

CAREGIVERS CHALLENGES AND QUALITY OF CARE TOWARDS MENTALLY RETARDED CHILDREN

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Background: *Mental retardation is a lifetime disability with a considerable impact on the lives around them. The challenge of caregivers in attending mentally retarded children is multidimensional involving physical, emotional, financial, social and physical burden. Parents and/or caregivers playing an important part in the family have to deal not only with the concerns associated with child's impairment but also have to maintain the household. As a result, the high quality of care needed by a mentally retarded child may become psychologically, emotionally and physically stressful to caregivers. Although there have been numerous studies conducted to determine the burdens of families with a mentally retarded member around the globe, little was known about the association of the caregivers care-related constraints and their quality of care.*

Objective: *The purpose of this study is to determine the practical, emotional and psychological constraints that exist in caring mentally retarded children and its relationship to caregivers' quality of care.*

Methodology: *This study used the Descriptive-Correlational Design with self-structured questionnaires divided into 5 parts and were given to the computed sample size of 40 respondents who were the primary caregivers of the mentally retarded children studying at Iligan City SPED Center, selected through random sampling technique. Data generated by the questionnaires were then analyzed and interpreted using SPSS.*

Results: *High quality care was positively associated with caregivers' capability in responding to practical concerns such as providing constant supervision to the mentally retarded child. Caregivers' emotional constraints like being embarrassed with the mentally retarded child and having a sense of inadequacy in caring the child can adversely affect their quality of care. Being able to manage generalized anxiety disorder in the part of caregivers has a positive impact in their quality of care to mentally retarded children.*

Conclusion: *These findings may shed light on the struggles that caregivers face as well as to ascertain the need for awareness and support for such challenged families in order to provide quality care to mentally retarded children.*

Keywords: *Mental Retardation, Practical, Emotional & Psychosocial Problems, Quality of Care*

INTRODUCTION:

World Health Organization estimated approximately 156 million people worldwide were afflicted with mental retardation. Mental Retardation has been a huge problem throughout the world because of its complex medical, psychological, social educational and legal aspects apart from different unexpected problems. It is considered as difficult problem to educate, understand, define and manage to everybody's fulfillment at various levels in the society.

Parents of mentally retarded children are facing myriad of challenges (Cherry, 1989; Minnes, 1988). The disability of subnormal child can have a disruptive and restrictive effect on the family and they may be emotional, economic and social (Schonell et al., 1956). The obligation related in bringing up a mentally handicapped child usually affects the entire aspects of family life including routines, emotional and financial aspects (Kaur et al., 2010). Consequently the caregiver giving high level of care necessary for mentally retarded can become psychologically and physically taxing to caregivers. (Kasuya et al., 2000) infer that the multifaceted concerns of caregivers can produce emotional, social, physical, financial and psychological distress in caring mentally retarded. Vast studies have noted the unique physical and emotional demands to parents brought about by raising a child with a chronic medical condition or handicap (Bruce, et al., 1994; Florian et al., 2001; Hauser-Cram et al., 2001; Shonkoff et al., 1992; Wade et al., 1996; Warfield et al., 1999 According to (Featherstone, 1980; Fredrich et al., 1981; Gath, 1973) another aspect of concern for some families is the difficulty in handling the relationship of family members. Reorientation of roles in the family may be required (Faber, 1960; Kazak et al., 1984) since family problems in this situation can lead to marital breakdown, family quarrelling and divorce. (Gath, 1973); Association with Professionals may also add stress (Turnbull, 1986) as parents encounter hardships in finding sufficient services for their child.

Among the concerns of families with mentally retarded children are increased financial constraints (Holoroyd, 1974; McAndrew, 1976). The need of medical care, special tools, tutoring, programming, etc. required extra budget. Family problems ranges from difficulties in transporting the child, monitoring of child's behavior, disturbance of their daily routine, social, physical and economic burden (Venakatesan et al., 1994).

