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Influence of Marital Conflicts on Depression among Parents Living With Mentally Retarded Children (Intellectual Disability)

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Abstract: This study investigated the influence of marital conflict on depression among parents living with mentally retarded children (Intellectual disability). One hundred and eight (108) comprising 61 parents of mentally retarded children and 47 parents of non-retarded children between the ages 28-54 drawn from population of parents with mentally retarded children attending school at the Therapeutic Day Care Center (T. D. C. C.); Evami special school independence layout Enugu and UNTH Ituku Ozalla (OPD section) were used for the study using criterion sampling technique. Omeje (1998) 37-item marital conflict behavior checklist and Radloff (1977) 20-item depression scale were administered. Cross-sectional survey design was used. One Way ANOVA F- test revealed that parents with normal children presented more depressive symptoms than parents with mentally retarded children, F (1, 106) = 16.23, P< .05. One way ANOVA F-test as statistical test revealed no significant influence of marital conflict, F (1, 57) = 2.98, P> .05 on depression among parents with mentally retarded children. Marital conflict significantly influenced F (1,104) =7.70, P> .05 depressive symptoms among parents who have normal and those who have mentally retarded children. On the basis of these findings, it was been concluded that marital conflict were not determinants of depression among these parents with mentally retarded children. The results were discussed in relation to relevant literature.

Keywords: Marital conflict, depression, Parents and Mentally Retarded Children (Intellectual disability).
Introduction

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I. INTRODUCTION

"Marriage is a natural obligation, except for the religious, that empowers human beings to make indispensable contributions to the perpetuation of the human race. Marriage is a legal union of man and a woman as husband and wife. The society expects changes in the status of its members from being a son or daughter to being a husband or wife, to be followed by fatherhood and motherhood. It could then be asserted that marriage is one of the criteria for assessing the status of people. In a bid to fulfill this social expectation as well as respond to the natural call to procreation, two unique individuals from different socio-economic environments, distinct in their personality attributes and goals come together in the name of marriage having performed marital rites. The two people now united become involved in seemingly intimate interaction as a family (Omeje 2000)."

A family is made up of two people or more related by marriage, blood ties, or adoption and who live together (World Health Organization, 2007). Basically, it is in the family that life begins and expands with the coming together of man and woman. As the two people come together in the name of marriage, they become involved in an intimate relationship which as time goes on results in increased family size. Besides, the responsibilities which the couple supposed to shoulder increase as well. No other factor influences children as deeply as their families. The family is the basic unit of the society charged with many responsibilities.

Some of the responsibilities include: to inculcate the norms and values of the society, child education etc. In the family the child imbibes the traditional values such as good morals, sense of identity, respect for life, honesty etc. As a social unit with genetic, emotional, and legal dimensions the family foster's the child growth, development, health and well-being. The family provides the child with affection, sense of belonging, and validation. Every area of a child's life is affected by the family. In order for the family to meet a child's psychological needs, its members must be nurturing, convey mutual respect, provide for intimacy, and engage in bonding and attachment (Waller, 2006). However, a child's upbringing is a consequence of the child-rearing philosophy, the specific practices they employ, and the nature of their own and child's personality. Denga and Denga (1998) opined that the way parents bring up their children can influence their adult behaviours. The home

environment is important in developing the personality of the child. There is face-to-face interaction in the family which determines the character and personality make-up of the child. Parent's child rearing style may influence the child's social competence.

The phenomena of child rearing and duties of parents include also those of the mentally retarded children/intellectual disability children. All parents wish for a healthy baby, but some parents though not by their choice are gifted with mentally retarded children. Mental retardation also known as intellectual disability is a type of developmental disability that produces significant limitations in intellectual functioning ability and adaptive behaviours. These limitations result in problems with reasoning, learning or problem-solving as well as communication and social skills difficulties. Mental retardation as clinically defined by "subaverage intellectual functioning but also significant limitations in adaptive skills such as communication, self –care, and self-direction that become manifest before age 18" (Mgbenkemdi, 2014). Mental retardation is not without symptoms like early childhood developmental delay, limited speech and vocabulary, problems understanding verbal institution and following directions, learning difficulties, attention problems, difficulty communicating with peers, needs life skills training and assistance with self-care and safety, echolalia or repeating words phrases out of context, repetitive behavior and symptoms vary and range from mild to severe etc. The parents noticing the above symptoms, the usual reactions of these parents to their intellectual disability or mentally retarded child would be first of all denial. This would leads the parents to force the child to doing things ordinary normal children should do, when the child fails to achieve this, the parents react with anger which may be against the child or care givers. The second stage is Anger. When the first stage of denial cannot be maintained any longer by these parents, it is replaced by feelings of anger, rage, envy and resentment. The parents having expressed anger and then noticed that anger could not help matters would move beyond the anger to problem-solving strategies in order to cope with the situation that caused the feeling. The next reaction is bargaining, that is a process of explaining the condition in a milder, more acceptable manner and searching for responsibilities of rehabilitation if the child has not been destroyed up to this stage. Despite this new strategy, the handicapping condition still persists and the parents become depressed. The depression may then finally lead to the acceptance of the disability (Kubler-Rose, 1969). Some are able to cope up with such a situation and some experience a psychological stress. Parenting a mentally retarded child is not an easy task (Peshawaria & Ganguli 1995). Parents having a mentally retarded child experience a variety of psychological stress related to the children's disability. Parents especially mothers need every help and encouragement possible in their different task, which is indeed, easier for them while the child is still a baby. Psychological stress refers to pressures on an individual that are in some way perceived as excessive or intolerable, and also to the psychological and physical changes in response to those pressures i.e., the pattern of specific and non-specific responses an individual makes to the stimulus events that disturb his/her equilibrium and that exceed their ability to cope (Zimbardo, 2009). People differ not only in the life events they experience but also in their vulnerability to them. A person's vulnerability to psychological stress is influenced by his or her temperament, coping skills and the available social support. Vulnerability increases the likelihood of maladaptive responses to psychological stress.

