Thus, the acquisition or extinction of any coping strategy depends on its efficacy in problem-solving as well as on the cognitive appraisal of the self and the meaning given to the problem of adaptation.

Considering, this theory in view of the coping strategies adopted by parents with mentally retarded children, problem-focused and emotion-focused coping strategies depend on their hereditary and environmental factors. For instance, naturally some people are endowed to think and approach challenges realistically (problem-focused) while some are endowed to think and approach challenges unrealistically (emotion-focused). In the same vein, some people overtime learn to tackle their challenges realistically and practically, problem-focused while some learn to tackle their challenges unrealistically. This learning of tackling challenges either realistically (problem-focused) or unrealistically (emotion-focused) depends on the reinforcement received. For example, using emotion-focused approach can give temporary relief (reinforcement) thereby making parent to ignore, direct and release tension. In view of these, therefore, this theory suggests that parents with mentally

retarded children can adopt either problem-focused strategy or emotion-focused strategy depending on their hereditary and environmental factors (experiences). Invariably, these coping strategies will influence their experiences of depression

Cognitive theory of depression

The cognitive theory of depression posited by Becks (1967) sees depression as a result of the negative perception, belief and thought people have about their experiences, their lives and future. Becks (1982), asserts that depression is linked with self-defeating belief that depressed persons think and perceive life irrationally and negatively. Becks contended that they have intense negative assumptions about themselves, their situations and their future and this negative assumption leads them to magnify bad experiences and minimize good ones.

Bringing this cognitive theory to bear on coping strategies and depression among parents of retarded children, it could be contended that parents living with mentally retarded who become depressed have accepted to be so because they believe that things will not change for better in the future. So instead of doing something to minimize or to overcome the experiences, they become helpless as a consequence of their self-defeating belief about their child's conditions, self, world and the future.

Considering this theory in the light of the repeated experiences of negative events of parents with mentally retarded children, parents who adopt emotion-focused coping strategy to deal with the condition of a mentally retarded child see it as one of those things, may be a punishment from God as a result of one's sins. This approach is unrealistic approach that prevents positive thoughts and actions. Such unrealistic thought and actions may lead to marital conflict and depression. Moreover, if a parent with mentally retarded child twists the reality and becomes unrealistic about the health condition of the child, he or she may think that an enemy or even relatives and spouse have done this, that it is a spiritual matter. These will likely lead to the same wrong attribution of the causes of the problem.

In this case, such a parent may accuse the wife or husband, relatives, friends and even enemies for being the cause of the problem. In view of this, the parents will likely adopt emotion-focused approach to the problem. This can lead to disharmony in the family resulting in depression.

However, these challenges (e.g. depression) as experienced by these parents living with mentally retarded children are likely to depend on the kind of coping strategies adopted by these parents. Besides, considering the available related empirical studies on coping strategies, and depression among parents living with mentally retarded children as revealed, the majority of these as revealed were done using participants from America, Europe & Asia. Moreover, substantial works in this area have not been done in Africa (e.g Nigeria) to cross validate these findings. In the same vein, the only study that has been done in Nigeria, for example, Ebigbo & Ebigbo, 1992, Izuorah, 1989, & Isichei, 2010 who explored parents of mentally retarded children in Nigeria but did not consider the coping strategies adopted by these parents of mentally retarded children either problem-focused coping strategy or emotion-focused coping strategy and the relationship between parents of mentally retarded children and parents of normal children in South- East.

In summary, the bulk of the literature reviewed so far on the variables of interest in this study both theoretical and empirical theories suggested that coping strategies were not determinants of depression among these parents of mentally retarded children (Festinger, 1957, Moos & Schaefer, 1993).

Hypotheses

The following hypotheses were tested based on the literature reviewed and problems identified:

1. There will be a significant difference in depressive symptoms between parents of mentally retarded children and those with non retarded children.
2. There will be a significant difference in depressive symptoms between parents of mentally retarded children who adopted problem-focused and those who adopted emotion-focused.
3. There will be a significant difference in depression symptoms between parents (retarded and non-retarded) who used emotion-focused strategy and those who used problem focused strategy.

VI. METHOD

Participants

Participants were 108 comprising 61 parents of mentally retarded children and 47 parents of non-retarded children between the ages 28-54 in Igbo land. They were drawn from the population of parents with mentally retarded children attending school at the Therapeutic Day Care Center Abakpa (T. D. C. C.), Evami Special School Independence Layout Enugu, and University of Nigeria Teaching Hospital (UNTH) Ituku Ozalla Children out Patient and outpatient Department sections (CHOP & OPD) using criterion sampling technique.