Mothers of children with developmental impairment expressed a high level of overall problem, specifically in financial areas, increased subjective caregivers stress, extra disability-related costs; mother being too young and lesser social support. Extra cost related to handicap was the strongest determinant of increased caregiver stress and the social support can decrease the burden (Heykyung oh et al.,2009). In 2003 (Pinquart et al., and Vitaliano et al.,) noted that caring mentally retarded children is in itself emotionally and physically taxing.(Byrne et al.,1985) pointed out that parents of mentally retarded children undergo high level of emotional, physical and financial stress Previous study of Goldman 1962 documented that a lot of mothers experience drop in self-esteem when they realize retardation in their child. They may feel accountable for disappointing her partner and other family members with the disabled child. Social rejection, shame, compassion or ridicule and loss of prestige can be related to the problem.. As the child grows, many families start coping with life uncertainties about the child's present and future capacity to function.(Kazak et al.,1984).Social ridicule and social stigma is another problem parents can be concern of. As the handicap becomes noticeable by others, parents may suffer very distressing social embarrassment. This can lead to isolation of both the child and the sometimes the family. Vitaliano et al in 2002 documented that caregivers will experience burden, depression, lesser social support, and less coping resources than non-caregivers. Generally, mental retardation poses social issues, psychological problems, and lifestyle restrictions that can alter quality of life of family members and caregiver.

Caregivers and parents play a pivotal role in caring for mentally retarded children. Learning the challenges they face in caring for children with mental handicap is the primary step in determining ways to enhance support for such caregivers. It is crucial that children can receive quality care in order to provide their mental health needs. Vast studies were conducted about parental burdens in caring mentally retarded children but the shortage of these researches in Iligan City and the hiatus in available evidence relating the problems to quality care highlights the significance of this study. The study was undertaken in order to explore the practical, emotional and psychological challenges of caregiver and determine its relationship to their quality of caring mentally retarded children.

MATERIALS AND METHODS:

3.1 Research Design

The study followed a Descriptive-Correlational Research Design. Descriptive in the sense that this study dwelled on describing and evaluating the different kinds of practical, emotional, and psychosocial problems in the home care of mentally retarded children. Correlational in the sense that it seek to determine a relationship between the practical, emotional, and psychosocial problems and quality home care of the mentally retarded children. Such research design was chosen to aid in the attainment of the objectives stated in this study.

Respondents

The subjects of this study consisted of the primary caregivers of mentally retarded children enrolled at Iligan City SPED Center. The respondents are from Iligan City only and are limited to the parents or primary care givers having mentally retarded children, regardless of their age, gender, religion, civil status, educational attainment, work status, family monthly income, area of residence and severity of their child's diagnosis and age. The respondents were randomly selected via draw lots from the total population of 61 students enrolled at the said school. From this total population, the exact number of respondents chosen were then determined using the Sloven's formula.

Sampling Design

This study used random sampling in the collection of the sample wherein all of the elements within selected clusters are included in the sample. Students in SPED Iligan City were randomly selected via draw lots and the respondents were the parents of the selected students. Using simple random sampling, the researchers were able to determine the respondents included for the collection of data.

Research Instrument

In this study structured questionnaires were given to the respondents. The sets of questionnaires were developed in the Visayan dialect, Tagalog and the English language. Data generated through the pilot study which was conducted before the actual study were validated through Cronbach's alpha. Modifications were done to several items of the questionnaire which showed discrepancies in its reliability. Questionnaires were then given to the parents of the diagnosed mentally retarded child of Iligan City SPED Center selected through simple random sampling and ranked the responses as directed.

The questionnaire was categorized into three parts. The first part was structured to assess the demographic data of the respondents. The second part was principally structured to determine the practical, emotional and psychosocial problems of the respondents toward the mentally retarded child and were categorized as agree, sometimes agree or disagree. This was to determine the nature and incidence of such problems in the home care of the retarded children. The third part was formed to assess the quality of home care given to the mentally retarded child by the parents, and whether or not the incidence of practical, emotional and psychosocial problems affected the quality of home care.

