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VULNERABILITY TO DEPRESSION IN MOTHER OF EMOTIONALY AND PHYSICALLY HANDICAPPED CHILDREN FROM DIFFERENT SOCIO- ECONOMIC STATUS

Farrukh. Z. Ahmad

Institute of Professional Psychology

And

Fouzia Naeem Khan

(SZABIST) Shaheed Zulfikar Ali Bhutto

Institute of Science and Technology, Karachi.

ABSTRACT

In the present study, it was hypothesized that mothers of emotionally and physically handicapped children from lower socio-economic status will be more vulnerable to depression as compared to the mothers from upper socio-economic status .In order to test these hypotheses the Beck Depression Inventory (BDI) was given to 300 mothers. Sample was divided into 3 groups, 100 mothers of emotionally handicapped children, 100 mothers of physically handicapped children and 100 mothers of healthy children. Z-test was applied in order to get statistical significance of the results. The results of the present study show that the mothers of emotionally and physically handicapped children from lower economic status were more depressed than the mothers of emotionally and physically handicapped children from upper status .

Email: fouzia@szabist.edu.pk

INTRODUCTION

Health is the fundamental birth right of every individual. This fact has been highlighted by the WHO (1984) in selection of its current slogan "Health for all by the year 2000". The slogan has brought significant boost to the political leverage on governments throughout the world especially the third world or the developing countries and prompted the planners of the respective countries to devise efficient methods to realize this objective.

According to WHO (1982) today in developing countries over 40 million men, women and children are suffering from serious untreated mental disorders. Many of these countries have to contend with the very serious threats to their citizens well being associated with rapid population growth, crises of food production, internal migrations and accelerated social change. Well-conducted epidemiological studies in several parts of the world have shown no fundamental differences either in the range of mental disorders that occur or in the prevalence of seriously incapacitating mental illness.

Serious mental disorders are often a source of fear and in many developing countries they are considered as the result of supernatural forces. In some cases this leads to rejection of the mentally ill person and in some case they are accepted as the result of fate. Patients and their families tend to lack confidence in modern medicine. The mental hospitals are usually seen as custodial institutions in which troublesome and frightening individuals are segregated, rather than as curative in function. In our culture the extended family system is able to tolerate mentally ill patients and keep them at home.

A research in Pakistan has shown that the incidence of mental illness is about 15 % of the given population. In developed countries the main causes of such disability are chronic psychosis, depression, dementia and other organic brain syndromes of middle and late life. In developing countries the principal causes of chronic mental and social impairment are similar to those found in developed countries but in addition there is an excess of psychological reactions associated with severe environmental stress and of organic brain syndrome due to a variety of causes including trauma, infections and diseases caused by parasites, Sarwar, (1990).

In Pakistan the belief about mental illness, on the part of the educated public, is that the insane persons are not possessed by demons. At present the public is beginning to find out the status of mental disorders. The discrepancy in the past and present verbal description of mental illness differ sharply. Attitudes toward the afflicted may have improved to some extent, but mental disease itself is still terribly threatening and ominous. In fact, it is possible that the public is more afraid of and feels more vulnerable to mental illness now than at any time in the past.

An individual's personality is determined largely by the manner in which they were raised as a child. People are thought to be shaped more or less permanently during their early years, for nearly everyday, teaching and other family experiences are held responsible for this effect (Burt, 1952).

There is a greater reliance upon the genes to explain abnormal development, however, all theorists, even those convinced that the genes are critically

important in the severe pathologies, tend to consider the milder abnormalities as environmentally caused. Of course, many experts believe that environmental factors are largely or totally responsible for all mental illness. The environmental factor that is held critical by these theorists is the family, the parents and especially mothers, are assumed to have special characteristics that cause pathology (Clearly, 1987).

THE ROLE OF MOTHER IN THE FAMILY

Over the years there has been a continuous concern about the mother's role, Siegelman, Block, Lippe. (1970) obtained convincing evidence that the mother is important, who carried out a technically adequate study of this sort, mothers of well adjusted adults, in comparison with mothers in other group, had been rated 25 to 30 years earlier as more intelligent, more able to cope with problems, and better integrated. On the other hand, mothers of the poorly adjusted adults had been rated more neurotic and anxious. The nature of their maternal differences are especially noteworthy, as they provide cues about the kinds of family experiences that are crucial in determining adjustment. The authors reported "The mother's own cognitive coping skills appeared to be more relevant to adjustment than her emotional warmth".

It is possible that some women's role obligations give them moretime than men to consult mental health professionals; therefore, they are diagnosed more often as mentally ill. A number of studies found that reports of mental illness were lower for married women then for women who were single. The researchers concluded that the more demanding requirements of marriage made it more difficult for married women to seek professional help and to assume the sick role (Nathanson, 1975).