Criterion sampling involves selecting cases (eg participants) that meet some predetermined criteria of importance (Patton, 1990). This sampling can be useful for identifying and understanding cases (eg participants) that are information rich, providing important qualitative component to quantitative data and for identifying

cases from a standardized questionnaire that might be useful for follow-up. Specifically, the assumptions of criterion sampling hold that you set criteria and pick all cases (eg participants) that meet those criteria. Criterion sampling is strong for quality assurance (Patton, 1990). To this end, the parents of mentally retarded children selected for this study had spent at least one year as parents, married, living with their mentally retarded child, and have had at least one mentally retarded child. This was to ensure that stress from such children was likely to be experienced in the lives of all the participants. All the participants had a minimum educational qualification of secondary school certificate. This was to enable the participants to read, understand and fill the questionnaire properly. Primary school certificate parents and single parents were not included.

Instrument

Two instruments were used in this study which included, Moos, Cronkite & Finney,(1990) 32-item coping strategies scale validated by Omeje (2000) measuring coping strategies, with reliability and validity index of 0.68 and 0.82 respectively, and Radloff (1977) 20-item center for epidemiological studies-depression scale (CES-D) validated by Omeje (2000) measuring depression in a general population, with reliability and validity index of 0.85 and 0.92 respectively.

Section A. **The Health and Daily Living Form: Adult Form B (Moos, Cronkite & Finney, 1990)** This scale measures five categories of coping strategies namely: Logical analysis, Information seeking, Problem solving, Emotional discharge and Emotional regulation. These were grouped into two, namely; Problem-focused and Emotion-focused strategies. The logical analysis, information seeking and problem solving items constitute problem-focused strategies, while emotional discharge and emotional regulation formed the emotion-focused strategies.

The items in the inventory were rated on a four point scale, Thus: rarely = 1, sometimes = 2, often = 3 and always = 4. Those constituting problem-focused strategies have a sum total of 20-items while emotion-focused strategies have 12-items for each subscale. The scale HDL was used to categorize participants into problem-focused strategists and emotion-focused strategists. For classification, the 20-items that constitute the problem-focused subscale was scored from 1-4 while 12-items of the emotion-focused strategies were scored in the reverse order, 4-1. As such the highest score in problem-focused plus the lowest score on emotion-focused items placed a participant as problem-focused, while the highest score on the emotion-focused plus the lowest score on the problem-focused placed a participant as emotion-focused. For instance, Highest score on PF = 80, Lowest score = 20; Highest score on EF =48, Lowest score = 12. Meanwhile, problem-focused category = 80+12= 92, while Emotion-focused category = 48+20= 68. Therefore, below 68 is emotion-focused and above 68 is problem-focused.

Center for Epidemiological Studies-Depression scale (CES-D) Radloff (1977)

Section B: Comprised 20-items center for epidemiological studies-depression scale (Radloff, 1977). This scale was developed at the American Institute of Mental Health designed to measure symptoms of depression in the general population (Radloff, 1977). The instrument was validated in Nigeria by Okafor (1997) with reliability index of 0.85, Ugwu (1998) with concurrent validity index of 0.41 and Omeje (2000) with reliability and validity index of 0.85 and 0.92 respectively. The choice of center for epidemiological studies-depression scale was that the researcher was not interested in participants diagnosed as depressed.

The scale has 20-items designed to determine the presence or absence of depressive symptoms among parents of mentally retarded children. However, the scale was scored on a four point scale ranging from 1-4 for example rarely = 1, sometimes = 2, often = 3, and always = 4. But, items 4, 8, 12 and 16 reflect positive outcomes and are scored in the reverse order, for example (rarely =4, sometimes = 3, often = 2 and always = 1). The remaining 16- items reflect negative outcome. The participants were instructed to report the frequency with which the 20-items were experienced within the previous 6 months. If any participants scored above 20, that indicated the participant had experienced depression.