Data Gathering Procedure

A letter of request was given to the principal of Iligan City SPED Center, Mr. Ernesto G. Perez, to allow the parents of his students to participate in this study. The respondents were given a brief introduction about the researchers and what is the study about. Participation was voluntary, and the respondents were assured that personal details were kept confidential for ethical considerations. Each of the respondents, upon their approval, was given questionnaires to evaluate their practical, emotional and psychosocial problems

in relation to quality care of their mentally retarded child. Subsequently, the filled-up questionnaires were then collected.

The questionnaires were subjected to test for reliability using the Cronbach's alpha. The content validity was solved after they answered the questions. If the weight mean is greater than the undecided, then the statement is retained.

Data generated from the questionnaires were tallied and analyzed using Statistical Package for Social Sciences (SPSS) software.

RESULTS AND DISCUSSIONS:

PRACTICAL ASPECT	Weighted Mean	Interpretation
Constant supervision	2.36	Moderate
Frequent attention at night	1.95	Moderate
Requirements of professional nursing care	2.41	Moderate
Cause of extra expenses	2.23	Moderate

The score of 2.36 implies that the caregivers have provided moderate level of supervision to the children. Most of them agreed to give more attention to the child who is mentally retarded than the other children. They made the needs of their handicap child comes first. According to (Harris, 1994) parents verbalize concern about balancing the needs of the special child with those of other kids. This is natural for parents to spend more time with the most important needs, unfortunately other children felt jealous or neglected of the extra time given to disabled child (Crnic, 1983). On the other hand Harris (1994) observed that siblings of children with impairment have distinct capacity to be an asset. These siblings are often more sympathetic and caring than average. Caregivers admitted that the disadvantage of raising a mentally retarded child is that you don't have enough free time to do just as you like. The study of Kazak and Wilcox, 1984 supported this, stating that it is more difficult for families of child with unique needs to go outing, having meals or go shopping. Many admitted exhaustion in taking care of the child. Most parents give more attention to the child who is mentally retarded at night than other children. In fact sometimes they get up in the middle of the night and don't get enough sleep just to attend to the needs of the special child. This can be related to the fact that most parents believed that their mentally retarded child would be better off if he/she would be taken care of by professionals in a special institution. However (Boyd 2011) explained that in the past, caregivers were often encouraged to institutionalize a child with considerable intellectual impairment. Nowadays, the aim is to help the child with mental problems stay in the family and take part in daily life. In other places, the law grants them educational and other services through public support (Costigan et al., 1997) study encourages improvement in the involvement with institutional and other educational structure. Among parents main concern is that their mentally retarded child takes a large toll on our family finances. They

often run out of budget because of the additional expenses. (Holoroyd, 1974; McAndrew, 1976) observed that families often face added monetary burdens. Children may need special devices, medical care, and programming, management of problem, specialized transportation, tutoring, adaptive learning materials (Venakatesan et al., 1994). Lucy Boyd (2011)

Recently (Heykyung oh et al., 2009) found out that extra cost related to handicap was the strongest predictor of heightened caregiver burden

EMOTIONAL ASPECT	Weighted Mean	Interpretation
Parental Disappointment	2.36	Moderate
Guilt	2.14	Moderate
Sense of Inadequacy	1.68	Moderate
Shame	1.36	low

Parental disappointment scored the highest weighted mean with an average of 2.36. This means that that disappointment is common to parents with mentally retarded child. Some parents ask "why" and go through a spiritual crisis or blame their partners. Most parents have ambitions for their child and will be experience severe disappointment that their kids will not become a physician, an actor or president (Lucy Boyd 2011). According to Ziolk (1991) there is grief of fantasized child but gradual acceptance of the child was observed by (Beckman, 1983). This coincides with the study of (Cherry, 1989; Rimmerman et al., 1996; Winkler, 1981) noting initial period of grieving which is followed by some degree of acceptance. However there are fluctuations of stress and grief especially during developmental milestones such as talking, walking school entry, and school completion. Beckman, 1983; Cherry, 1989; Winkler, 1981 also discussed the experience of families of mentally retarded children undergoing grief and stress when their child has not achieved the normal developmental milestone. This coincides with the previous study of Abbot et al., (1986) noting the importance of considering milestone and grieving for family to adapt the situation.

