Role of Gender and Education in Parental Attitude towards Mental Retardation

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Abstract

The aim of present study is to find out the differences in the attitude of parents towards mental retardation. Two groups of parents were included in the study: one group comprised of parents of mentally retarded children, while the other comprised of parents of normal school going children of the same age group. Female parents in both the groups were found to have a more negative attitude towards the disability than male parents. Education of parents also had an impact on their attitude, with graduate and post graduate parents having a more positive attitude than those educated up to the X and XII level.

KEYWORDS: Mental retardation, parental attitude, gender, education

Introduction

Society places a huge emphasis on intelligence and scholastic ability in children, both of which are considered important for success in life. In a fast changing world, school grades and pay cheques are considered prime parameters of accomplishments, and those who do not, or cannot, stand these tests are treated as second-grade citizens. In its mad gold rush, people often neglect those unfortunate among us who are weak, or differently abled, and push them out of the mainstream. Much of the apathy towards the disabled comes from a lack of understanding of their problems and the corrective steps that can be taken to improve their conditions. It is not just the broader society but also parents of disabled children who lack appreciation of the genesis and outcome of the problems that makes matters worse.

Disability is said to be the disturbance in performance of social roles that would be normally expected of an individual in the habitual milieu, arising in association with diagnosable mental disorder (Jablensky, Schwartz and Tomov, 1980). One such highly prevalent disability among children is mental retardation. The American Association on Intellectual and Developmental Disabilities (AAIDD, 2010) (formerly American Association of Mental Retardation/AAMR) lists three criteria for an individual to be considered as mentally retarded: intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition manifests before the age of 18. Adaptive skills are those that are required to live and interact with the society in a meaningful way. AAIDD has included ten adaptive skills with regards to mental retardation: communication, self-care, home living, social skills, leisure, health and safety, self-direction, functional academics, community use, and work. AAIDD defines mental retardation as ‘a significantly subaverage general intellectual

functioning, resulting or associated with concurrent impairment in adaptive behaviour and is manifested during the developmental period' (AAIDD, 2010).

According to the World Health Organization (WHO), 10% of the world's population has some form of mental disability and 1% suffers from severe incapacitating mental disorders (WHO, 1989). In India however, there is a huge variation in the data for the occurrence of mental disability gathered by different sources. Such was the neglect of the problem that after independence, there was no concrete data to suggest the prevalence of the mental disabilities in the country. The first major mental health survey in India was undertaken only in 1961 under the aegis of ICMR in Agra on a sample of 29,468 (Shah, Parhee, Kumar, Khanna, & Singh, 2005). ICMR then organized a multi centric collaborative study from 1976-83 on severe mental morbidity at four centres in India – Bangalore, Baroda, Calcutta and Patiala – and estimated the prevalence at 9.4 persons per 1000 population (Shah et al, 2005). The National Sample Survey Organization report estimates the prevalence of mental disabilities in India to as little as 0.2% (NSSO, 2003). A meta-analysis of community-based surveys conducted during the past two decades in India showed the prevalence of psychiatric disorder at around 5.8%. (Reddy & Candrashekhar, 1998). This highlights the need for more concerted efforts in the study and rehabilitation of people suffering from such disabilities.

The birth of a mentally deficient child causes a lot of agony and disturbance in the family. There is a feeling of shame and guilt, and many a times of shifting blame among the parents (Rangaswami, 1995; Drew, Logan, & Hardman, 1984). The male dominated society is quick to accuse the mother, holding her responsible for the child's deficiency. Out of shame and embarrassment, families prefer to keep their mentally deficient children socially isolated. This only aggravates the problem as it affects the overall development of the child (Rastogi, 1981). Parental attitude and social interaction are both important for the healthy development of every child, normal or deficient. But such behaviours are the fallout of rejection of the deficient child by community groups of which he/she is, or aspires to be, a member. This leads to a conflict between love and hate for the child, often resulting into feelings of guilt and consequent rejection (Kanner, 1953; Zuk, 1959).

Parental attitude is not only important for the adaptation of the deficient child, but it also shapes the attitudes and personality of siblings in the family (Frude, 1992). In fact, the personality and lifestyle of all members of the family are affected by the arrival of a mentally retarded child (Weingold & Hermuth, 1953). The objectives of the study are stated as follows:

1. To investigate any differences that may exist in the attitude of parents of mentally retarded and normal children towards the deficiency.
2. To study the effect of gender of parents on their attitude towards mental retardation in children.
3. To study the effect of education of parents on their attitude towards mental retardation in children.

