ANALYSIS OF MOTHER’S PSYCHOLOGICAL ISSUES OF CHILDREN HAVING EITHER AUTISM OR DOWN SYNDROME

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ABSTRACT

The analysis was conducted to compare the level of Psychological issues among the mothers whose children have either Autism disorder or Down syndrome. The review of literature collected was compared to the present study. The tool selected for this research was Mental health inventory developed by Jagadish and A.K Srivastava. Totally 60 subjects were taken for this study and disturbed as 30 mothers of children with Autism disorder and 30 mothers of children with Down syndrome. Purposive sampling technique was used for collecting the data.

The validity of the tool has been, already established by the author. The pilot study was conducted on 30 subjects (15 mothers of children with Autism and 15 mothers of children with Down syndrome) to test the reliability of the tool. Fifteen hypothesis were formulated for collecting and analyzing the data. The data collection was done in four ‘special’ schools. They were located at Alwarpet, Raja Annamalaipuram, Besant nagar and Neelankarai. The test was administered to mothers of children with either Autism or Down syndrome. It took almost a month to finish the data collection. The collected data was tabulated and statistically analyzed. The formulated hypothesis was tested and the conclusions were drawn from the findings.

Keywords: Down Syndrome, Autism, Mosaicism,

I. INTRODUCTION

1.1 ‘Special’ child in the family

This is the spirit with which every human being has to live one’s life. Insurmountable problems can be varied for different individuals. One such could be nurturing a ‘Special’ child. The serenity to accept it has a lot to do with one’s mental makeup.

Excitement and happiness surrounds when a baby is born. That excitement comes to an end when the baby is diagnosed with either physical or mental disability. The family undergoes a different mental state after the birth of the baby. Physical abnormality or mental abnormality the change is similar. Nurturing a child with mental disability is a huge challenge for the parents and the family. Conflicts raise when parents are forced to support a child with limited psyche. The expectations of the world along with the chaos inside the family leads to a stressful life. The stress created worsens the situation instead of developing positiveness.

Giving birth to a child with mental disability is one of the most difficult parenting experiences. Parent’s realization leads to unhappiness and sadness, which is reflected in the form of shock, guilt, anger, desperation and anxiety. Individuals handle these situations in different ways. Most of them face social rejection, embarrassment and ridicule. Almost all the parents who have a “special” child suffer from chronic sorrow throughout their lives. The degree of sorrow differs from each other. That reaction differences is based on economic status, personality
traits, marital stability. Common initial response in emotional disintegration, some parents cannot cope beyond the initial stage of disintegration.

Number of practical problems have to be faced by the parents while nurturing a “special” child. Challenged children are demanding in nature. Taking care of them exhausts parents physically and mentally. One of the major mentally exhaustive challenge for parents is financial strain. Medical expenditures, special equipment, education and caretakers blow a huge hole in their wallets. The mothers of “special” faces a great challenge than their counterpart. Managing the daily needs of child is time consuming and exhaustive. The presence of a special child in a family creates a great impact on the functioning of family and affect the parents unconsciously. The parents are challenged to give their “challenged” child 24/7.

**Autism Features**

The distinct feature of a Autism is the impairment or abnormal development in social interaction, social communication, limited activity and interests. Indications of the disorder vary greatly of the age of the individual. Autism disorder is sometimes referred as early infantile autism, childhood autism or Kanner’s autism. The impairment in reciprocal interaction is sickness. To regulate social interaction and communication, multiple non-verbal behaviors are introduced (ex: facial expressions, posture and eye contact). Common inability identified in autism disorder is the ability to develop peer relationships, appropriate to the developmental level. The interest in establishing peer relationship differs according to the age. Younger individuals have little or no interest in finding a partner or friend. Older individuals have the desire to find a friend or partner is halted due to their inability to react spontaneously and share their feelings for others (ex: not appreciating, failure to empathize, inability to understand cues). The lack of social and emotional reciprocity leads to development of certain behaviors like, preference towards solitary activities, involving others as a mechanical aid or support. Individuals with this disorder fails to realize the need of others and unable to notice stress and pain among their peers.

The impairment of communication affects both verbal and non-verbal skills. Most of the individual fails to develop communication skills. In few scenarios individuals learn to communicate in their later stage. Those who learned to communicate have impairment in constructing coherent sentences, sustain in a conversation, repetitive usage of same words, inability to answer a question, failure to guide directions, inability to react for a joke and idiosyncratic language. Individuals with autistic behavior often have repetitive, restricted, predictable and textbook behaviors. Those individuals indulge in non-functional rituals, unproductive rituals, repetitive mannerisms and unhealthy friendship towards objects and non-living things.

**Associated disorders**

In most cases there are symptoms of mental retardation. Approximately seventy five percent of children with Autism Disorder suffer from mental retardation and functions like retarded. Their IQ ranges from 35-50. They also develop a range of behavioral symptoms such as Down Syndrome. Down Syndrome is a condition with chromosomal abnormality. The individuals suffer from Down Syndrome is usually identified shortly after their birth. Human body is made of cells called nucleus in the center. The function of nucleus is to store genetic material. The stored genetic materials are called genes. These genes are responsible for our inherited traits and characteristics. Genes are grouped together and called as chromosomes. They are grouped in X like structure. The nucleus contains 46 chromosomes. 23 chromosomes are inherited from our mother and 23 chromosomes are inherited from our father. Down syndrome is a result of additional chromosome. The extra chromosome occurs in the chromosome pair number 21. Trisomy 21 is the presence of 3 chromosomes, instead of two in pair 21. 95 % of Down Syndrome occur because of Trisomy 21.

**Types of Down Syndrome**

Non disjunction

Non disjunction happens either during conception or prior to conception. When the 21st pair of chromosome fails to separate either in the ovum or the sperm results in an embryo with three numenthe 21 chromosome instead of two. The extra cell in the chromosome replicates itself in every cell of the body when the embryo develops. This process leads to 95 % of all cases of Down Syndrome.

**Mosaicism**

[www.turkjphysiotherrehabil.org](http://www.turkjphysiotherrehabil.org)
Mosaicism occurs when nondisjunction of the 21st chromosome takes place in one of the initial cell incisions after fertilization. After fertilization some cells end up containing 46 chromosomes and some cells containing 47 chromosomes. Due to mosaic like pattern of the cells the term mosaicism is used. The cells containing 47 chromosomes is responsible for Down Syndrome. Mosaicism is responsible only for 2% of all cases in Down Syndrome.

Translocation

Translocation occurs only in 3-4% of people with Down Syndrome. When a part of the pair 21 chromosome detach itself during cell division and attached to another chromosome leads to Translocation. The detached cell attaches itself to the pair 13, 13, 21 or 22. This extra chromosome causes features of Down Syndrome.