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

In addition, the presence of a child with mental retardation in the family creates additional needs, whether the family is able to meet the needs or not is dependent on number of factors like nature of the event, the family resources and its perceptions of the event. Unmet needs, tangible or intangible however create psychological stress (Rees, 1976). Research has indicated that families, who are successful in managing with mentally retarded children, are able to mobilize their internal and external means of support to deal effectively with the special needs of their children. Resources that act as facilitators to effective managing could be of two types: internal coping strategies (i.e., coping through passive appraisal, reforming, spiritual and religious support) and external coping strategies (e.g. social support from other parents who have already overcome the shock and stigma of having such intellectual disability). The elements of such social support include encouragement, assistance, feedback and pragmatic in the completion of tasks important in daily life (Houser, Seligman & Milton, 1991). In addition, support and help from extended family members like grandparents also

act as significant facilitators to coping. Moreover, attitude to events is significant in coping with change when faced with problems to remain stable. That is the principle of cognitive consistency. We seek consistency in our beliefs and attitudes in any situation where two cognitions are inconsistent. According to Festinger (1957), cognitive dissonance theory suggests that we have an inner drive to hold all our attitudes and beliefs in harmony and avoid disharmony or dissonance.

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

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

Causes and signs

Mental retardation can be caused by any condition which impairs development of the brain before birth and or in the childhood years. Several hundred causes have been discovered, 1/3 of the people affected, the cause remain unknown. Three major known causes are, Down's syndrome, Fetal alcohol syndrome and fragile X syndrome.

- Down's syndrome is caused by an abnormality in the development of chromosome 21. It is the most common genetic cause of mental retardation.
- Fragile X syndrome is a defect in the chromosome that determines sex, it is the most common inherited cause of mental retardation while;
- Fetal alcohol syndrome is caused by excessive alcohol intake in the first twelve weeks of pregnancy. Some studies have shown that even moderate alcohol use during pregnancy may cause learning disabilities in children, drug abuse and smoking of cigarette etc.

Maternal infections and illnesses such as glandular disorders, rubella, and toxoplasmosis and cytomegalovirus infection may cause mental retardation/ intellectual disability when the mother has high blood pressure or blood poisoning (toxemia), untreated typhoid, untreated material, because the flow of oxygen of the fetus may be reduced, causing brain damage and mental retardation or intellectual disability. Problems during pregnancy: Use of drug and alcohol during pregnancy, malnutrition, physical malformations of the brain and HIV infection originating in prenatal life may also cause mental retardation.

Problems at birth: Any birth condition of unusual stress may injure the infants brain, prematurity and low birth weight predict serious problems more often than any other conditions.

Problems after birth: Childhood diseases such as whooping cough, chicken pox, measles, and hip disease can lead to meningitis and encephalitis can damage the brain. Substances such as lead and mercury can cause irreparable brain damage.

Poverty and cultural deprivation: Children in poor families may become mentally retarded because of malnutrition, disease producing conditions, inadequate medical care and environmental health hazards. Also, children in disadvantaged cultural settings may be deprived of many common contemporary day today experiences.

Iodine deficiency: Iodine deficiency causes goiter, an enlargement of the thyroid gland. It is more common than full fledged cretinism. Affecting approximately 2 billion people worldwide iodine causes mental disability in areas of the developing world where iodine deficiency is endemic. India is the most outstanding with 500 million suffering from deficiency, 54 million from goiter and 2 million from cretinism. Among other nations affected by iodine deficiency are China, Russia and Kazakhstan etc. The use of forceps during birth can lead to mental retardation/ intellectual disability. They can fracture the bone leading to brain damage.