Findings of the study would facilitate the understanding of the problem from a broader perspective.

Method

The study was conducted on a sample of 60 parents, 30 of mentally retarded and 30 of normal children, from schools in the same vicinity in Aurangabad city, Maharashtra. A questionnaire was prepared that covered various aspects of a child's mental retardation and administered to the sample with prior permission of the school authorities.

Material

A 10 item questionnaire was prepared, with each statement in English and Marathi, followed by 'Yes/No' type answers (see Appendix 'A'). The statements dealt with issues like perceived causes, fallouts, implications, emotional aspects, and social-familial effects of the problem. A psychiatrist, counselor, social worker, and 2 teachers from a special school were consulted before and after constructing the questionnaire. The most common and pronounced issues in dealing with mental retardation of children were included in the questionnaire. All 'Yes' responses were awarded 1 mark and 'No' responses zero. The marks were added to give a total score.

Sample

Three schools in Aurangabad city (Mah) were selected for generating samples. One was a school for special (retarded) children, while the other two were regular day schools. All the schools were run by Christian missionaries and were in the same locality, and the parents of children in the schools were from relatively similar socioeconomic strata. 30 students in the age group 10 to 12 years were randomly selected from the special school and 15 each from the two regular schools from the lists made available by the teachers. Although an attempt to create a random sample within the available respondents was made, the hue was definitely purposive.

Results

No difference is observed in the attitude of parents of mentally retarded children ($M=3.13$, $SD=1.96$) and those of normal children ($M=2.9$, $SD=1.6$), $t(58) = 0.504$, $p>0.05$. On further analysis, it is seen that there are gender differences in parental attitude with female parents (mothers) having a more negative attitude as compared to male parents (fathers). A 2*2 ANOVA shows that there is a significant difference in gender-wise parental attitude towards mental retardation, $F(1,3) = 8.345$, $p<.001$. Mothers of mentally retarded children ($M=4.36$, $SD=1.69$) had the most negative attitude, followed by mothers of normal children ($M=3.67$, $SD=1,78$). Fathers of mentally retarded children ($M=2.06$, $SD=1.53$) and normal children ($M=2.13$, $SD=1.36$) shared almost similar attitudes towards the disability. Tukey's post-hoc test revealed that male-male or female-female differences in attitude did no exist across the two groups, but that male and female parents of both types of children differed significantly with parents of the opposite gender irrespective of the mental status of their children.

The level of education of parents was found to have a significant effect on the attitude towards mental retardation, $F(1,3) = 8.345$, $p<.001$. Post-graduate ($M=2.0$, $SD=1.05$) and graduate ($M=1.95$, $SD=1.7$) shared a more positive attitude towards mental retardation than those who had 10+ level education ($M=3.94$, $SD=1.57$). Parents who had not completed education upto the 10^{th} standard ($M=4.21$, $SD=1.19$) had the most negative attitude towards the disability. Tukey's post-hoc test revealed that there is no difference

in the attitude of graduate and post-graduate parents, or between 10+ and below 10th standard educated parents. However, both graduate and post-graduate parents had a significantly better attitude towards the disability than the 10+ and lower than 10th educated parents.

Table 1 Mean and SD for Parents' Attitude towards Mental Retardation

Parent Type	Gender	Mean	SD	N
Parent of Mentally Retarded Children	Male	2.06	1.53	16
	Female	4.36	1.69	14
	Total	3.13	1.96	30
Parent of Normal School Children	Male	2.13	1.36	15
	Female	3.67	1.78	15
	Total	2.9	1.6	30

Table 2 Tukey's Post-hoc Test for Gender Differences in Parental Attitude towards Mental Retardation

Parent Type	Parent Type	Mean Difference	Sig
MRC-M	MRC-F	-2.29	0.001**
	Norm-M	-0.07	1.00
	Norm-F	-1.60	0.02*
MRC-F	MRC-M	2.29	0.001**
	Norm-M	2.22	0.001**
	Norm-F	0.69	0.61
Norm-M	MRC-M	0.07	1.00
	MRC-F	-2.22	0.001**
	Norm-F	-1.53	0.04
Norm-F	MRC-M	1.60	0.02*
	MRC-F	-0.69	0.61
	Norm-M	1.53	0.04*