Procedure:

The researcher went officially with letter of introduction from the Department of Psychology to the management of the three schools namely: Therapeutic Day Care Center (T. D. C. C. Abakpa), Evami Special School, Independence Layout, and Ethics Committee, University of Nigeria Teaching Hospital (UNTH) Ituku Ozalla (see Appendix H) and visited them respectively. The researcher sought the permission to use a sample of the parents of children with mental retardation in their schools as participants for the study. The researcher explained the nature of the research to the managements. For instance, they were told that the study would involve only married parents with children with mental retardation. Parents that had secondary school educational qualifications. The requested permission was granted. In order to identify this category of parents of children with mental retardation, the researcher assisted by the research assistants as appointed by the managements/principals went through the files of these mentally retarded children. This process although

rigorous, enabled the researcher to identify the number of this category of parents of children with mental retardation in each of the (3) three schools. Consequently, the managements/principals of T. D. C.C., and Evami Special School told the researcher that he came in the middle of the term and would not be able to reach the parents then. As such that they only have two contacts with these parents at the reopening and closing of every term; therefore, that the researcher should make available the instruments before the closing of the term on which the closing date was told to the researcher. On the other hand, the researcher met the UNTH Chairman of the Ethics Committee on one of the Mondays and explained the nature of the research as above. The chairman followed the same procedure, and introduced the researcher to the research assistants who went through the files of these patients as above. The chairman told the researcher that the patients attended Children out patient (CHOP) and out patients department (O.P.D) section on Fridays. Thus, with this necessary information gathered, the researcher left to prepare for the next stage.

Following the approval and the arrangements made thereof, the researcher equipped with the information gathered from the principals/ chairman of ethics committee and with the help from research assistants, beckoned these parents, explained to them and solicited for their consent. They were told that participation was not compulsory but voluntary. To this end, those who volunteered were asked to move aside. This exercise enabled the researcher to identify those parents who possessed the set criteria as demanded by criterion sampling. Interestingly, the rapport created by the researcher and the research assistants made some of the parents indicate interest.

The researcher told the four (4) research assistants that the purpose of the study was to find out whether coping strategies and marital conflict were determinants of depression among parents with mentally retarded children. The researcher instructed the research assistants to administer the instruments one after the other in a uniform order.

The researcher produced a total of 163 copies of the questionnaire: Health and Daily Living Form: Adult Form B, and center for Epidemiological Studies-Depression Scale) which were given to the research assistants who administered them to the identified parents with mentally retarded children in their respective schools. The participants were instructed to take the copies of questionnaire home, study them carefully, complete them and return to the research assistants within one week for the UNTH participants, for two other schools, the re-opening day.

The researcher went back to the schools at the end of the exercise to collect the returned copies of the questionnaire from the research assistants. Out of the 163 copies of questionnaire administered, 108 copies were properly completed and returned while 30 copies were discarded on grounds of educational qualification, and single parent, 15 not properly completed and 10 were not returned. Therefore, the 108 copies properly completed and returned were used for analysis and testing of the hypotheses.

The table below shows the number of copies of questionnaire administered in each school and the number properly completed and returned.

S/N	Name of school	Number Administered	Number Properly Completed & Returned	No discarded
1	Therapeutic Day Care Center (TDCC) Abakpa	100	71	29
2	Evami Special School Independence Layout	33	14	19
3	UNTH Ituku Ozalla CHOP, and OPD Section	30	23	7
	TOTAL	**163**	**108**	**55**

Design/ Statistics

The study involved a cross-sectional survey design to measure the 2 levels of coping strategies, problem-focused coping strategy and emotion-focused coping strategy and One Way ANOVA used for data analysis.

Table I

Table of Means, showing the influence of coping strategies on depressive symptoms among parents with mentally retarded children

Coping strategy	mean	SD	N
Problem-focused	42.8947	8.14328	38
Emotion-focused	39.1739	9.68435	23

The mean scores as shown in table I above have shown that parents who used problem-focused coping strategy obtained a higher mean score on depressive symptoms (M=42.89) than those who used emotion-focused coping strategy (M=39.17).

Table II

One- Way ANOVA showing the influence of coping strategies on depressive symptoms among parents with mentally retarded children

Source	Type III Sum of Squares	Df	Mean square	F	Sig.	Partial Eta Squred
Corrected model	475.499	3	158.500	2.131	.106	.101
Intercept	68808.559	1	68808.559	925.076	.000	.942
Coping Strategies	59.707	1	59.707	.803	>.05	.014

The ANOVA as shown in table II, coping strategies has non-significant influence on depressive symptoms among parents with mentally retarded children F (1, 57) = .803, P> .05. This means that parents with mentally retarded children who adopted emotion-focused coping strategy were found not to be different from those who adopted problem-focused coping strategy on the presentation of depressive symptoms. Thus, hypothesis 2 was rejected.