Low IQ scores and limitation in adaptive skills are the hallmarks of mental retardation. The child may be very shy, withdrawn, fearful, and dull or over-friendly has no fear of strangers or is too afraid of strangers. He could be quite often also aggressive, irritable, hyperactive restless, self-injury, and mood disorders are sometimes associated with the disability (Serpel, 1989). The severity of the symptoms and the age at which they first appear depend on the cause. Children who are mentally retarded reach developmental milestones significantly later than expected, if at all. If retardation is caused by chromosomal or other genetic disorders, it is

often apparent from infancy. If retardation is caused by childhood illness or injuries, learning and adaptive skills that were once easy may suddenly become difficult or impossible to master. In about 35 percent of cases, the cause of mental retardation cannot be found. Biological and environmental factors that can cause mental retardation include genetics, prenatal illness and issues, childhood illnesses and injuries, and environmental factors (American Association of Mental Retardation, 2010).

Genetics

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

Prenatal illness and issues

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

Maternal infections and illness such as glandular disorders, rubella, toxoplasmosis, and cytomegalovirus infection may cause retardation. When the mother has high blood pressure (hypertension) or blood poison (toxemia), the flow of oxygen to the fetus may be reduced, causing brain damage and mental retardation. Birth defects that cause physical deformities of the head, brain, and central nervous system frequently cause mental retardation. Neural tube defect, for example, is a birth defect in which the neural tube that forms the spinal cord does not close completely. This defect may cause children to develop an accumulation of cerebrospinal fluid in the brain (hydrocephalus). By putting pressure on the brain, hydrocephalus can cause learning impairment.

Childhood illness and injuries

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

Environmental factors

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

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

Classes of Mental Retardation

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

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

Source: (AAMD 2010)

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

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

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

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

Types of Mental Retardation

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

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

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

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

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

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

1986). Society's attitude has changed dramatically in the past 30 years with public acknowledgement of the importance of caring for the mentally retarded and the constitutional rights for the retarded (Newman, 2003). Several trends such as advances in technology, medical care, mandated services, and mainstreaming the individuals with disabilities back into society rather than placing them in institutions have also helped the disabled live better lives and function in the community. Most childhood disabilities are referred to as developmental disabilities; defined as any physical or mental condition that may impair or limit a child's ability to develop cognitively, physically, and emotionally compared to other children (Pueshel & Bernier, 1988). The origin of a child's disability may be the result of a variety of conditions that can occur at any time such as childhood accidents, chronic illness, infections, or genetic disorders (Rose, 1987). Even with the advancement of medical technology, some causes of certain disabilities are still unknown (Rose 1987). Unlike obvious physical anomalies, which are usually noticed at birth many developmental disabilities are left undiagnosed until a child reaches school age. Identifying a developmental disability may be difficult for a parent if he or she is unaware of a child's developmental stages. According to Thompson (2000), children with disabilities need additional items such as special clothing, equipment, communication devices and bathroom aids all these affect the parents financially, emotionally, physically, and hence predict conflict and depression. Although children with disabilities may have additional needs, despite their disabilities they are children first (Capper, 1996).

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

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

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

Studies have revealed that there is a significant cause-effect relationship between stress and illness. This relationship results from the activation of the autonomic nervous system and endocrine system as well as their effects on the immune system. The relationship invariably leads to degenerative disease conditions like chronic hypertension, heart diseases, strokes and kidney failure (Hubert, 1994). Psychologically, the stress response process is manifested by disorganization and exaggerated defense reactions, a break with reality, apathy and stupor (Coleman, 1976). Featherstone (1980) reports a sense of isolation, stress and loneliness that many parents experience with disabled children. When a child is born with a disability, it brings deep sorrow and disappointment for the entire family especially the parents (APA 2008). This stress could have a negative impact on the parents, leading to anger, anxiety, depression and marital conflict (Bromley, Hare, Davison & Emerson, 2004). According to Mgbenkemdi (2014), Marital conflicts happen when one or both persons are self-centered. One selfishly wants what he wants without consideration for the capabilities, plans, or goals of his

spouse. Marital conflict is not just a difference of opinion. Rather, it is a series of events that have been poorly handled so as to deeply damage the marriage relationship. Marriage issues have festered to the point that stubbornness, pride, anger, hurt and bitterness prevent effective marriage communication. The root of almost all serious marital discord is selfishness on the part of one or both parties. Saving a marriage means rejecting selfishness, giving up pride, forgiving hurt and setting aside bitterness; these steps grow more difficult, so it's best to avoid the downward spiral of marital conflict

How marital conflict affects marriage relationships

When husbands and wives are unable to navigate their disagreements, they fall into fairly predictable patterns of behavior, as suggested by the four stages of marital conflict. It's important to recognize that all of these stages are dysfunctional. The stage of negotiating and compromising can appear to be positive, but it will fall apart without commitment and a mature understanding of the difficulties and distractions that must be overcome. When marriage communication breaks down, feelings are hurt, emotions run high, and solutions seem out of reach. When marital conflict and children live in the same home, the damage is multiplied.