Guilt ranks the second emotional constraint of parent with retarded child. Most parents think to have contributed to their child's mental retardation. They feel that they must carry the burden of raising the child since they cause the child's condition. Boyd (2011) noted Parents of mentally handicap children often struggle with guilt. One or both partners may feel that they are the ones to be blamed the disability due to either from genetics, alcohol use or stress. (Mary, 1990; McConachie, 1986; Ntombela, 1991) documented early parental reactions to the handicap child includes guilt, grief, anger, self-pity, blame, feelings of helplessness, depression, disappointment, impulses to kill the child and suicidal impulses. 97% of the caregivers are the parents themselves; only 3% percent are uncles or aunts.

The lower score of 1.68 in "sense of inadequacy" implies that most caregivers felt capable of dealing with mentally retarded children. They trusted their caregiving capacity and think they are not useless as parents.

Another challenge often observe in literatures is that parents of mentally retarded child are subject to stigma. There are people who are not oriented or educated about mental retardation (Kazak et al.,1984). In addition, the general public don't possess a higher tolerance for behaviors and actions that are not within the norm. Surprisingly, ion the emotional aspect of this study "Sense of shame" has the lowest score of 1.36.This is a positive response because it indicates that the caregivers are not ashamed of the mentally retarded child. They don't avoid conversations about their child. Although occasionally feel embarrassed that their child is mentally disabled (Naerde et al., 2000) but most of the time they're not. In fact they even bring their child to social functions. This can be related to Filipinos way of life where relatives and friends are supportive showing deep concern and compassion with the disabled child.

PSYCHOSOCIAL ASPECT	Weighted Mean	Interpretation
Social Isolation	1.69	Moderate
Anxiety	1.66	Moderate
Depression	1.68	Moderate
Generalized Anxiety Disorder	1.38	low

Literatures suggest that among the challenges facing parents with special child is isolation. Cherry (1989) and Minnes (1988) both documented that families of mentally retarded is at high risk of feeling socially isolated. Kazak and Wilcox (1984) noted that families of children with handicap have fewer social associations. Ammerman and Campo (1998) cited difficulty in finding time and joining social activities to adults with disabled child. Fortunately this study yielded a lower score of 1.69 in social isolation which implies that most of the time caregivers were not detached from social relationships. The possible factor for this social contact is that family and friends' support is part of Filipino's life. In spite of the hectic schedule Filipinos find time to visit less fortunate friends and relatives.

Parents of children with biochemical genetic disease also run a risk of maternal anxiety because of the range of parental demands Naerde et al (2000), however our findings showed only moderate degree (1.66) of anxiety in caregivers. Feelings of depression are also common especially when realization of the child's mental handicap is recent. A number of studies noted increased incidence of maternal depressive disorder and symptoms of depression in parents of children with medical disorder. (Blacher et al.,1997; Breslau et al.,1986; McKinney et al., 1987; Speltz et al.,1990).Recent studies revealed that parents suffer disappointment and psychological stress when their child does not achieved their expectations and dreams(Barnett et al.,2003)This is supported by previous study of Wilker et al.,(1981) stating that parents endure recurrent chronic sorrow caused by child's deviation from typical activity. In contrast, the depression score of 1.68 in our study indicated that caregivers and parents have bounce back from depression. Though they are sometimes upset and feel like crying thinking about the child's condition most of time they were able to handle depression. Even if depression was usually observed in parents of children with impairment (Crnic et al.,1983;