Clinical Features

- The baby is short statured and has defective articulation with a guttural low-pitched voice.
- Muscle hypotonia, low muscle tone
- The baby has a small head (brachycephaly)
- Flat facial profile, a somewhat depressed nasal bridge and a small nose.
- There are extra folds of skin over the upper eyelids (epicanthal folds).
- Oblique palpebral fissures, an upward slat to the eyes.
- Dysplastic ear, an abnormal shape of the ear.
- A single deep crease across the center of the palm. The hands are short and broad and have a single crease on the palm (simian crease).
- Hyperflexibility, an excessive ability to extend the joints.
- The fifth finger of the hand is curved in (clinodactyly).
- Excessive space between large and second toe.
- Enlargement of tongue in relationship to size of mouth.
- There are associated abnormalities of the heart

Down syndrome and associated medical problems

- Cognitive hypothyroidism
- Reduced basal metabolism
- Enlargement of thyroid gland
- Disturbance of autonomic nervous system.
- Hearing less
- Congenital heart disease
- Vision disorder
- Hypotonia or poor muscle tone
- Atlanto axial instability (malformation of the upper part of the spine)
- Mental retardation

**Problems faced by mothers of children with Down Syndrome**

- Mothers of children who are affected by Down syndrome have to contend with the child’s level of mental retardation and delayed milestones.
- A child with Down syndrome can have severe mood swings and can be emotionally draining on the other.
- Congenital problems of the child with Down syndrome can be an added anxiety for the mother.
- Poor muscle tone of the child with Down Syndrome may need the mother to assist physically in a big way. This could become physically exhausting on the mother.

1.4 Mental health

Mental health is an important component of an individual’s overall health and wellbeing. It is important to maintain good mental health as it is to maintain good physical health.

Mental health is a state of successful performance of mental functions resulting in productive activities, fulfilling relationships with other people and the ability to adapt to changes and to cope with adversity.

Mental health refers to a person's ability to deal with events in his daily life, his functional responsibility in society and his experience of personal satisfaction and enjoyment. It includes a sense of self-esteem as well as a feeling of contentment and inner peace. Mental health is necessary for the complete functioning of the human mind. As it is a basic condition for the growth of the mind.

Mental or emotional health is something everybody has. It includes how people feel, think, behave and also what people think about themselves.

**Definitions**

World Health Organization (W.H.O) defines mental health in terms of ‘complete physical, mental and social well being and not the mere absence of diseases or disability’.

According to Goldensen(1920) mental health is the ability to handle everyday demands and situations without excessive strain and stress. A person who is mentally has a sense of well being and functions effectively in life. He can work quickly, think clearly, manage his emotions, enjoy life and be on reasonably good terms with most other people.

Klein (1960) defines mental health in terms of integrated personality, which is manifested in terms of emotional maturity, integrated self concept and the capacity to deal with emotional problems.

Chaplan (1961) defines mental health as the ‘capacity of an individual to solve his problems in a socially accepted way’. **Dimensions of mental health**

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Emotional health
↑
Social health ← Mental health → Intellectual Health
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Spiritual Health
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Emotional Health
This deals with healthy feelings, one has towards oneself, others and to life situation. An emotionally healthy person is able to understand his/her emotions and express them appropriately. Such individuals can adjust to change, solve problems and cope with life successfully.

Intellectual Health
This deals with a person’s ability to make effective use of his or her intellectual capacity. To perform such functions as, evaluating information and taking decisions.

Social Health
This deals with person’s ability to perform comfortably and effectively in a variety of social roles. This requires ability to assume responsibility, communicate effectively and adapt successfully to one’s environment. Spiritual Health
This can be expressed through deep religious faith, a feeling of oneness with nature, a sense of inner peace or loving and supportive relationships. They have a purpose in life and are able to experience love, joy and fulfillments.

FACTORS RESPONSIBLE FOR POOR MENTAL HEALTH
a. Hereditary Factors
Sometimes the roots of the mental ailments are found in the defective genes inherited from the parents. Inherited potentialities in terms of intellectual abilities, physiological structure, appearance etc. put limits on one’s mental health and the deficiency and inappropriateness of any sort in these potentialities furnish a fertile soil for the development of mental and nervous diseases.

b. Physiological Factors
Physical health of an individual affects his mental health. Poor health, physical defects, ailments and diseases brings deterioration in one’s strength and stamina for performing one’s duties. It arouses inferiority feelings and mental complexes that creates serious adjustments problems. Improper physical and physiological conditions provides a fertile soil for the growth of poor mental health.

c. Environmental Factors
Social and emotional maladjustment has been found to be the root cause of all mental illness and disorders. Noncongenial environmental conditions at home, neighborhood, community and society have a direct bearing on one’s mental health causing inferiority complexes, unusual conflicts, anxieties and complexes that lead to mental illness ad disorders.

d. Developmental Goals
The act of fixing goals which are unrealistic and faulty may lead to frustration and developmental of poor mental health.

e. Negative Thinking
The impact of negative thinking affect one’s skills, confidence and also develops the fear of failures. All these create stress on one’s performance affecting one’s positive ways of thinking.

Mental Health includes
- Feeling good about oneself and one’s life
- Being able to respond constructively to stress in one’s life.
- Being able to cope with crisis situations.
- Self esteem and confidence.
- How one views oneself and ones future.
• The state of one's mental health affects their relationships, work, responsibilities and commitment. In reality one's mental health is affected by everything and everyone, one has contact with. That means everything in one life can have a positive or a negative affect on one's mental health or emotional wellbeing. Stress, anxiety and depression affect the mental health of mothers who are primary care givers of ‘special’ children.

• Stress

Stress within normal parameters is acceptable for a person's functioning, but when they are too high or for prolonged periods, then the person has to be taught to cope with it. Every individual has a coping capacity. When the stress goes beyond that level, the person could get ill. It's like a scale that needs to balance. What causes stress?

Every individual is different and respond differently to situations. Some people get stressed about matters that do not worry other people.

• Family breakdown
• Death of dear ones
• Too many responsibilities
• Natural calamities
• Deadliness to meet
• Unable to express one's true feelings
• Caring for a child with special needs requirement

Stress can create

• Physical exhaustion
• loss of self confidence
• Depression
• Hair loss
• Skin eruptions

Body's response to stress

• Headaches
• Sore muscles
• Indigestion
• Sleeplessness
• Palpitation

Emotional response to stress

• Nervousness
• Sadness
- Aggression and anger
- Tiredness
- Tension

**Anxiety**

Anxiety is a normal feeling that people have when they are faced with something that could be dangerous, difficult, embarrassing or stressful. The feeling of anxiety can include feeling upset, tense and uncomfortable.

**Depression**

Everyone feels sad and low from time to time; this is normal, but a persistent feeling of ‘sadness’ is damaging to one’s health both physical and emotional.