Four stages of marital conflict that increase marital discord:

1. Have It Your Way.

Couples who are newly married and haven't learned how to successfully resolve their differences tend to try to settle things by avoiding confrontation. They give in to each other without ever discussing the heart of the problem. If you find yourself giving in whenever you have an argument with your husband, eventually you will find that you are tired of this pattern and will begin shifting your attitude toward the next stage.

2. Have It My Way.

After couples have exhausted themselves by ignoring their own needs, they often turn the opposite way and begin demanding that their needs are now met. A wife who has kept her opinions to herself may suddenly realize that this has contributed to her misery and may start voicing her thoughts and attitudes at every opportunity. But unfortunately, this stage doesn't work either as husband and wife begin butting heads.

3. Have It Our Way.

The third phase involves compromising and negotiating with each other. At first, the couple may be enthusiastic at their newfound communication style, but eventually the eagerness fades. About this time in a marriage, couples are facing more time demands and stresses from their parenting responsibilities, financial concerns and hectic schedules. Between an ineffective conflict resolution style and the growing pressures of life, couples may start to doubt their compatibility during this stage.

4. Have It Any Way You Want.

This stage marks a sense of resignation. Couples in this stage are exhausted over the unending conflicts and might even feel hopeless that all the unresolved issues will ever be worked out. If you find yourself in this stage, you need expert marriage guidance (Mgbenkemdi, 2014)

Marital conflict according to Risdal and Singer (2004) is the situation of having the lowest level of family harmony. Omeje (2000) noted the marital conflict arises when one person in a relationship pursues his/her goals and in doing so, interferes with the other person's goals. Imobighe (1995) defined marital conflict as a condition of disharmony in an interactional process. Marital conflict between the wife and the husband has a serious effect on the victims as well as the society. According to Omeje (2000) it is a threat to unity, a destabilizer of social relations and an enemy of intimacy and solidarity. It leads to both couple suspecting each other on the cause(s) of the mental retardation, emotional divorce and high level of divorce rate on marriage.

Higgins, Bailey, & Pearce (2005) reported that mothers and fathers living with a mentally retarded child have lower levels of marital happiness, family adaptability, and family cohesion; less flexible lack warmth and connection. Perry, Harris & Minnes (2006) opined that parents of children with mental retardation reported the lowest level of family harmony. Interestingly, Benson (2006) reported that parents living with mentally retarded children were at increased risk of poor mental health, not only because of the demands of caring for children with mental retardation, but also because of other stressors engendered or exacerbated by their children's disability. Baxter, Cummins & Polak (1995) concluded that in a longitudinal study of parental stress the time of diagnosis of mental retardation was the most stress inducing period for parents, followed by the time when the child entered school and when they presented transit from school to work. It could be deduced that parents present different levels of stress as their mentally retarded children pass through stages of development. Some of the stresses include:

1. Parents living with mentally retarded children have challenging behaviours indicated high levels of stress to the parents. According to Sharpley, Bitsika and Efremidis (1997) the permanency of the condition.
2. The lack of acceptance of behaviour associated with mentally retarded by the family members and the society.
3. The low levels of support provided.

4. The socio-economic burden of raising a mentally retarded child, including the negative impact on parent's career and/or income.
5. The future of their children especially the problems that may arise when the children reach adulthood.
6. The psychological characteristics of the parents such as perceived self –efficacy, locus of control and coping style.

Minuchin (1974) stated that family is a system and marital conflict is a disruption of that system which results in disruption of other relationships within the system and between the husband and wife it leads to depression hence depression seems to be one of the offshoot of conflict..

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

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

Etiological factors: Etiological factors may include, break up of intimate romantic relationship, loss of a loved one or highly prized job, disappointments in business or academic pursuits to genetic and biochemical factors.

Among married couples with retarded children marital conflict seems to abound as couples suspect or accuse one another for being responsible for the mental retardation of their children. These results in disagreements, which could result in beating, withdrawal of love, abandonment of children and other such abhor able behaviours. At times stories are told of men who have abandoned their wives and children because of conflict and these could lead to depression. Parents who live with retarded children reported higher level of physical, emotional, psychological and financial demands (Suls & David, 2001). Parenting is one of the most challenging jobs an individual will ever do. Raising children can be stressful at times, but also very rewarding. Becoming the parent of the child who has mental retardation is a time of great stress and change (Thompsom, 2000). Parents perception of having a child with a disability, the characteristics of the family, the parent's internal and external resources, and the child's characteristics are examples of factors that influence the amount of stress, marital conflict and depression the parents experiences. It is important that parents learn how to deal with their stress effectively in order to avoid negative psychological, emotional, and physical consequences.

Stress In Families Who Have Children With Mental Retardation.