Stoneman et al.,1990), many other studies showed that parents of handicapped children were not considerably different than control groups in the area of depression (Bristol et al.,1988; Goldberg et al.,1986). According to Wilker et al,(1981) the degree of reaction to mentally retarded child's deviant behaviors was associated with the family's coping ability. A study conducted by Hemant Chandorkar et al.,(2000) entitled "Psychological Morbidity of Parents of Mentally Retarded Children" conclusively document that the parents of children with mental retardation had greater prevalence of psychological disease than parents with normal children. Dysthymia the most common disorder followed by Generalized Anxiety Disorder and Moderate Depression. Our study yielded different results. Generalized Anxiety Disorder had the lowest score of 1.38 in psychosocial aspect. This affirmative response indicates that generally the caregivers were able to manage their worries in attending the needs of mentally retarded children. Common problems about family relationship, money, work issues, etc. may exist but they were able to cope with it decreasing the chance of developing generalized anxiety disorder. Although some prior studies recorded elevated stress level depending upon the child's characteristics (Kazak et al.,1984), not all researches have documented that family stress constantly differ from control groups (Cameron et al.,1991; Dyson et al., 1986). The idea of variability in family reaction to level of stress, personality variables and self-esteem was supported by the study of Longo et al.,(1984)

LEVEL OF QUALITY OF HOME CARE

This study showed high quality of home care was provided by caregivers to mentally retarded children. (Cleveland et al., 1977) observed that while raising a retarded child obviously give different burden and stress on families, most of them seem to be able to successfully handle the situation.(Vacca et al.,2000) research noted heightened stress and symptoms in parents with special child finds but most of them appears to cope well with these extra demands and showed resilience. In spite of various burdens families of children with mental retardation face, studies have indicated that they have tremendous resiliency and can mobilize resources to handle specific challenges (Abbott et al.,1986; Trivette et al., 1990).). The study of Summers et al.,(1989) asserted that in spite of the difficulties that exist, a lot of families have adapted positively.

Among the factors that may affect the quality of home care is the severity of the child's mental retardation. Upadhyaya, et al., (2008) noted that the needs revealed by the parents of *children* with mild retardation was commonly on adjustment and prevention while concerns of parents with moderately retarded child were more on financial security, lifelong adjustment and also government help for their child. Majority (57%) of our respondent has kids with mild retardation; 40% of them have moderately retarded children and only 3% has a severe case. This statistics coincides with (Jacobson, 1982; Iverson et al.,1989 study which documented that several researchers have concluded that the prevalence of mental disorder in persons with mental retardation is highest for persons with mild or moderate mental retardation. Volkmar et al in 2004 cited that nearly 90% of mentally retarded children are in mild range. Upadhyay et al. reveal that the level of psychosocial burden of parents with mentally

retarded children increases with the level of the retardation. Parents of children with moderate retardation reported more problems than parents of children with mild retardation.

CORRELATION

Table 1. Relationship between Quality Home Care and Practical Problems

Quality Home Care versus Practical Problems in terms of	Spearman Rank Coefficient	P value	Conclusion
Constant Supervision	0.332	0.036	Significant
Frequent attention at night	-0.052	0.752	Not Significant
Requirements of nursing care	0.063	0.700	Not Significant
Cause of extra expenses	0.085	0.603	Not Significant

The table above depicts a significant relationship between quality of home care and constant supervision, with spearman coefficient of 0.332 and p value of 0.036 which is less than 0.05. This fair positive relationship implies that when the constant supervision is high the quality of home care is also high, and when the constant supervision is low the quality of home care is low. As shown in table Caregivers in this study scored 2.36 in “constant supervision” indicating that they have attended and look after the needs of their child most of the time. Their overall quality of home was found to be high. This data is consistent with the fair positive relationship between home care and practical problems.

Table 2: Relationship between Quality Home Care and Emotional Problems

Quality Home Care versus Emotional Problems in terms of	Spearman Rank Coefficient	P value	Conclusion
Parental Disappointment	-0.057	0.727	Not Significant
Guilt	-0.208	0.197	Not Significant
Sense of Inadequacy	-0.341	0.031	Significant
Shame	-0.337	0.034	Significant

Both shame and sense of inadequacy in the table above displayed a fair negative significant relationship to the quality of home care with p value 0.034 and 0.31 respectively. This means that when shame and sense of inadequacy is low the quality of home care is high. This fair negative correlation coincides with the fact that caregivers are not embarrassed with their mentally retarded children, believed in their caregiving abilities and have high level of care.