**Symptoms of Depression**

- Feeling sad and down
- Feeling anxious
- Feeling hopeless
- Feeling empty and numb
- Having no energy
- Feeling lonely
- Being bad tempered
- Unable to sleep properly

**low self esteem and confidence**

Self esteem is how much you value yourself. Most people have days when they value themselves highly, feel confidently and believe in themselves. Some others have doubts and are unsure of their worth. Self esteem and confidence is affected when one is blamed for things that are not due to one’s fault. Constantly comparing themselves to others can give some people low self-esteem. Low self esteem can damage one’s general feeling of well being. Need for this study

Mothers shoulder many responsibilities. They play different roles within the confines of the home and outside too. They handle the role of being the emotional support system for their husbands; are the care giver for the elders at home; carry the major responsibility of being an affectionate mother who moulds her children to be god human being, who have to contribute to society; but not the least she manages her domestic ad career responsibilities too. A ‘special’ child in the family means additional responsibility for the mother, as she is the primary care giver. All of these, take away some of her personal time, leaving her over stressed, anxious and fatigued most of the time. In the long run, it may affect her physiological well being. Compared to other disabilities, mental retardation seems to be the worst, because mentally retarded children become life long dependents for their parents. Beside mental retardation, disabilities like autism, seems to be more complicated. So far, training has been on a trial and error method and no fool proof methodology is available for training these children. Hence the mothers of these children are especially worried about them. These mother are at times frustrated and lose their hope. Children with Down Syndrome seem to have more potential when compared with other categories of mental retardation, as they are educable and trainable to a certain extent. But the mothers of those children too, do not see a ray of hope with reference to the future of their children. Hence these factors may certainly affect their health, physically and psychologically. Therefore with this is mind, the present researcher wanted to find out the psychological well being of the mothers of children with Autism and those with Down Syndrome.
II. REVIEW OF RELATED LITERATURE

Need for the review of related literature

The analysis of relevant literature is an important feature of the research project. A researcher undertakes the survey of literature related to the problem as it gives information. This chapter includes facts, concepts, theories and previous research findings. Significance of the review It allows the researcher to decide the sample size, choose methods, collect data and choose the experimental instruments, analyze and evaluate the findings.

Miller and Keirn (1978) contrasted MMPI profiles of parents of psychologically ill or nonclinically impaired children with MIRPIs (Minnesota's Multiphase Personality Inventory). A sample of fifty (50) mothers and fathers were selected from each group of emotionally disrupted, psychologically disrupted and normal children. Access was given to parental adaptation using MMPI scores. There were high ratings for psychologically retarded and socially troubled mothers. Mothers with children with emotional issues mostly varied from typical children's mothers. In no group did the fathers vary substantially.

Narayan (1978) investigated the effects on their families of emotionally delayed infants. The research investigated the existence and form of difficulties faced in the day-to-day life of parents of mentally delayed children. Forty Four (44) consecutively registered cases (38 boys and 6 girls) of mental retardates aged 6-10 years with tested I.Q., below sixty seven (67) were taken. The tools used were an interview schedule based on that of Tizard and Grad (1961) and a modified form of Leeds Anxiety and Depression Scale of mothers. Mothers of mentally retarded kids were more prone to anxiety and depression. The comparative research on the maternal attitude of retarded children and ordinary children was done by Seth (1979). The results of the study indicate that mothers of children with behavioral retards displayed greater extreme and pathological attitudes than mothers of normal children.

Beckman's (1963) research concentrated on exploring the association between motherreported infant features and tension. Children's characteristics were growth speeds, social reactivity, temperature, repetitive, conventional actions and additional demands on treatment. There were 31 babies and moms in the study. The boy was between 6.6 and 36.6 months of age.

Holmes and Rehe (1967) The instruments used is a resources and stress questionnaire (Holroyd, 1974). Beckman's findings found that the amount of stress recorded by mothers is strongly associated with four of children's traits, temperature, repeated activity patterns of reaction and care demands.

Kazak (1987) studied stress and social networking in three samples in families with handicapped children. 125 parents of handicapped children compared with 127 parents of non-handicapped children from individual surveys about personal tension, marital happiness, scale and density. Only mothers with children with disabilities have had greater burden than parents in comparison. In social network variables, few variations were found.

Donovan (1988) explored mothers' view of family pressures in dealing with autism or psychologically ill teenagers. Study of 36 moms of each party. Samples included. Stress has been assessed by the Stress Capital Questionnaire (QRS) (Fredrich, Greenberg and Crinc). The Wallace marital adjustment short form (locke and Wallace (1959)) was used to assess marital adjustment and the effect of child tension on family working in general. For coping, the coping wellbeing inventory was used as an indicator of parental coping for the type D (McCubbin and Cauble, 1979). Results revealed discrepancies in the category between maternal stress reports. Any comparison of child-related trauma indicates a higher degree of family stress in moms with autistic teens than in mothers with an emotionally delayed teenager. Marital change by party was not different. In comparison, motherhood coping styles across groups were clear, demonstrating that mothers with youth with disabilities relied strongly on community funds and clinical support to cope.

In Singer, et al. (1988), parents of children with serious disabilities received instruction for stress control ad mental retardation. The breadth of skills management instruction was explored as a significant handicap. A recovery group and a waiting list monitoring group were randomly allocated to 36 parents of school children aged 4 to 16 years old with significant disabilities. The intervention consisted of eight self-monitoring courses, incremental muscle relaxing, constructive coping and cognitive reframing. Depression and anxiety measurements increased greatly in the therapy community. The results show that an occupational psycho-psycho-compatibility strategy in the support group may be a successful method for parents to help. For autistic children's mothers
Sandra, N, et.al. (1989) studied greater tension and depression and poorer marital familiarity than for the mothers of average children and the down syndrome children's mothers.

E.M. Livag. (1989) A family stress analysis and dealing with autistic children's mothers and husbands. A research exploring the stresses that cope with families with autistic children attending treatment, participated 13 mothers and 12 fathers. In Step 1, parents answered a questionnaire assessing the demographic profiles of family parents. In Step 2, a Sentence Completion Form and in-depth interviews encouraged parents to respond emotionally to the autistic child and to their reactions to the condition. Content analyzes of the SCF results suggest that households are more vulnerable to autism defects and delays, including speech absence, hyperactivity and tantrum behavior. The permanence of the child's welfare and the concern that the child would never feel normal is a second cause of tension. Two ways of coping, instrumental adaptation and emotional acceptance were established.

Ryde – Brandt and Brita (1990) have researched mothers with children with various disorders with anxiety and protection mechanisms. The hospital anxiety and depression scale (HAD) has been applied to 18 mothers with mentally-administered infants, 18 mothers with motor challenged children, 13 mothers of children with Down's syndrome, and 13 mothers of autistic children. In mothers of psychotic infants, high levels of anxiety were especially frequent. A precept genetic methodology was also used to evaluate all Ss, which illustrated problems triggered by a hostile stimuli and enabled defensive strategies. SSs with such signs of fear and few defensive measures had strong HAD ratings. This response trend was present in 50 percent of mothers who HAD anxiety levels. This mix was exceptional (8%) in children's mothers with other disorders with high HAD anxiety rates.

Steven. J. Etherwise (1990) study has found that mothers of over-the-top hyperactive boys and normale boys within 6 to 9 n years have shown significantly more cumulative tension in their relationship with their children when displaying more behavioural issues than mothers of over-the-top condition hyperactive moms. Moms of the omnipresent have found themselves to be less capable, less constrained and dissatisfied than mothers in charge. Mothers with situational hyperactives showed that their sons had more behavior difficulties and had more parental stress than typical mothers. Standard control mothers have been classified as socially qualified as mothers with hyper-active situational boys.

E.M. Et.al., (1990) analyzed mothers of mentally handicapped children through their perceived load and coping styles. The presumed pressure of the sex of the boy was unlikely to vary. In normal family events, ss reported substantial disturbance. When the children have a lot of similar issues, extreme burden on mental health was recorded by 70.9 percent of mothers. The most common coping styles for the Ss were denial, rehearsal of alternative scenarios, results and quest for help.

Jan. l. Wallander et.al. (1990) examined the contribution to the transition of 119 mothers of visually handicapped children from infant functionality and mammalian psychological stress. Maternal tension was special to the mental health of mothers. In fact, everyday difficulties and disorders leading to emotional tension placed moms at risk for psychiatric problems.