One of the characteristics of stress is change. Adding a member to an existing family is a change that alters the families' social system. This change can be particularly stressful if the child has a disability (Kazak & Marvin, 1984). Families of children with intellectual disabilities are likely to experience changes in their daily routines, roles and expectations of their child in addition to the normal stresses of parenting (Crnic, Friederich & Greenberg 1983). Parents of children without a disability have the potential relief of sharing household responsibilities with their children. One stressor of parents who have children with intellectual disabilities is that they may continue to care for their child for extended periods of time, which can be physically, financially and emotionally draining (Tumbull & Behr, 1986; Wikler, 1981). Another stressor that is chronic for parents having a child with developmental delays is society's negative attitude toward their child. Even though society's attitude toward mentally retarded child has gradually changed, but there are still some people who feel uncomfortable around these children and want to avoid contact with them (Wikler, 1981). Similarly, reflecting on personal experience and research, Featherstone, (1980) reports a sense of isolation and loneliness that many parents experience. The family's social and recreational patterns may be altered due to the added care needed by the child. Parental stress may also be related to attempts to locate appropriate services and

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

Purpose of the Study

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

1. To determine whether there will be a significant difference in depressive symptoms between parents of mentally retarded children and those with normal children.
2. To determine whether there will be a significant difference in depressive symptoms among parents of mentally retarded children in high marital conflict marriage and those in low marital conflict.
3. To determine whether there will be a significant difference between parents (both with mentally retarded children and non-retarded children) in high marital conflict and parents (both with mentally retarded and non-retarded children) in low marital conflict.

Statement of the Problem

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

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

Therefore, this study addressed the following questions:-

1. Will there be a significant difference in depressive symptoms between parents of mentally retarded children and those with normal children.
2. Will there be a significant difference in depressive symptoms between parents of mentally retarded children in high marital conflict and those in low marital conflict.
3. Will there be a significant difference between parents (of mentally retarded children and non-retarded children) in high marital conflict marriage and non-retarded and parents (both with mentally retarded children and non-retarded children) in low marital conflict.

Marital conflict is difficult to operationalize this is because it is very ambiguous and a complex concept. However, some theories have been put forward to account for conflict in social interactions especially in close relationships like marriage.

Theoretical Frame Work

Exchange/ Equity Equality Theory

This theory posits that relationships are maintained by the provision of rewards by both sides (husband & wife). Foa & Foa (2004) suggested that six classes of resources are used in these exchanges namely: money, goods, services, love, status and information. LaGaipa (1981) identified identity, affection, expressiveness,

sociability and instrumental aids, as the resources for the reward. Equity theory postulates that in any relationship, what people get or think or believe they should get is somewhat proportional to what they give. The equity rule contends that the larger the contribution an individual makes, the larger should be the resulting outcome. The equality theory holds that resources be divided equally among the parties concerned. Studies have shown that perceptions of fairness in a relationship are determined by the sense that each person's inputs and outcomes exist in some kind of balance (Harris, 2007). Thus according to the theory, conflict arises when one partner to a relationship is dissatisfied with the exchange achieved, and may now resort to the use of hostility as the ultimate bargaining move (Scanzoni, 2009).

Considering this in the light of the experiences on marital relationship and possible conflict in traditional societies, husbands contribute economically while wives do most of the house work, child bearing and rearing as well as provide sexual gratification with both receiving affection and companionship. Conflict seemed to have been less in those olden days because goals were defined and each partner was fulfilling his/her traditionally assigned responsibilities thereby contributing equitably to the relationship and partners seemed to be more at peace.

In recent times, the traditional division of labour is unrealistic. The family economic considerations as well as women's career have made this division of roles less satisfactory. Today, hunger and poverty are prevalent and women are compelled to join the labour force in addition to their traditional roles. This has resulted in role confusion. Goals are no longer defined clearly hence there is a high tendency for incompatibility. Now that women contribute economically, and have acquired higher education, definitely there is bound to be changes in their status. It is no longer the time were women were tied to the apron strings of their husbands with their status revolving solely around the men. These days, you can identify women by their own professional achievements hence we can find female managers, commissioners, heads of department, principals of schools and so on. But their achievements in various fields of endeavour do not liberate them from being wives except in cases of divorce or being unmarried. Thus, with their economic and political prowess interacting with their marital relationships, there are bound to be clashes of interest or incompatibility of goals or actions resulting from inequity in the socio-economic arrangement found in most contemporary families. These studies seem to suggest the presence of inequity in marital relationships of our time hence the apparent increase in conflict and divorce which sometimes result in psychological symptoms as well as divorce.

Similarly, the prevalence also sets out to explore the problems and attitudes of parents of mentally retarded children towards the handicapping condition of their children as a factor leading to conflict. The issue of having a mentally retarded child has disintegrated the existing love, peace and harmony of the couples there by causing conflict in the family. Many Nigerian parents especially the Igbos preferred to remain childless rather than having a handicapped child who will bring shame to the family.