Table 3: Relationship between Quality Home Care and Psychosocial Problems

Quality Home Care versus Psychosocial	Spearman Rank	P value	Conclusion
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Problems in terms of	Coefficient		
Social Isolation	-0.182	0.26	Not Significant
Anxiety	-0.096	0.556	Not Significant
Depression	0.056	0.731	Not Significant
Generalized Anxiety Disorder	-0.403	0.010	Significant

The table above showed a fair negative significant relationship between quality of home care and generalized anxiety disorder with p value 0.010 which less than 0.05. This implies that when the generalized anxiety disorder is low the quality of home care is high. The low score of 1.38 in table indicating better management of generalized anxiety disorder and the high level of care given to mentally retarded children prove consistency to their fair negative relationship.

Generally, the caregivers in our study not only showed favorable response to the challenges but were also able to provide high quality care to mentally retarded children. Several factors may have contributed to this including family and friends support, positive perception and attitude, and having strong faith in God.

Family and social support

Filipinos who need services for health problems considered family as their pillar of strength. According to...Filipinos are inclined to handle disability through the help of family, relatives and friends.7 Arcadio, R. (1997)When a family discovers impairment in their child their initial response are disbelief and shock and usually seek assistance from friends and relatives. Informal social support coming from extended families, friends, and other people with similar problems are promising factors related to successful coping especially when they are dealing with stress and anxiety. The studies of (Beckman et al., 1993; King et al., 1999; Quitner et al., 1990; Trivette et al. 1996) have supported the significance of social support (including family support). Quittner et al., (1990) and King et al.,(1999) cited that social support has been reported in various studies to have positive effect on family stress and must be considered by professionals in helping families in same situation. Beckman et al., (1993) observed that social support seems to buffer the stress related with raising a handicap child. According to research findings the presence of social support significantly predicts the individual's ability to cope with stress .The thought that they are valued by others has a vital psychological effect in helping them dwell and focus on the positive side of life. It is noted that social support can boosts the immune system and enhance well-being. Thus it is the main factor in restricting adverse symptoms like anxiety and depression from developing. (Corey 2005). Studies cited social support as predictor of successful adaptation.

Filipinos are family-centric(Aguilar, 2002, Jocano,1999). Even if parents suffer initial grief eventually, many of them learn to accept their child’s disability and treat him/her with tolerance, love, patience and understanding (Oka 1988).Most members of Filipino families would also adjust their lives and roles in order to prioritize the needs of the disabled child. Siblings sometimes stop going to school to

provide care to the child. Relatives have also positive attitudes towards the child with impairment and exhibit deep concern and compassion towards the family. Whatever the reason, because of Filipinos' prevailing obligation to family, they generally genuinely accept and fight for their handicap family members, sacrificing time, money effort, career, and sometimes marriage, to take care of a parent, child or sibling. It was noted that support from friends, spouses and family have favorable effect on healthy adaptation among families (Barakat et al., 1992; Crnic et al., 1983; Florian et al., 2001; McKinney et al., 1987).

Positive perception and attitude

Perception and attitude plays a pivotal role in dealing with disability. Summers and colleagues (1989) documented family perceptions as powerful predictors to successful family adaptation.

We often view family of children with mental handicap as people who are always experiencing distress but we miss the fact that some of them are not distress. (e.g., Beckman, 1991; Byrne et al., 1985; Hauenstein, 1990; Longo et al., 1984) Even if reports of monetary constraints, heightened stress in handling behavioral problems, heightened stress and worries about the future are usually noted Beckman, 1983; Singer & Irvin, 1989 but it does not automatically mean that these families were unable to adapt with the demands of their situation. Winkler (1981) cited that most parents expressed chronic sorrow but a lot of families were strengthened from the experience caring a handicap child (Dunlap et al., 1977; Hancock et al., 1990; Turnbull et al., 1986; Trute et al., 1988). In 1991 Beckman observed that through the years, it has become clear that elevated stress in families with disabled child does not necessarily lead to dysfunction of distress.