MRC-M: mentally retarded child's male parent; MRC-F: mentally retarded child's female parent; Norm-M: normal child's male parent; Norm-F: normal child's female parent; Sig: * $p<0.05$; ** $p<.01$

Table 3 Education-wise Mean and SD for Parents' Attitude towards Mental Retardation

Level of Education	Mean	SD	N
<10	4.21	1.19	14
10+	3.94	1.57	16
Graduation	1.95	1.70	20
Post-graduation	2.00	1.05	10

Table 4 Tukey's Post-hoc Test for Education-wise Differences in Parental Attitude towards Mental Retardation

Level of Edu	Level of Edu	Mean Difference	Sig
<10	10+	0.28	0.95
	Grad	2.26	0.001**
	PG	2.21	0.001**
10+	<10	-0.28	0.95
	Grad	1.99	0.001**
	PG	1.94	0.01*
Grad	<10	-2.26	0.001**
	10+	-1.99	0.001**
	PG	-0.05	1.00
PG	<10	-2.21	0.001**
	10+	-1.94	0.01*
	Grad	0.05	1.00

* p<0.05; ** p<.01

Discussion

Attitudes are formed through our interaction with society. Both gender and education are cultivated and transmitted by social agents, and being social constructs, it is apparent that these attributes would influence our attitudes. In the present study, differences are observed in the parental attitude towards mental retardation as an effect of gender and education.

Gender does not refer to the biological differences between males and females, rather it is considered to be a sociocultural construct used to describe the characteristics we ascribe to people because of their being male or female. These sociocultural constructs are formed by social roles, traditions, history and mythology, religious prescriptions, and a host of such factors (Lobel and Menashri, 1993; Marcus and Overton, 1978; Martin and Little, 1990). It is since birth that these differences occur, like the traditional practice of putting on pink coloured clothes to girls and blue coloured clothes to boys in many cultures. Even toys are determined by the gender of the child, with girls getting dolls to play with, while boys receiving cars (Carter and Levy, 1988; Emmerich and Shepard, 1984).

As children grow into adults, they not only learn gender specific roles, but also internalize them. They start behaving in ways and manners in which their gender is expected to. Their attitudes are similarly shaped by their gender, which includes the sociocultural expectation associated with their gender. It is for this reason that we see the as a group, parents do not differ significantly in their attitude towards mental retardation in children, but when a deeper analysis in lines of gender is made, the rift is seen wide open. Female parents of both normal and mentally retarded children are seen to have a more negative attitude towards retardation than their male counterparts. So having a retarded or normal child does not seem to affect the attitude of parents as much as their gender does. In other words, the study has found that even female parents of retarded children have a negative attitude towards the disability, while male parents of retarded

children have a more positive attitude. Post hoc results clearly show that within male-male and female-female groups, there is no significant difference in attitudes.

One of the reasons why mothers are having a highly negative attitude towards the disability could be because of societal attitude to put onus of the disability, or for that matter any disability, on the mother (Jamison, 1965). In fact, despite clear evidences in science that the sex of the child is determined by the X or Y chromosome of the father, society still 'blames' the mother for it. Women are also blamed for infertility in the absence of conception, even though this is medically unverified (Widge, 2001). Such attitudes in society make women feel vulnerable to blame and criticism, which in turn can make them, develop hostile attitudes towards such problems. Analyzing some of the responses helps us better understand the gender divide towards the disability. While 12% male parents saw retardation as a curse, 68% of female parents thought so. The fear of conceiving a retarded child is also more pronounced in women than men, with only 28% of men believing that having a mentally retarded child increases the chances of having other children retarded too, while 94% of women in the survey had this belief. Similarly, 18% men believed that mentally retarded children were a negative role model for other children, while 78% of women thought so.

Education allows us to comprehend the world in a more coherent and meaningful way. Education instills in us a desire to seek rational answers to our problems, however mundane. Perceptions are but meaningful interpretations of the events that occur around us. They are guided by our culture, experience, knowledge, and a host of cognitive functions. An educated person would rely more on factual information than faith in ascribing causes to events. In the present study, parents who have completed their graduation and post-graduation are seen to have a less negative attitude towards the mental disability than those parents who are educated upto the S.S.C. (X) or H.S.S.C (XII) level. This shows that education has a positive impact on social attitudes. Educated parents are less likely to view mental retardation as shameful or retarded children as being very different from normal children. They do not seem to carry the guilt or blame of the disorder that uneducated parents do.