Cognitive theory of depression

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

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

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

In this case, such a parent may accuse the wife or husband, relatives, friends and even enemies for being the cause of the problem. This could lead to disharmony in the family resulting in marital conflict and depression. However, these challenges (e.g. marital conflict & depression) as experienced by these parents living with mentally retarded children or intellectual disability are likely to depend on the kind of coping strategies adopted by these parents. Besides, considering the available related empirical studies on marital conflict and depression among parents living with mentally retarded children as revealed, the majority of these

as revealed were done using participants from America, Europe & Asia. Moreover, substantial works in this area have not been done in Africa (e.g Nigeria) to cross validate these findings. In the same vein, the only study that has been done in Nigeria, for example, Ebigbo & Ebigbo, 1992, Izuorah, 1989, & Isichei, 2010 who explored parents of mentally retarded children in Nigeria but did not consider the coping strategies adopted by these parents of mentally retarded children either problem-focused coping strategy or emotion-focused coping strategy and the relationship between parents of mentally retarded children and parents of normal children in South- East (Enugu).

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

Hypotheses

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

1. There will be a significant difference in depressive symptoms between parents of mentally retarded children and those with non retarded children.
2. There will be a significant difference in depressive symptoms between parents of mentally retarded children in high marital conflict and those in low marital conflict.
3. There will be a significant difference in depression symptoms between parents of mentally retarded and non-retarded children in high marital conflict and parents of mentally retarded and non-retarded children in low marital conflict.

II. METHOD

Participants

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

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

Instrument

Two instruments were used in this study which included, Omeje (1998) 37-item marital conflict behaviour checklist scale measuring marital conflict with the reliability and validity index of 0.94 and 0.80 respectively and Radloff (1977) 20-item center for epidemiological studies-depression scale (CES-D) validated by Omeje (2000) measuring depression in a general population, with reliability and validity index of 0.85 and 0.92 respectively. However, during data collection, the instruments were categorized into four (4) sections (A, B, & C,) for easy administration and scoring (see appendix). Section A. comprised demographic information like, marital status, years of marriage, educational qualification, number of retarded children, and whether they are living with their retarded children.

The Marital Conflict Behaviour Checklist (Omeje, 1998). Section B: Comprised 37-items marital conflict behaviour checklist scale. The MCBC designed to assess the presence of conflict based on its frequency in marital relationships. Each item in the instrument was scored on a four point scale: rarely = 1, Sometimes = 2, often = 3 and always = 4. The participants were instructed to place a check mark (√) in the column that best described their status. Based on the scores reflected by the frequency of the items in the lives of the participants, they were classified into high or low conflict groups using the median score as the point of discrimination.

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

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

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

Procedure:

The researcher went officially with letter of introduction from the Department of Psychology to the management of the three schools namely: Therapeutic Day Care Center (T. D. C. C. Abakpa), Evami Special School, Independence Layout, and Ethics Committee, University of Nigeria Teaching Hospital (UNTH) Ituku Ozalla respectively. The researcher sought the permission to use a sample of the parents of children with mental retardation in their schools as participants for the study. The researcher explained the nature of the research to the managements. For instance, they were told that the study would involve only married parents with children with mental retardation. Parents' that had secondary educational qualifications. The requested permission was granted. In order to identify this category of parents of children with mental retardation, the researcher assisted by the research assistants as appointed by the managements/principals went through the files of these mentally retarded children. This process although rigorous, enabled the researcher to identify the number of this category of parents of children with mental retardation in each of the (3) three schools. Consequently, the managements/principals of T. D. C.C., and Evami Special School told the researcher that he came in the middle of the term and would not be able to reach the parents then. As such that they only have two contacts with these parents at the reopening and closing of every term; therefore, that the researcher should make available the instruments before the closing of the term on which the closing date was told to the researcher. On the other hand, the researcher met the UNTH Chairman of the Ethics Committee on one of the Mondays and explained the nature of the research as above. The chairman followed the same procedure, and introduced the researcher to the research assistants who went through the files of these patients as above. The chairman told the researcher that the patients attended Children out patient (CHOP) and out patients department (O.P.D) section on Fridays. Thus, with this necessary information gathered, the researcher left to prepare for the next stage.

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

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

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

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

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

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

Design/ Statistics

The study involved a cross-sectional survey design to measure the 2 levels of marital conflicts (High and low) and One Way ANOVA used for data analysis.

Table I

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

Marital Conflict	Mean	SD	N
High	45.1000	7.93327	20
Low	39.7317	8.84880	41

The table I above indicated that parents who experienced higher marital conflict obtained higher mean score on depressive symptoms (M=45.10) than those who experienced lower marital conflict (M=39.73).

Table 11

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

Source	Type III Sum of Squares	Df	Mean square	F	Sig.	Partial Eta Squared
Corrected model	475.499	3	158.500	2.131	.106	.101
Intercept	68808.559	1	68808.559	925.076	.000	.942
Marital conflict	221.763	1	221.763	2.981	>.05	.050

The ANOVA table II indicated a non-significant influence of marital conflict on depressive symptoms among parents with mentally retarded children F (1, 57) = 2.98, P> .05. This means that parents with mentally retarded children who experienced high marital conflict were found not to be different from those who experienced low marital conflict on depressive symptoms. Thus, hypothesis 2 was rejected.