Patricia S1oper, et.al., (1991) investigated that elevated pressures are caused by the psycosomatic symptoms of parents. For mothers the behaviour issues of the children is closely correlated with psychosomatic problems of enthusiasm and level of self-sufficiency. The characteristics of treatment in adult households with autism and down syndrome were studied in Non Homes and Janet Carr (1991). Most treatment was given to the mothers, while fathers primarily assisted them with supervision rather than physical attention or homework. Autistic adults had far more behavioral problems than adults with Down Syndrome. The social pressure faced by mothers of handicapped children was analyzed by Tangri and Verme (1992). The study was made up of mothers with 50 children who were physically challenged and 50 children with mental disorders aged 35 and 70. Physically disabled infants had orthopedic disorders and more average intelligence. It consists of 0 of 24 objects arranged in 6 separate categories: the financial burden, disturbance of family regular tasks, disruption of family recreation, obstruction of family contact. Social burden was used. Impact on other people's physical health and effect on other people's mental health. Moms with children with mental disorders reported greater social burdens than those of children with physical disabilities.

In the family with children with disabilities, Dyson (1993) examined maternal stress and family function over time. In the initial study, 74 (74) out of 100 (110) families took part in this study. Thirty-eight families (38) were from the disability group, and 30 6 (36) were from the non-disability group due to disability in their children.
Resource and stress questionnaire (Fredrich and Greenberg, 1983) and Family Climate Scale were instruments for the study (Moos and Moos, 1981). The findings suggest a greater continuity in the functions of households with autistic children and a limited degree of consistency over time. Families with children with disabilities have been characterized by the extremely higher stress level. Krauss (1993) produced a study which examined whether substantial differences in the amount of child-related and parenting stress existed between mothers and fathers of young children with disabilities. The subjects were 121 mothers and fathers with disabled children. There were 221 mothers. Parenting Burden index, child stimulation scale localus, parent assistance scale, family adaptability and stability appraisal scales 2 and bayley children's growth scales were the instruments used. The personal effects of parental treatment were more traumatic for mothers.

Orr et al., (1993) examined developmentally delayed families with an infant. A pre-school, middle-aged group, and a teenage group were allocated for mothers of children aged 2 to 18 years. In order to assess stress, the parenting Stress Index (Abidin) was used. Four Factor's Social Status Index, Hollingshead's, was used for calculating family social status. There have been results that children from all three classes have been a strong cause of tension for mothers. The second apparent finding was that mothers in the middle childhood community regularly registered higher stress levels than mothers in the other two categories.

Mary Roach and Orsmond (1999) also shown that Down's parents get more treatment than the parents of average child-developing children with challenge and stress linked to their parents (incompetence, depression, psychiatric problems and task restriction). Mothers who reported more childcare obligations, were barely aware of their fitness, function constraints and spousal support.

Anneren and Wikblad (2000) studied children with Down Syndrome and their selfperceived wellbeing. In the survey, fields such as physique, vitality and mental wellbeing were analyzed. Results also shown that children with Down Syndrome mothers have registered far less vitality and mental wellbeing than those children's dads. Hedov.G. Hedov. And Anneren.G (2002) examined parents with Down syndrome and normal control groups in parenthood transition capability. The burden was best handled by those with higher consistency ratings. Moms with children with Down Syndrome were more stressful than moms in regular control groups, impacting their overall mental health.

Greenberg, et al. (2004) studied the consistency and mediation of this impact by dispositional optimism between maternal care providers and adults with disabilities for mother's health. The three classes were Autism, Down Syndrome and Schizophrenia children. Optimism was associated with increased emotional and physical health for all three classes. The results underlined the value for family members in individuals with a disorder in dispositional optimism, a relational advantage virtually overlooked.

Bonjs S. (2016) Stress and parents with children with autism by synthesizing the effect of parents' familiarity of caring for children with autism (ASD) and recognizing the influence of parental stress and decision making on parenthood. Study and procedure guidelines include early detection intervention implementation and parental stress relief intervention

Vernhet C., 2019, Child Autism Spectrum Disorder Coping Mechanisms. To contend with stress, ASD parents we copy techniques to overcome the difficult state of their child's rest.

Disorder De Pape AM, 2015 analyzed the parent's relationship of childcare with the Autism spectrum, an analysis of observational facts, search and electronic data incorporating and abstract review 4,148. 4,148. They established themes of Sir, forecasting, diagnosis, adjustment of the family life, device navigation, parental permission and development. The results will guide the implementation of family programs and resources and offer insight for health professionals.


Mahapatra, Sinha. Rajeshwari. – 2019 The research seeks to decode parent understanding of ASD and to recognize the early signs of ASD awareness in parents pursuing a care that takes their experiences and challenges in the whole process, as well as the challenges of the behavioral condition system. The consequence is lack of understanding and an authentic recovery facility. In order to save time in the diagnosis and initiate timely care on ASD, it is equally important to create a referral and counter referred process.
EWA Picula. – 2012 Parent stress study Mother and fathers with children with emerging disabilities in households of children with down-syndrome disabilities tend to be affected by a variety of stress-related causes, greater stress levels in child parents with developmental disabilities relative to the mother and father with normally child development. Research has found that based on the child's disability, the level of parental tension varies. NimbalkarSomashekhar 2014. Qualitative analysis of the psycho-social problem among parents in two tertiary care clinics in India of children with cerebral paralysis. Exploring the psychosocial concern in rural and urban areas that children with cerebral paralysis face. The parents of children with CP face a wide variety of psycho-social issues

E. Picula 2020. Parenting stress and coping styles in moms and fathers of autistic and down syndrome pre-school children The study analyzed the stress profile in mothers and fathers of autism and down syndrome pre-school children. The finding indicates the parents with children with autism have higher stress levels. In parental stress, mothers rate higher than dad. KS Crittenden, Shin, NV Khan. – 2006 Their finding that mothers has faced more tension from fathers. Mother and fathers with small children with developmental delays in Vietnam Nishi Tripathi (2015) studied parenting and stress of autism spectrum disorders infants. The research focuses on the method of parenting used in children with autism spectrum disorders by parents who were depressed at various stages.

Keller and Sterling (2004) researched tension for school-aged children with disorder between mothers and parents. Trail analyzes found that childhood demands and caring needs are more closely associated with material tension and infant acceptability of parents. Therapists or special teachers who served families with children with disabilities to engage in intervention services to help fathers become more expressive towards their atypical children.

Hastings et al. (2005) analyzed the prediction of depression in moms for maternal tension and positive thinking. Stress in moms was associated with developmental illness of their children (not adaptive or autistic) and the depression of their spouses.