VULNERABILITY FACTORS IN DEPRESSION

The issue of vulnerability is so central to this argument that a preliminary discussion of prior research and ideas may be useful; the basic notion is that those who are vulnerable will only develop depression once a relevant life event has occurred. Inadequate social support from caretaker appears to be particularly critical for women, but less is known about men in this respect; it is possible that in their case, vulnerability only emerges with greater limitations is bonds of intimacy (Murphy 1982, Bolton and Oakley, 1987).

However, the matter is complicated by the fact that vulnerability may not remain constant and may well change once an event has occurred; for example at the death of her mother, a women may receive support from her husband of a kind she has not known for years. If, however, the notion of vulnerability is restricted to the pre-event situation, it is possible to avoid the tricky task of trying in some way to amalgamate such differing patterns of support. One possible reason why long-term situations, such as chronic neglect on the part of a husband, can induce vulnerability is that they work through a person's sense of self, especially via feelings of low self-worth. Further more, such feelings are important because they increase the likelihood of general hopelessness, once a major loss or disappointment has occurred–the feelings that nothing can be done about restoring what has been lost, replacing what has gone, or emerging from a deprived situation in which one is trapped(Beck 1972, Brown and Harris 1978, Oakley and Bolton 1985).

Women are often considered less at risk from unemployment than the conventional male breadwinners, but some of the evidence does not support this. Lack of employment outside the home was identified by Brown and Harris (1978) as a vulnerability factor in the development of depression, and since time, social and economic pressures on women to go to work have increased further amongst the young unemployed studied by Bank and Jackson (1982), females scored consistently higher than males.

A vulnerability factor is one, which shows little or no effect on its own in terms of causing onset of disorders, but increase risk in the presence of another factor. For depression, that other factor will be a severe event or marked difficulty. The issue of vulnerability is critical- most severe life events are coped without any serious depressive reaction. The early model of depression described by Brown and Harris in (1978) showed that of most important, in terms of vulnerability, was current support, loss of mother in childhood, that is, past support, was the next most important indication of vulnerability. Although a great deal of research has followed this, and much more is known about both factors, these two remain of central importance. Past loss of mother has now been explained in terms of " early inadequate parenting", and its role traced through structural environment factors and personality factors, but the importance of parental support in childhood to adult vulnerability to depression is clear.

Depression is a major public health problem. But reports and surveys even in developed countries show that not more than 30% patients receive proper and adequate treatment. Situation is much worse in the third world (Nolen-Hoeksema, 1987).

The health problems of Pakistan are typical of the poor countries of Asia; high prevalence of infectious and deficiency diseases, uncontrollable population growth steadily growing urbanization, inadequate sanitation, continues exposure to disease vectors, and the ominous threat of environment.

In fact many depressed people do not feel helpless, but instead tend to blame themselves too much and usually feel that they should have been able to do something to prevent a bad event or out come. That is, they seem to assume an unreasonable amount of responsibility for various things, even those over which they actually had no control (Buchwald, et al, 1978; Raps, et al, 1982; Rizley, 1978). Thus, it appears that most depressives are excessively self-blaming rather than helpless peers.

THE EFFECT OF EMOTIONALLY HANDICAPPED CHILDREN ON MOTHERS IN PAKISTAN

Before the birth of a child parents frequently develop an image, which reflects a variety of social and cultural ideas. Parents generally expect the newborn to be able to compete and achieve according to the norms and values of their own cultural group. Parent's relationship with their children is mostly of untiring love and affection. Obviously their mental and emotional health is a great concern for parents. Any ill health of the children can cause serious behavior problems in the parents. Especially in the mother because mothers are usually primary care givers for infant and toddlers which goes on from childhood to adolescence in this and most other cultures. While not having a healthy and normal baby, mothers may experience a series of painful

feelings and reactions. It is a well known fact that any serious behavior problem can cause stress on the parents specially the mothers as they are responsible, mostly for the upkeep and development of their children, in case the child is not normal and healthy, the mother goes through painful reactions and feelings.

The handicaps in the child can be of various types; it can be of an emotional nature or can also be a physical handicap. The mother of physically handicapped child learn and accept the deformity, whereas it is the emotionally handicapped which is difficult for mothers to accept, as the emotional handicapped child appears physically normal and other people do not realize that there is any thing wrong with the child. The mother obviously becomes depressed because such a healthy looking child is actually suffering from emotional handicap, which is difficult to explain to the family In particular and society at large. Mothers often deny the emotional handicap, as they are ashamed of it.