Summary of Findings

The findings of this study were summarized thus:

1.) There was a significant difference in depressive symptoms between parents of mentally retarded children and non-retarded children.
2.) There was no significant difference in depressive symptoms among parents of mentally retarded children in high marital conflict and those in low marital conflict.
3.) There was a significant difference in depressive symptoms between parents (both with mentally retarded and non- retarded children) with high marital conflict and parents (both with mentally retarded and non-retarded children) with low marital conflict.

III. DISCUSSION

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

The parents of non-retarded children who experienced socio-economic problems and challenges may believe that discussing their family problems would be derogatory and would place them in an inferior position among their peers. Thus, the parents internalize their emotional trauma which may begin to manifest in the form of depression. It is known that free association of feelings or ventilation brings about emotional relief and is highly therapeutic. But, when one begins to hold back experiences especially awful ones, it may result in pathology. This outcome could be that parents of non-retarded children may have faced multitude of challenges, stress and anxiety (Cherry, 2012; Minnes, 1988) than the parents of mentally retarded. They were left with their family problems all alone. Still more, among the challenges frequently faced by the parents of non-retarded children is that they are subjected to training their children alone (Omuru zubanwaya). As a matter of facts, parents of normal children are not often sensitive to Igbo slogan "omuru nwa zubanwaya" meaning whoever that gives birth to a child should train the child. The popular Igbo adage "ozuzu zuchaa, onyenwenwa nwenwa" (that after training a child that is not yours, the owner would take over later to enjoy the fruit of the labor) was applied here. Invariably, these negative influences drawn may have affected the parents of normal children adversely making it difficult to get support hence they go into depression. However, hypothesis 2 which stated that there will be a significant difference in depressive symptoms between parents of mentally retarded children in high marital conflict and those in low marital conflict was also rejected. This showed that parents with mentally retarded children in high marital conflict and those in low marital conflict were found not to be different in their presentation of depressive symptoms. Thus, among these parents who had mentally retarded children, the level of marital conflict did not make them to present different levels of depression.

These findings were not incongruence with Johnston, MacMillan & Crow, (1987) and Bradury & Fincham, (1990). Weiss, (2002), have also shown that parents, primarily mothers of children with intellectual disabilities reported significantly more depressed and lower levels of well-being than both parents of children without disabilities. This stress could have a negative impact on parents, leading to depression, anger, anxiety, and marital discord. However, the marital conflict in the etiology of depression among parents of mentally retarded children appeared to be reasonably accounted for by the socio-cultural and diathesis theories of psychopathology. While the socio-cultural then shows experiences in the person's environment (stressor), the diathesis theory emphasizes the interaction of biological predispositions and environment stressors in the etiology of psychopathology Omeje (2000). Thus, having a mentally retarded child in the family pre-disposed to depression, exposed to marital conflict begins to present depressive symptoms because the conflict activate the immune system thereby lowering its defensive power (Hutton & Caron, 2005). The findings of this study which are not in congruence with previous studies done in Europe and America could be attributed to the cultural differences between the West and Africa. According to Hofstede (1997) as cited in Gorodnicheko and Roland (2010), United Kingdom, United States of America, Netherlands are consistently among the individualist countries, while Nigeria, Pakistan and Peru are among the more collectivist culture, it is argued that Nigerian patients (chronic illnesses as such mentally retarded) are likely to enjoy social network, social support, and spiritual support borne out of conformity and cooperation and good will. Relatives, friends and co-worshippers give one another social support by involving cooperatively towards common goals. This collectivist culture cuts across various cultures in Nigeria especially in Igbo land. Thus, social support and spiritual support (prayers) from relatives, friends and co-worshippers would likely reduce the stress, anxiety, marital conflict and depression emanating from caring for a mentally retarded children/intellectual disability which ordinarily would affect the parents. In certain cases, relatives, friends, and co-worshippers may go out of their ways to help the parents of mentally retarded child. For instance, it is a common notion in Igbo land or South-Eastern part of Nigeria that a sick person (e.g. mental retardation) belongs to all (imi bewe, anya ebewe) what affects one person affects another person. To this end, relatives, friends, and co-worshippers without request could assist the mentally retarded child through charity, free will donation or levies. This observation indicates that when parents of mentally retarded children possessed strong social network, social support and spiritual support; they are more likely to cope positively and efficaciously. Parents who experience high marital conflict and those who experience low marital conflict and the same level of depression could be attributed to the nature of the population. Both groups as demonstrated have overcome the denial, resistance, shocked, depression and have accepted the problem of their children. This could be inferred from their willingness and acceptance to send their children to therapeutic schools. This has indicated that they have gone beyond blaming one another and social stigma which would have made them experience conflict leading to depression. In addition hypothesis 3 which stated that there will be a significant difference in depressive symptoms between parents of mentally retarded children and non-retarded children in high marital conflict and those in low marital conflict was accepted. These findings have indicated that among these parents who had high marital conflict and those with low marital conflict, adopting different ways of managing the situation (coping strategies) made them present different levels of depression. This is in line with APA (2010). The result showed that the consistency could be because the interaction effect of conflict and mental retardation seem to suggest that the intensity of the conflict depends on the effectiveness of the disability. Thus, the result shows that marital conflict and disability of the