Sabin and Sajid (2005) demonstrated that parents of autistic children endured significant tension. In contrast with husbands, mothers faced more discomfort. In parents with the rising age of children the level of tension was different. In 54 children with ASD (M = 26.9 months), Davis and Carter (2008) revealed children's actions and parenting tension in the mothers and fathers. More parental stress has been documented by mothers and fathers. A loss of social connection in autistic children was linked with complete maternal tension, parent-child issues and mothers’ and fathers’ agony. Problems in mothers were attributed to stress, while habits outsourced to parental stress. IT, contact disruptions and unusual behaviors were not attributed exclusively to parental tension. Medical review of parental tension, identification of disparity between mothers and fathers' autism in their experiences of parenting. Estes et al. (2009) explored the impact of childhood on tension and emotional suffering among moms and dads. The research consisted of mothers and pre-school children matched with ASD (N=51) and emerging lag (DD) (N=22). The results showed that mothers and fathers had higher levels of stress and emotional anxiety than the DD group among the mothers in the ASD group. Increased maternal tension and depressive depression in the mothers in ASD and DD classes is associating children's problem behaviors. The DD party has a better association. The desire to survive on a regular basis was not associated with parental stress or feelings.

Phetrasuwan and Supapak (2009) have found that the main source of parental stress in mothers is behavioural symptoms. There was no connection between the characteristics of the infant and parental tension. Moms that have more maternal burden have more signs of depression and poorer health standards. In his report, Burrows (2010) said that children with autism's mothers and fathers can be overwhelming because of the way that they nurture a child with autism. The quality of life and health of this community will cause this tension. This parents require services to enhance their physical health and well-being (e.g. rest, nutrition, fitness). One of the main techniques used by these parents for handling stress levels efficiently is to commit consistently to physical exercises. Results revealed exceptionally high stress levels for caregivers with children with autism. A reverse week of parental workout involvement (r = 0.16) was observed and physical activity was not exercised (r = 0.24). While these relationships are statistically important (p < 0.05), the association is not strong enough, as shown by their determination coefficients. In future studies, testing is required to determine causality. Future research on the effect of physical exercise, wellness and well-being on depression can help parents identify ways to reduce stress levels efficiently.
Vidyasagar, Nischa and Koshy, Susan (2010) observed that children's mothers who have autism are more stressful than typical children's mothers and more likely to be more stressful when finding social assistance, absorbing or reassessing their condition completely more often than normal children's mothers. The use of confrontational coping for mothers of children with autism demonstrated a significant positive association between stress.

Pottie and associates (2009) analyzed 93 autism parents and reported that higher daily affirmative levels of temperature were related to more poignant and influential support as well as a lower degree of parenting and uncooperative tension. Greater daily depressing mood was related to troubling support and more parental tension, intolerable experiences and disturbing behaviour of children. The stress-mood relationship was moderated by emotional encouragement, unsupportive relationships and upsetting children's behaviour.

The meetings of mothers with an autistic child in the rational design of the qualitative belief have been discussed by Kucuk, Derela, and Bilgin (2010). 43 mothers were interviewed about their encounters with their autistic children in semi-structured fashion. Mothers heard of difficulty and endless anxiety about their child's autism behaviours, their own responsibility and prospects, and about their children's complication in home treatment. A mild to positive association between perceived seriousness’s of aberrant conduct and parental tension was observed in Cheryl Shaffer (2012). Low negative associations were also observed between family support assessments and parental stress, and between future aspirations and parental stress. Unlike the prediction, a low adverse correlation was observed between maternal and parental stress. The most important parental expectations and presumed seriousness of aberrant behavior, reflecting 32% of the overall difference in recorded parenting stress levels.

The relationship between the opinions of the parent pair on the styles of the family and the capabilities of its autistic children, examined by Nuovo and Azzara (2012). The study found that stability, connectivity and happiness in the family system are improved if there is no correlation between intellectual disability and autism. The stability, resilience and the communication level of the family system contribute to higher cognitive abilities in the infant, while verbal and attentive speech and affective language defects are due to unequalled familial workings. In healthy forms of families fewer maladaptive traits were observed in infants. The opposite association between child visual engine imitation and family harmony may be related to a person's difficulties in articulating and detecting the signs of successful imitation in a strongly cohesive structure correctly. The impacts of stressors and assistance for families of people with ASD have been measured by Meadan, Halle and Ebata (2010). The center focuses research into stressors and encourages stress in the following areas: (a) marital subsystem stress; (b) parental subsystem stress; (c) family-based coping strategy; and (d) implicit and structured help sources that families utilize.

Stoddart (2011) has demonstrated that income shortage is related to detrimental effects that could hamper children's growth, more specifically, the development of disabled children. In addition, eminent levels of mother depression, stress and decreased social assistance are attributed to income scarcity or conditions at risk. In principle, the burden faced by mothers and fathers or children in the group can be minimized by social assistance. The parental factors employed along with the use of social welfare, questions of access to institutional support and perceived social assistance. 269 moms and young people and older individuals with autism were investigated by Greenberg and Seltzer (2011). The study showed that a higher social network is related to better well-being for mothers. Higher levels of negative reinforcement and an increase of negative support is related to increases in signs of depression and negative effects and positive effects. Social help expected improvements in well-being beyond the effects of issues with children's behaviour. Sander and Morgan (1997) researched the influence of autism on families after diagnosis.

Nigel V. March (2019) Parental and potential anxieties have been examined. The effect of the intellectual condition of an infant.

RukuyeAylaz – (2017) examined Anxiety assessment and coping mechanisms for parents of autistic children. The findings of the report were higher among parents with children with disabilities who receive clinical and social aid in dealing with anxiety.

KumaranRajan, Deuri Sonia (2017) In the mothers of children with developmental disabilities, anxiety, depression and quality of life were examined. The study showed that mothers with mentally disabled children had

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greater angst and depression than mothers of stable children. A.S. The psychological condition and the treatment of care providers of people with developmental disabilities and mental disorders have been examined in Panicker, S. Ramesh (2019). The conclusion is that the level of treatment and outcomes of proper coping style will mitigate the consequences of their signs and mental wellbeing play an important part.

Sandra & Michael Hayes (2020) have been researching the mental health of parents of autistic children. Parents of developmentally disabled children have impaired mental health. They need mental health interventions and resources.

III. METHODOLOGY

Researcher in common parlance refers to the search for knowledge. Research is the scientific and systematic search for pertinent information on a specific topic. Research is an art of scientific investigation. It is actually a voyage of discovery. This chapter contains statement of problem, objectives of the study, hypothesis, tools selected for the study, sampling technique, statistical analyses used to test the formulated hypotheses.

3.1 STATEMENT OF THE PROBLEM

To find out the level of Mental Health of mothers whose children are having either Autism or Down Syndrome.

3.2 OBJECTIVES OF THE STUDY

1. Studying mothers who have either autism or down syndrome regarding their levels of mental wellbeing.

2. Comparing the mental wellbeing level of mothers whose children are either autistic or down depending on the mental health factor.

3.3 HYPOTHESES

1. There would be a significant difference in the level of mental health between the mother’s of children with either Autism disorder or Down Syndrome, momentous divergence in the level of mental health among the different age groups of mothers with either Autism disorder or Down Syndrome, a significant difference in the level of mental health between the mothers possessing different educational qualification, and in the level of mental health between working and mom-working mothers. There will be a significant differences in the level of mental health between the rural and urban, different family backgrounds.

2. There will be significant difference in the level of mental health between the mothers of children with Autism disorder and Down Syndrome based on the number of years the child has attended school.

3. There will be a significant difference in the level of mental health between the mothers of children who are administered or not administered medication for the problems associated with either Autism or Down syndrome.

4. There will be a significant difference in the level of mental health between the mothers of children with or without behavior problems associated with either Autism or Down syndrome.