Some of the questions in the present study exemplify the role of education in the formation of social attitudes. For the statement 'Mentally retarded children cannot take care of even their basic needs', 84% of parents from the graduate-post graduate group answered in the negative, while 100% of parents in the X-XII group answered in the affirmative. Similarly, 78% of the graduate-post graduate parents saw mental retardation as any other illness, while 92% of the X-XII educated parents saw mental retardation to be different than other illnesses. While 68% of graduate-post graduate parents believed that mentally retarded children can understand and express emotions, only 12% of X-XII educated parents thought so. These differences in attitudes show that education definitely helps understand the disability in a more rational and humane way.

References

AAIDD (2010). American Association on Intellectual and Developmental Disabilities published 'Intellectual Disability: Definition, Classification, and Systems of Supports' (11th Ed). Washington, DC: AAIDD manual.

Carter, D. B., & Levy, G. D. (1988). Cognitive aspects of children's early sex-role development: The influence of gender schemas on preschoolers' memories and preferences for sex-typed toys and activities. *Child Development, 59*: 782-793.

Drew, C. J., Logan, D. R., & Hardman, M. L. (1984). *Mental Retardation – A Lifecycle Approach.* Toronto: Times Mirror/ Mostle College Publishing.

Emmerich, W., & Shepard, K. (1984). Cognitive factors in the development of sex-typed preferences. *Sex Roles, 11*: 997-1007.

Frude, N. (1992). *Understanding Family Problems: A Psychological Approach.* Chichester: John Wiley.

Jablensky, A, Schwartz, R., & Tomov, T. (1980). WHO collaborative study on impairment and disabilities in schizophrenic patients: A preliminary communication- objectives and methods. *Acta Psychiatr Scand Suppl* 62: 285. In Thara, R., Rajkumar, S., & Valench, V. (1988). (eds) Schedule for assessment of psychiatric disbility: A modification of DAS-II. *Indian Journal of Psychiatry,* 13: 47-53.

Jamison, J. W. (1965). Impact of mental retardation on the family and some directions of help. *Journal of the National Medical Association*, 57 (2): 136-138.

Kanner, L. (1953). Parent's feelings about retarded children. *American Journal of Mental Deficiency*, 57: 375-384.

Lobel, T. E., & Menashri, J. (1993). Relations of conceptions of gender-role transgressions and gender constancy to gender-typed toy preferences. *Developmental Psychology, 29*: 150-155.

Marcus, D. E., & Overton, W. F. (1978). The development of cognitive gender constancy and sex role preferences. *Child Development, 49*: 434-444.

Martin, C. L., & Little, J. K. (1990). The relation of gender understanding to children's sex-typed preferences and gender stereotypes. Child *Development, 61*: 1427-1439.

Mental Health Research in India: Technical Monograph on ICMR Mental Health Studies. New Delhi: ICMR Pub.

NSSO (2003). National Sample Survey Organization: A report on disabled persons. New Delhi: Department of Statistics (GOI).

Rangaswami, K (1995). Parental attitude towards mentally retarded children**.** *Indian Journal of Clinical Psychology*, 22: 20-23.

Rastogi, C. K. (1981). Attitude of parents towards their mentally retarded children. *Indian Journal of Psychiatry*, 23(3): 206-209.

Reddy, M. V. & Chandrasekhar, C. R. (1998). Prevalence of mental and behavioural disorders in India: A meta-analysis. *Indian Journal of Psychiatry*, 40: 149-57.

Shah, B., Parhee, R., Kumar, N., Khanna, T., & Singh, R. (2005). Mental Health research in India- Technical monograph on ICMR mental health studies. New Delhi: ICMR pub.

Weingold, J. T. & Hermuth, R. P. (1953). Group guidance of parents of mentally retarded children. *Journal of Clinical Psychology*, 9: 118-129.

WHO (1989). World Health Organization report on Training in the community for people with disabilities. Geneva: WHO pub.

Widge, A. (2001). Sociocultural attitudes towards infertility and assisted reproduction in India in "Current Practices and Controversies in Assisted Reproduction: Medical, Ethical and Social Aspects of Assisted Reproduction". Geneva: WHO Pub.

Zuk, B. (1959). Autistic distortions in Parents of retarded children. *Journal of Consulting Psychology*, 23: 171-179.