Summary of Findings

The findings of this study were summarized thus:

1.) There was a significant difference in depressive symptoms between parents of mentally retarded children and non-retarded children.
2.) There was no significant difference in depressive symptoms among parents of mentally retarded children who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy.
3.) There was no significant difference in depressive symptoms between parents of mentally retarded children and non-retarded children who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy.

VII. DISCUSSION

The finding that showed significant difference in symptom presentation between parents of mentally retarded children and non-retarded children supported the first hypothesis which stated that there would be a significant difference in depressive symptoms between parents of mentally retarded children and those with non-retarded children was accepted. The results showed a significant difference in depressive symptoms between parents of mentally retarded children and parents of non-retarded children. Parents with non-retarded children persisted more depressive symptoms. This result is in contrast with Ifeagwasi (1992).

The parents of non-retarded children who experienced socio-economic problems and challenges may believe that discussing their family problems will bring derogation and place them in an inferior position among their peers. Thus, the parents internalize their emotional trauma which may begin to manifest in the form of depression. It is known that free association of feelings or ventilation brings about emotional relief and is highly therapeutic. But, when one begins to hold back experiences especially awful ones, it may result in pathology.

This outcome could be that parents of non-retarded children face a multitude of challenges, stress & anxiety (Cherry, 2012; Minnes, 1988) than the parents of mental retardation. They were left with their family problems all alone. Friends and family members may not understand the special needs of a normal child (Friedrich, Greenberg, & Crnic, 1983) and thus, may not be able to provide the childcare support often available to less privileged parents with more young children. It is often more challenging and demanding for parents with children to go out with them into the community for shopping, church activities, enter into commercial vehicles or other family outings begging for arms (Kazak & Wilcox, 1984). Still more, among the challenges frequently faced by the parents of non-retarded children is that they are subjected to training their children alone (Omuru nwa zubanwaya). As a matter of facts, parents of normal children are not often sensitive to Igbo slogan "omuru nwa zubanwaya" meaning whoever that gives birth to a child should train the child. The popular Igbo adage "ozuzu zuchaa, onyenwenwa nwenwa" (that after training a child that is not yours, the owner will take over to enjoy the fruit of the labor) was applied here. Invariably, these negative influences drawn may have affected the parents of normal children adversely making it difficult to get support hence they go into depression.

Similarly, parents of non-retarded children often express concern on socio-economic situations in Nigeria which is biting hard on the parents regarding balancing the needs of a child with those of other siblings. It is natural for parents to try to invest a great deal of time, energy, and strain into the child with the most significant needs (Harris, 1994).

A Socio-economic problem has been shown to affect the personality of the individuals. The individual has been described as low-self esteemed and helpless (Hilberman & Munson, 1977), unassertive, shy and reserved (Weitzman & Dreen, 1982). Thus, these personality traits could be likened to major traits associated with the depressed as posited by Beck's (1967) Cognitive Theory of Depression. According to the theory, the depressed is unassertive and has negative assumptions about themselves, their situation and their future. According to Myers (1987), these self-defeating beliefs may raise from learned helplessness, a feeling that develops from repeated experiences of uncontrolled negative life events (E.g. hardship). The parents may

become passive, withdrawn and depressed. This should not be the case since marital relations are meant to enhance the well-being of partners and not to devalue or devastate them. Thus, couples need to be advised to find more healthy approaches to the resolution of their situations, finances and differences rather than resort to negative tendencies. However, these negative tendencies supported the present findings of this study that there would be a significant difference in depressive symptoms between parents of mentally retarded children and those with non-retarded children.

The second hypothesis which stated that there will be a significant difference in depressive symptoms between parents of mentally retarded children who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy was rejected. This shows that adopting different coping strategies did not affect the depressive symptoms of the parents. This is in line with studies on coping strategies and psychopathology (Abbott & Meredith, 1986; McCubbin & Patterson, 1983).

Coping strategies which are stress-modulators can become etiological factors in psychopathology when they are maladaptive (Judge, 1998). Judge, asserted that since coping strategy appears to be an important modulator of stress; it will presumably have some influence on the etiology and maintenance of psychological disorders like anxiety and depression. This seems probable because when a stress modulator becomes ineffective it will invariably turn into a stress-illness mediator. Thus, emotion focused coping strategies which are avoidance mechanisms in nature, did not prevent parents of mentally retarded children from seeking solutions to their problems thereby did not also encourage the omnipresence of conflict in their lives. This invariably results in no significant measure in the findings of this present study which indicated no significant difference in depressive symptoms between parents of mentally retarded children who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy.