3.4 COLLECTION OF TOOL

“The Mental Health Inventory” developed by Jagdish and Dr. A.K. Srinivastava was used for this study.

3.5 DESCRIPTION OF TOOL

Mental Health Inventory questionnaire developed by Jagdish and Dr. A.K. Srinivastava. This scale has six dimensions. They are:

1. Positive self evaluation

2. Realistic perception

3. Integration of personality

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4 Autonomy
5 Group oriented attitudes
6 Environmental mastery

This inventory consists of a number of statements (totally 55 statements) relating to one’s feelings about oneself in everyday’s life. One has four alternatives to respond, to each of the statements, namely, always, most of the times, sometimes, r never, which most suitably indicate the frequency of one’s feelings and views. The inventory expects all statements to be answered without leaving any statement unanswered.

3.6 RATIONALE
This test was administered to mothers since it was found suitable to assess the good mental health or psychological wellbeing of the individual. It was standardized on Indian population and hence the researcher used it for the present study.

3.7 ADMINISTRATION PROCEDURE
The questionnaire with 55 statements along with the bio-data requirement was neatly typed with enough space to enable the respondents to put a mark in the respective boxes or spaces. The questionnaire was distributed to a number of potential respondents after explaining to them the purpose of the study and the related instructions with respect to filling up the questionnaire.

SCORING
The questionnaire was divided into positive questions and negative questions and the marks for the respective positive and negative questions were allotted as follows:

<table>
<thead>
<tr>
<th>Total no. of questions</th>
<th>Positive question number</th>
<th>Positive scoring if marked as</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>2,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,25,26,28,30,31,33,37,38,40,42,43,44,45,49,50,51,53,54,55</td>
<td>Always -3, Most of the times-2, Sometimes-1, Never-0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total no. of questions</th>
<th>Negative question number</th>
<th>Negative scoring if marked as</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>1,3,4,7,8,9,10,12,13,14,15,16,17,20,21,22,23,24,27,29,32,34,35,36,39,41,46,47,48,52</td>
<td>Never- 3, Sometimes -2, Most of the times -1, Always -0</td>
</tr>
</tbody>
</table>

INTERPRETATION
A high score attributed to good mental health and a low score to poor mental health.

3.8 PILOT STUDY
To find out the feasibility of the test, the pilot study was conducted. The researcher initially administered the test to 30 subjects and obtained their responses. The procedure adopted is as follows.

Test administration procedure
The mental health questionnaire prepared in English was given to 15 mothers whose children have Autism and to another 15 mothers whose children have Down syndrome.

The subjects were selected from different ‘Special Schools’ in the city of Chennai. The researcher explained the procedure of the test and clarified their doubts. Accordingly the subjects answered the questionnaire and returned their responses sheets within a few days. The researcher enquired if they respondents faced any difficulty while answering them. All the respondents informed the researcher that they understood all the questions and had answered honestly, based on their feelings. Hence the researcher decided that the mental health questionnaire could be administered without making any notifications.

3.9 VALIDITY
The validity of the test has been already established by the author. Hence the present researcher did not make any attempt to find out the validity again.

3.10 RELIABILITY
The test-retest reliability was established for the mental health inventory during the pilot study test. The first test was administered to 15 mothers whose children have Autism and 15 mothers whose children have Down syndrome and again after a gap of 2 weeks, the researcher administered the same test to the same subjects and found out the correlation between the first test and the second test score. The correlation value was 0.85 which is significant at 0.01 level.

3.11 SAMPLING TECHNIQUES
A purposive sampling technique was used to find out the levels of mental health between the mothers whose children have either Autism disorder or Down syndrome.

3.12 MAIN STUDY
To conduct the main study, 60 mothers whose children have either Autism Disorder or Down syndrome were selected. The researcher approached four special schools in Chennai, namely MathruMandir, Rasa, V-Excel and we can. The researcher sought the permission of the heads of these institutions to conduct this study. MathruMandir is an institution exclusively for children with Down syndrome; ‘V-Excel’ and ‘We Can’ are institutions catering to the needs of children with Autism and Rasa is an institution catering to the needs of children with varied disabilities. The researcher approached 10 mothers at Rasa and 25 mothers at MathruMandir and distributed the Mental health questionnaire along with the bio-data sheet. All the instructions were given to them orally. The filed in questionnaires were collected after a week. In the mean time to the Mental Health questionnaires and bio-data forms were distributed to 16 months in ‘V-Excel’ ad to 9 mothers in ‘We Can’ on different days. Instructions were given orally each time. The completed questionnaires were returned after two weeks. The heads of the above mentioned institutions and their respective staff were extremely co-operative and helpful in this endeavor.

3.13 SELECTION OF SAMPLE

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Mothers of children with Autism</th>
<th>Mothers of children with Down syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rasa</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>MathruMandir</td>
<td>Nil</td>
<td>28</td>
</tr>
<tr>
<td>V-Excel</td>
<td>19</td>
<td>Nil</td>
</tr>
<tr>
<td>We Can</td>
<td>12</td>
<td>Nil</td>
</tr>
</tbody>
</table>

3.14 SELECTION CRITERIA
• Inclusive Criteria
The researcher has considered mothers of children with Autism disorder and Down syndrome from different socio-economic backgrounds, age groups, educational levels and family set up.

• Exclusive Criteria
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Fathers, grand parents or siblings of ‘special children’; Mothers of children who have other disabilities like cerebral palsy, mental retardation, visual or auditory impairment, or any other form of physical impairment.