child jointly contribute to preservation of depressive symptoms by these parents. Both high and low conflict participants presented depressive symptoms, although those in high conflict presented more symptoms than those in low marital conflict. This finding suggests that conflict and managing influence the presentation of depressive symptoms especially when participants are in high marital conflict. This finding is in line with the socio-cultural model of psychopathology (Szasz, 2000) balance theory of unstable beliefs (Heider, 1946). According to the findings parents of mentally retarded children and non-retarded children with high marital conflict and those with low marital conflict were found to be different in their presentation of depressive symptoms. This outcome was supported by Achenbach & Edelbrock, (1983) which showed that studies in marital conflict (stressful life events) and depression represents a major life crisis capable of affecting the physical, emotional, and psychological well-being of an individual. This positive association as indicated by these findings is in congruence with findings of previous studies by Hubert (1994) which demonstrated that stress activates the autonomic endocrine system which affect the immune system. This effect not only leads to degenerative disease conditions like chronic hypertension, heart diseases, strokes and kidney failures (Hubert, 1994), Ezeilo, and Coleman, (1976), psychological consequences.

Implications of the Findings

This study appeared to be one of the foremost studies in Nigeria which demonstrated the strong assertion that parents with normal children do not have everything going for them. They equally presented more psychological problems such as depressive symptoms than parents of mentally retarded children. Thus, this study seems to be the first study that has considered parents of these mentally retarded children. Many studies as reviewed focused on the children and their psychological well-being; without considering the caregivers (parents). The information is important for other parents who have children with intellectual disabilities and the professionals, psychologists, who help these families with mentally retarded children.

Professionals, especially the psychologists' should help the parents foster positive attitudes, locate needed services and be willing to discuss spirituality and social support if applicable. As delineated in the review of literature, one reoccurring theme reported by parents of mentally retarded children is the added stress, related to raising mentally retarded children (Kazak & Marvin, 1984). Parents often need assistance in understanding and identifying sources of stress and developing ways of manage those stresses (Harris, 1994; Kazak & Marvin, 1984). However, not all families would experience high amounts of stress, and high amount of marital conflict therefore, it is necessary to asses a family's strengths and needs separately. Professionals also need to be sensitive and knowledgeable about diverse cultures in order to be aware of strategies that correspond to the family's belief system. For clinical psychologists and health professionals too, the study has set a spring board for diagnosis, management techniques and prophylaxis on mentally retarded children/ intellectual disability. Besides, attention should be focused not only on the events in the environment of patients but also on the way they handle their problems. Worthy of note is that, the study seems to make us responsible for our pathological states.

Suggestions for Further Studies

This study was limited to parents of mentally retarded children/ intellectual disability attending school at T. D. C. C, Evami Special School Independent Layout and UNTH, (CHOP & OPD ie Children out patient and outpatient department section) all in Enugu. The experiences of these parents may not be applicable to other parents outside Enugu; further research beyond Enugu seems both desirable and essential. This study was limited to parents of mentally retarded children/ intellectual disability mostly from the literate group. This factor has significant relationships with marital conflict. However, it becomes expedient that a comparative study be done among literate and non-literate parents. This study has paved way for further studies that will focus on parents living with mentally retarded children/ intellectual disability that will consider other variables such as personality, emotional stability, locus of control and stress level of the parents, occupation age, and source id income etc.

IV. CONCLUSION

Considering the findings of this study, which indicated positive, support for the hypotheses 1 and 11 depressive symptoms are not associated with marital conflict among parents of mentally retarded children and the parents of non-retarded children. Both groups as demonstrated have overcome the denial, bargaining, resistance, shock, depression and have accepted the problem of their children. Parents of mentally retarded children in high marital conflict showed more depressive symptoms than those in low marital conflicts, which indicated a significant difference in depressive symptoms between parents of mentally retarded children and non- retarded children and between parents of mentally retarded children and non-retarded children in high marital conflict and parents of mentally retarded children and non-retarded children in low marital conflict. This seems to mean that these groups of parents have not accepted the problem of their children. To this end, if

parents that experienced higher marital conflict presented more depressive symptoms then effort should be made by clinicians, therapist, and professionals doctors etc. to help them resolve their marital conflict, stress and depression in order to face the realities of life. Furthermore, the findings are just a spring board for the study of parents of mentally retarded children/ intellectual disability in Nigeria. Finally, this study indicated that the parents of the mentally retarded children attending school at the T.D.C.C., Evami Special School and UNTH (CHOP & OPD sections) Enugu, have really made progress in their efforts to accept the reality of their children conditions or come to terms with taking care of their mentally retarded children.

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