Based on the above observation, it is advocated that problem-focused coping strategies which are action and solution oriented and emotion-focused coping strategies which are avoidance oriented should be adopted to forestall depression depending on the level of acceptance of the conflict. This should be applicable not only to the parents of mentally retarded children and non-retarded children but to all and sundry because life is nothing more than coping process and to cope effectively, adaptive strategies must be adopted to ensure healthy living. Parents who used problem-focused were found not to be different from those parents who used emotion-focused coping strategy. The lack of difference in depression could be attributed to the two groups maintaining cognitive consonance.

Subsequent results indicated that hypothesis 111 which stated that there will be a significant difference in depressive symptoms between parents of mentally retarded and non-retarded who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy were rejected. The result indicated that there is no significant difference in depressive symptoms between parents of mentally retarded and non-retarded who adopted problem-focused coping strategy and those who adopted emotion-focused coping strategy. These findings have shown that among these parents who had mentally retarded children and those with non-retarded children, adopting different ways of managing the situation (coping strategies) did not make them to present symptoms of depression.

This outcome indicated that the findings are not consistent with the studies on coping strategies and psychopathology (Folkman & Lazarus, 1980; Long, 1985 and Moos 2008). Similarly, the findings of Bailey & Smith, (2000) indicated that problem-focused coping strategies are found to be more effective than emotion-focused coping strategy in reducing stressors. This is in line with Ebata & Moos, (1994) and Cherry, (2012). This inconsistency could be because more parents coped by invoking their religious faith or other emotion-focused strategies as they adapted to circumstances that would not change (Gray, 2000; Abbott & Meredith, 1986).

Therefore, Nigerian parents especially in South-Eastern Nigeria where this study was carried out might have attributed the condition to external factors. The mental retardation could be attributed to enemies, forces, environment and relatives other than accepting the responsibility. These actually made them to cope effectively unlike in the Western culture where people usually make internal attribution. Consequently, in Igbo culture critical conditions like mental retardation are seen in light perspective. For instance, an individual would be in critical condition when asked 'how are you?' instead of telling you the situation report, the individual would reply 'fine', 'all is well', 'no problem', 'I am okay', and 'Thank God' etc. Yes, this is an average Igbo person for you who believes that any problem is a stepping stone. The individual would not allow any problem to weigh him down. The person believed that tomorrow would be better than today. A typical Igbo person is very optimistic no matter the condition. It could be inferred that use of encouraging words lead to reductions in stress, depression, and anxiety for parents of mentally retarded children as well as increase life satisfaction. It is therefore being suggested that the attributes should be applicable not only to parents of mentally retarded children but also to all and sundry because life is nothing more than coping process and to cope effectively, efficaciously, and positively, adaptive strategies must be adopted to ensure healthy living.

Implications of the Findings

The previous observations about parents of mentally retarded children not showing enough coping strategy; rather reported higher levels of depression, and stress has been debunked. The observations about coping with a mentally retarded children start with parents of such children who initially may show denial, conflict, and resistance. Their dispositions towards manifesting depressive symptoms have been overcome during the initial phase of denial and conflict of living with a mentally retarded child.

Thus this study seems to be the first study that has considered parents of these mentally retarded children. Many studies as reviewed focused on the children and their psychological well-being; without considering the caregivers (parents). As the result indicated, this study contains useful information regarding parental coping strategies. The information is important for other parents who have children with intellectual disabilities and the professionals, psychologists, who help these families with mentally retarded children.

The mentally retarded children/persons are everywhere. There is no nation on earth without the problem of mental retardation. The mentally retarded persons exist side by side with normal persons.

VIII. CONCLUSION

This study indicated that the parents of the mentally retarded children attending school at the T.D.C.C., Evami Special School and UNTH (CHOP & OPD sections) Enugu, have really made progress in their efforts to accept the reality of their children conditions or come to terms with taking care of their mentally retarded children. The findings revealed that parents with normal children presented more depressive symptoms than parents with mentally retarded children. This may be as a result of free association of feelings or ventilation experienced by parents of mentally retarded children which brought about emotional relief and is highly therapeutic. But, when one begins to hold back experiences especially awful ones, it may result in pathology. The findings also revealed no significant influence of coping strategies on depression among parents with mentally retarded children. The findings are just a spring board in Nigeria for the study of parents of mentally retarded children.

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