IV. RESULTS AND DISCUSSIONS

Table No. I: Shows Mean, Standard Deviation of the various level

<table>
<thead>
<tr>
<th>S. No</th>
<th>GROUP</th>
<th>N</th>
<th>MEAN</th>
<th>S.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mothers of children with autism disorder</td>
<td>30</td>
<td>108.50</td>
<td>25.12</td>
</tr>
<tr>
<td>2.</td>
<td>Mothers of children with Down Syndrome</td>
<td>30</td>
<td>112.93</td>
<td>26.11</td>
</tr>
<tr>
<td>3.</td>
<td>Mothers who have completed school education</td>
<td>16</td>
<td>102.75</td>
<td>26.42</td>
</tr>
<tr>
<td>4.</td>
<td>Mothers who are graduates</td>
<td>27</td>
<td>107.22</td>
<td>24.91</td>
</tr>
<tr>
<td>5.</td>
<td>Mothers who are post graduates</td>
<td>17</td>
<td>114.94</td>
<td>15.00</td>
</tr>
<tr>
<td>6.</td>
<td>Mothers below 35 years</td>
<td>23</td>
<td>99.04</td>
<td>24.71</td>
</tr>
<tr>
<td>7.</td>
<td>Mothers between 36-50 years</td>
<td>27</td>
<td>111.0</td>
<td>17.51</td>
</tr>
<tr>
<td>8.</td>
<td>Mothers above 50 years</td>
<td>10</td>
<td>118.8</td>
<td>27.70</td>
</tr>
<tr>
<td>9.</td>
<td>Mothers who are Housewives</td>
<td>40</td>
<td>103.83</td>
<td>25.03</td>
</tr>
<tr>
<td>10.</td>
<td>Mothers who are working</td>
<td>20</td>
<td>117.00</td>
<td>15.81</td>
</tr>
<tr>
<td>11.</td>
<td>Mothers from rural background</td>
<td>5</td>
<td>90.00</td>
<td>18.84</td>
</tr>
<tr>
<td>12.</td>
<td>Mothers from urban background</td>
<td>55</td>
<td>109.87</td>
<td>22.88</td>
</tr>
<tr>
<td>13.</td>
<td>Mothers who belong to joint families</td>
<td>15</td>
<td>105.20</td>
<td>29.67</td>
</tr>
<tr>
<td>14.</td>
<td>Mothers who belong to nuclear families</td>
<td>45</td>
<td>109.22</td>
<td>20.77</td>
</tr>
<tr>
<td>15.</td>
<td>Mothers who have only one child</td>
<td>26</td>
<td>107.23</td>
<td>22.19</td>
</tr>
<tr>
<td>16.</td>
<td>Mothers who have more than one child</td>
<td>34</td>
<td>108.97</td>
<td>28.08</td>
</tr>
<tr>
<td>17.</td>
<td>Mothers who are from the family income group of 5000-10,000</td>
<td>20</td>
<td>102.90</td>
<td>24.03</td>
</tr>
<tr>
<td>18.</td>
<td>Mothers who are form the family income group of 10,000-20,000</td>
<td>28</td>
<td>105.39</td>
<td>24.40</td>
</tr>
<tr>
<td>19.</td>
<td>Mothers who are from the family income group of more than 20,000</td>
<td>12</td>
<td>123.66</td>
<td>8.39</td>
</tr>
<tr>
<td>20.</td>
<td>Mothers of children are less than 10 years</td>
<td>32</td>
<td>104.28</td>
<td>22.58</td>
</tr>
<tr>
<td>21.</td>
<td>Mothers of children who are between 10-20 years</td>
<td>13</td>
<td>110.53</td>
<td>23.31</td>
</tr>
<tr>
<td>22.</td>
<td>Mothers of children are more than 20 years</td>
<td>20</td>
<td>114.60</td>
<td>23.86</td>
</tr>
<tr>
<td>23.</td>
<td>Mothers of female children</td>
<td>14</td>
<td>116.14</td>
<td>15.49</td>
</tr>
<tr>
<td>24.</td>
<td>Mothers of male children</td>
<td>46</td>
<td>105.80</td>
<td>24.60</td>
</tr>
<tr>
<td>25.</td>
<td>Mothers of children with associated problems</td>
<td>20</td>
<td>107.90</td>
<td>22.55</td>
</tr>
</tbody>
</table>
The above table reveals the ‘t’ value of 0.91 which is not significant at any level. This findings indicate that there is no significant difference within the level of mental health between the mothers of children with either Autism disorder or Down Syndrome. This findings rejects the hypothesis No.1 (i.e) ‘There will be a significant differences difference in the level of mental health between the mothers of children with Autism Disorder and Down Syndrome’. From the above finding, we can say that irrespective of whether the child has Autism Disorder or Down Syndrome, the mothers of these children have to take care of all their needs, find solutions to solve their problems and cope with the day to day stress situations arising while rearing these children. These factors could be the possible reasons for having equal of mental health among these mothers irrespective of their children’s disability. This is not in line with the findings of Sandra (1989) who found greater stress, depression and lower marital intimacy in mothers of Autistic children than in mothers of Down Syndrome children.

Table No. 2: Shows the Mean, Standard deviation of dimensions of mental health of mothers of children with Autism disorder and those with Down Syndrome:

<table>
<thead>
<tr>
<th>Dimensions of M.H.</th>
<th>Groups</th>
<th>Mean</th>
<th>SD</th>
<th>SEM</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Self Evaluation</td>
<td>Autism</td>
<td>20.85</td>
<td>2.09</td>
<td>0.93</td>
<td>0.28</td>
</tr>
<tr>
<td></td>
<td>Down Syndrome</td>
<td>21.14</td>
<td>5.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of reality</td>
<td>Autism</td>
<td>16.57</td>
<td>3.43</td>
<td>0.98</td>
<td>1.29</td>
</tr>
<tr>
<td></td>
<td>Down Syndrome</td>
<td>17.84</td>
<td>4.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integration of Personality</td>
<td>Autism</td>
<td>17.12</td>
<td>6.42</td>
<td>1.33</td>
<td>0.61</td>
</tr>
<tr>
<td></td>
<td>Down Syndrome</td>
<td>17.95</td>
<td>3.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td>Autism</td>
<td>7.71</td>
<td>1.27</td>
<td>0.51</td>
<td>1.17</td>
</tr>
<tr>
<td></td>
<td>Down</td>
<td>8.35</td>
<td>2.70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The above analysis of variance shows ‘F’ value of 3.13 which is significant. It is possible to say from this finding that there is significant difference in the level of Mental health of mothers whose children have either Autism or Down syndrome based on the age group the mother falls into. Mothers below 35 years are the young mothers who are still in the stage of shock and denial; unable to accept the fact that their child is a ‘special’ child. Hence their mental health is lower when compared to mothers who fall between the age 36-50 years. The second group of mothers who fall between the 36-50 years have a ray of hope due to the professional help and assistance they are able to provide for their child. The mental health of mothers above the age of 50 is best as they are already reconciled to their situation. By now the child may be inducted partially to main stream society and the mothers are less anxious and more relaxed, as they have done the best they would for their ‘special’ child.

The above analysis of variance shows the ‘F’ value of 1.20 which is not significant at any level. It is possible to say from this finding that the level of mental health of post graduates, graduates and under graduate mothers are almost at par. Mothers with higher or lower educational qualification show similar levels of mental health. Hence the Hypothesis No.3 is rejected (ie) “There will be a significant difference in the level of mental health between the mothers possessing different educational qualification, whose children have either Autism disorder or Down syndrome “. The Socio economic set up, the belief system, the emotional support the mothers gets and the resilience the mother has, have a bearing in this content rather than her educational qualification with regard to her psychological well being.

The above table reveals the ‘t’ value of 2.48 which is significant at 0.01. This finding indicates that there is a significant differences within the level of mental health of working and non-working mothers whose children have either Autism Disorder or Down Syndrome. This findings proves the hypothesis No. 4 (ie). “There would be a significant differences in the level of mental health between working and non- working mothers whose children
have either Autism Disorder or Down syndrome”. From the above finding it can be said that working mothers spend a few hours away from domestic responsibilities, interact with the outside world and also find avenues to maximize their potential, which give them a sense of accomplishment. Further they may have wider contacts and hence may find out different types of rehabilitation services for their children. Financially they are in a position to contribute towards these expenditure. These factors could be the possible reason for the working mothers having better mental health when compared to their non-working counterparts.

The above table reveals the ‘t’ value of 2.21 which is significant at 0.05. This findings indicates that there is a significant difference in the mental health of mothers from the rural and urban background. This findings proves the Hypothesis. No.5 (ie) “There would be a significant difference in the level of mental health of between rural and urban mothers whose children have either Autism disorder or Down syndrome”. From the above findings it is possible to say that mothers from the urban background offer better facilities for their ‘special’ child and get help at hand during her absence. The professional help the ‘special’ child gets in the form of ‘special’ school, therapy or individual care, far supersedes the facilities that a child from the rural background gets. Hence the mother from the rural background is more anxious about the future of her ‘special’ child than a mother from the urban background. Therefore Hypotheses No. 5 is accepted.