Some professionals have displayed biases in presuming that families with disabled child have always problems when in reality the problem does not exist. (Longo et al., 1984; Summers et al., 1989; Trute et al., 1988). The assumption of inevitable psychological distress has caused wrong generalization in families of children with impairment (Byrne et al., 1985). Biases caused stress to families due to interactions determined by these negative perceptions (Summers et al., 1989). Distress is not always produced by the handicap child but may emanate from societal attitudes (Bronfenbrenner, 1979). The study of Bebeko et al., (1987) and Nelson et al., (1992) regarding perceptions of family stress highlight the need that professionals' views must not be determined by general stereotype.

The handicap child was perceived differently by various nationalities. Persons with impairment were completely rejected in some places while in some they were treated as financial liabilities and grudgingly raised by their families. Many retarded children were abandoned on riverbanks or near the sea so that such children who look like an animal could go back to what was thought to be their own kind. Most societies considered persons with impairment as "deviants rather than citizens in the society." (Lippman 1972) In the Philippines mentally retarded children were loved, accepted, respected and were given the opportunity to develop their abilities to the fullest. Some Filipinos also view children with mental impairment as "bringers of luck" especially in business (Carandang 1987). Franzen Bjorn (1990) noticed that in some places in Zimbabwe and Kenya, a handicap child

is a symbol of curse to the whole family. Such child is a "shame" to the entire family and rejected by society. Children living with people having those attitudes and beliefs can hardly develop to their full capability. They get less stimulation, less education, less medical care, less attention, less upbringing and sometimes less nourishment than other children (Franzen Bjorn 1990). In contrast, these children were treated with tolerance, kindness, gentleness and patience in the Philippines. Such treatment of Filipino families to disabled children can positively affect the quality of their care.

Perception has a significant impact to healthy adaptation. (King et al., 1999) noted a close link between an individual's perception of social support, capacity to tolerate stress and coping resources to either illness or wellness depending upon the perception.

Caregivers and parents in this study depicted positive perception and attitude in caring mentally retarded children. Abbott et al., (1986) identified acceptance and positive outlook towards the mentally retarded child as positive contributors to coping.

Faith in God

Filipino families have the natural tendency to cope with impairment through faith in God. Gill et al., (1991) stated that families can find meaning through their spirituality can find deep inner strength to handle stressful situations.

Religious beliefs are employed for various disabilities. They have also rituals to help alleviate the child's disease.

Improvement of the child's condition is perceived as a miracle. Family rituals are also a healthy way to gain some sense of control in the situation. Blacher et al., (1987) observed that families of children with developmental impairment seem to be a bit disorganized than typical families. Having meaningful rituals can aid in reorganize the entire family. (Knox et al., 2000 and Summers et al., 1989) noted that control in the home atmosphere was a factor for stress reduction.

In times of dwindling in financial and moral resources families often turn to faith and religion for strength and hope. Religious communities in the Philippines are also supportive to the disabled children and disadvantage families. Previous researches (Appelquist et al., 1999; Gill et al., 1991; Minnes, 1988) documented the importance of support from faith communities. Minnes (1988) noted that faith communities were definitely a significant part of support system.

CONCLUSION:

Constant supervision leads to quality home care. Care givers who are not ashamed with their mentally retarded child and have a sense of adequacy in their caregiving capabilities can positively impact the quality of home care. Being able to avoid or handle generalized anxiety disorder is significant in improving the quality of care to mentally retarded children.

It is vital that interventions will be focused on improving the primary care givers ability to consistently monitor and attend to the mentally retarded child's needs. We need to devise programs that can develop caregiving abilities and enhance capability to manage psychological constraints like generalized anxiety disorders. We can encourage

caregivers to verbalize related concerns to social support group; open to their partners or to a health care staff whenever he/she may feel stressed out and burdened in any way. Families can be assisted in developing effective coping mechanism towards stressors and have a positive perception and attitude towards their mentally retarded child. Faith in God can also be integrated in the program.

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