The above table reveals the ‘t’ value of 0.49 which is not significant at any level. It shows that there is no significant differences in the level of mental health of mothers based on the type of family she lives in. This finding rejects the hypothesis No. 6 (ie) ‘There would be a significant difference in the level of mental health of mothers from different family backgrounds whose children have either Autism disorder or Down syndrome’. From the above findings it is possible to say that irrespective of the family background these mothers are from, they have learnt to cope with the situation all by themselves. They seem to derive strength from within themselves and rise up to the situation.

The above table shows ‘t’ value 0.29 which is not significant at any level. This shows that there is no significant difference in the mental health among mothers of both the groups. Hence Hypothesis No. 6 is rejected, (ie) ‘There would be a significant differences in the level of mental health between the mothers of children with Autism disorder and Down syndrome’ based on whether they have one child or more children. The level of mental health of the mothers from either group are almost equal. The ‘special’ child is always a cause of concern for the mother; having other children does not ease this pain.

The above table analysis of variance shows the “F” value of 3.74 which is significant at 0.01. It possible to say from this finding that the socio-economic status of the family has a bearing on the mental health of the mothers, whose children have either Autism disorder or Down syndrome. Hence the hypothesis No. 8 is accepted (ie) ‘There would be a difference in the level of mental health among the mothers of different socio-economic strata whose children have either Autism disorder or Down syndrome. The higher the family income the better the mental health of those mothers. Money to some extent an take care of certain expenses like a part time care taker for the child; special school needs; special equipment for the child or certain therapies the child needs like speech therapy, movement therapy etc. lack of funds to meet the needs could mean regression for the ‘special’ child. This thought could weigh down on the mother’s mental well being. Hence mothers with better financial resources at their disposal tend to have better mental health.

The above analysis of variance shows ‘F’ value of 1.10 which is not significant at any level. It is possible to say from this finding that the level of mental health of mothers of both the groups are equal, irrespective of the age of the ‘special’ child. Hence Hypothesis No.2 is rejected (ie) ‘There would be a significant difference in the level of mental health among the different age groups of mothers with Autism disorder or Down syndrome’. The possible reasons could be that the requirements or demands of the special child are varied from time to time. The mothers have to cater to these demands from time to time. It could be initially feeding and toilet training the child, in later years it could be adolescent problems to contend with, later it may be the anxiety and worry of who would take care of the ‘special’ adult after the demise of the parents. Throughout life these mothers exchange one worry for another as the child grows up. This is in line with the findings of Orr (1993) that ‘special’ children belonging to any age group were a source of stress for mothers.

The above table reveals the ‘t’ value of 1.88 which is not significant at any value. This finding rejects the Hypothesis No.10 (ie) ‘There will be a significant difference in the level of mental health between the mothers of children from either gender who suffers fro either Autism disorder or Down syndrome. From the above findings

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it is possible to say that the gender of the ‘special’ child makes no difference to the psychological well being of the mother. The complete responsibility and onus of taking care of a ‘special’ child falls on the mother and she has to be the source of strength irrespective of the gender of the child.

The above table reveals ‘t’ value at 0.31 which is not significant at any level. This finding indicates that there is no significant differences in the level of mental health among mothers from both the groups. This finding rejects the Hypothesis No. II (i.e.) ‘There would be a significant difference in the level of mental health between the mothers of children with or, without associated problems linked to either Autism disorder or Down syndrome. From the above findings it is a possible to say that the mothers whose children have either Autism disorder or Down syndrome learn to cope with the disability of their child as a whole; whether the child has an associated problem or not is of least importance to the level of mental health of the mother. She learns to draw strength from within the cope with the situation as a whole rather than compartmentalizing it. This is not in line with the findings of Sequiera (1990) who investigated the perceived burden and coping styles of mothers of mentally handicapped children. About 70.9% of mothers showed severe strain when the child had large number of associated problems.

The above table reveals the ‘t’ value of 1.14 which is not significant at any level. This indicated that there is no significant difference within the level of mental health between the mothers of children with their Autism disorder or Down syndrome, irrespective of the birth order of the ‘special’ child. Hence this finding rejects the Hypothesis No. 13 (i.e.) ‘There will be a significant difference in the level of mental health between the mothers of children with, Autism disorder and down syndrome based on the birth order of the child From this finding it can be said that irrespective of whether the ‘special’ child was the first born in the family or not the mental health of the mothers from both the groups are at par. These mothers still have to cater to all the needs of the child while coping with their own anxiety and stress, at the same time.

The above table reveals the ‘t’ value at 1.80 which is not significant at any level. This findings indicates that there is no significant difference in the mental health between the mothers of both the groups, irrespective of the number of years their ‘special’ child has attended the Hypothesis No. 13 (i.e.) ‘There would be a significant difference in the level of mental health between the mothers of children with either Autism disorder and those with Down syndrome based on the number of years the child has attended the school’. Irrespective of whether the child attended school, the mothers are always worried and anxious about their future. The irreversible permanence of the condition, is the main cause of anxiety of the mothers. The ‘special’ schools may not address all the concerns of the mothers; they have their limitations to.

The above table reveals the ‘t’ value of 0.52 which is not significant at any level. This finding indicated that there is no significant differences in the mental health levels of the groups. This rejects the hypothesis No. 4 (i.e.) ‘There would be a significant differences in the level of mental health between the mothers of children with or without mediation for the problems associated with either Autism and Down syndrome’. Care giving primarily depends on the severity of the disability, the child has, rather than on whether the child is medicated or not. Medication could be to suppress a negative behavioral problem or to support life due to a congenital condition. Irrespective of the manifested behavior of the ‘special’ child the level of care giving cannot diminish. And hence the mental health levels of both the sets of mothers are almost at par.

The above table shows the ‘t’ value of 0.41 which is not significant at any level. Hence the hypothesis No. 15 is rejected (i.e). ‘There would be a significant difference in the level of mental health between the mothers of children with or without behavior problems associated with either Autism disorder and Down syndrome. The behavior of the child has very little impact on the mental health of the mothers from the above mentioned groups. The medical condition of the child is of greater concern to these mothers than their associated behavior problem.

V. SUMMARY AND CONCLUSION

Analysis was conducted to understand the level of mental health among the mothers whose children have either Autism disorder or Down syndrome. The mental health of mothers, who are primary care givers of these ‘special’ children is of great importance. The review of literature collected was compared to the present study. The tool selected for this research was mental health inventory developed by Jagadish and A.K Srivastava. Totally 60 subjects were taken for this study and disturbed as 30 mothers of children with Autism disorder and 30 mothers of children with Down syndrome. Purposive sampling technique was used for collecting the data.

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2034
The validity of the tool has been established by the author. The pilot study was conducted on 30 subjects (15 mothers of children with Autism and 15 mothers of children with Down syndrome) to test the reliability of the tool. Fifteen hypothesis were formulated for collecting and analyzing the data. The data collections were done in four special schools. They were located at Alwarpet, Raja Annamalaiapuram, Besant Nagar and Neelankarai. The test was administered to mothers of children with either Autism or Down syndrome. It took almost a month to finish the data collection. The collected data was tabulated and statistically analyzed. The formulated hypotheses were tested and the conclusions were drawn from the findings.

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