The mother of an emotionally handicapped child is especially vulnerable to depression. She is already emotionally and physically depleted. The quality of the parent's relationship to their new baby will depend on the nature of the grief reaction on her, and are therefor support . All mothers grieve when they learn that their child is either defective or abnormal. There is numbness, shock and disbelief before a tentative awareness of the realityemerges, and then she begin to feel disappointed and sad a sense of loss and despair, helplessness, guilt, rage, anxiety and physical symptoms may occur repeatedly as denial. The grief of the mother will also be affected

by her relationship with her spouse. If the husband is cooperative her grief will be automatically diminished and decrease. In the process of re-experiencing memories, expectation, and painful events a parent achieves varying degrees of emotional acceptance. The balance of denial and acceptance is dynamic and occurs on many levels. The reality of the event is accepted rather than the current feelings and short-range implications. There are various stresses which many women face, due to their major responsibilities at home and work, social expectations also play a role here. Women's reproductive events, birth control measures and the decision of not having children often bring fluctuations in mood for some women which result in depression. Studies show that individuals with certain characteristics-pessimistic thinking low self-esteem, a sense of having to excusive worrying, are more likely to develop depression. These attributes may heighten the effect of stressful events or interfere with taking action to cope with them, some experts have suggested that the traditional upbringing of girls might foster these traits and that may be a factor in the higher rate of depression in women. Full significance of a serious handicap is often denied for a long time. Parents of severely handicapped children may experience chronic sorrow.

Intellectual handicaps are especially hard to deal with because they are often invisible, ambiguous, and unpredictable in the early years. The impact of the defect may only be evident latter. In these instances, longer periods of denial may result and mothers often experience repeated episodes of loss and grief each time the defect become more apparent (Eugene, 1978).

While not having a healthy and normal baby, parents especially mothers may experience a series of painful feelings and reactions. Depression is one of the most commonly experienced reactions (Lurie, 1938).

Mothers of children with greater limitations in their normal functioning were more likely to perceive themselves as having role restriction, the investigators report, and were more likely to be depressed than were mothers of children with less severe functional limitations mothers with chronically ill children frequently express dissatisfaction with their role as a parent and often display severe symptoms of depression, new research reveals (Hayes, 1989).

A handicapped child in usually disliked by other children at home, school and in the neighborhood. Adolescence brings added problems for an emotionally handicapped child, mental and physical maturity increases his restlessness. Mounting frustration and depression in mothers. Mothers of emotionally handicapped children tended to be less mature and had lower levels of ego development. Such mother's ability to understand and accept an emotionally disturbed child relates to the development of her own personality as she deals with the varied stress situations that the introduction of a disturbed child into the family inevitably brings.

REACTIONS OF MOTHERS TOWARDS A HANDICAPPED CHILD

There are many different ways in which a mother can react emotionally to the fact that her child is emotionally or physically handicapped. The patterns of mother's behavior may vary from constructive form of adjustment (such as a realistic acceptance of the child's condition) to a destructive, maladaptive form of adjustment (such as rejection or denial of the handicapped).

Reactions of mother's to handicapped can be categorized in three major ways. She may accept, deny or disguise the child's handicap. Each mother reacts in her own unique manner to the stress situation created by the handicapped.

A mother is constructive and adaptive when she maturely acknowledges and accepts the reality of the child's disability. Such an acceptance of the child leads to many positive benefits for both the child and the parents as well as the family unit and, in the last analysis, for society as a whole. The mother eventually comes to a full acceptance of the child and loves the child as he or she is. She does not attempt to substitute a fantasized picture of the child for the child for the way he is in reality. She clearly perceives her role as a parent and recognizes that she has as identity of her own that must be preserved. Therefore, the accepting mothers deals with the problems of the child in a realistic manner and does not make a slave of herself in her relationships with the child (Wynne, 1985).

Another major category of mother reactions to the handicapped child includes those modes of behavior that attempt to disguise the child's condition in some manner. Such attempts are made not only to hide his condition from other people, but more important, to hide it from the parents themselves. In general, the disguising mother does perceive, to some extent that there is "Something wrong" with the child. But she is unable to recognize or admit that the child's inability to perform tasks that are ordinary done by other children. For the emotional disturbance of the child, the disguising mother searches very hard, consequently, medical consultations may be frequent. The child is given one medical examination after another, each time

with the hope that a specific remediable cause for the emotional disturbance will be discovered and corrected.

A severe emotional reaction to the stress situation resulting from the handicap of the child is shown by the type of mother who feels the need to deny, both to others and to herself, the reality of the child's disabilities. This mode of defense is called denial. It is said that the ostrich, when faced with a threatening situation, attempts to avoid it by burying his head in the sand, as though blocking out the visual perception of the situation is enough to remove the threat it self. But even though the ostrich buries its head and so does not see the danger, it is still vulnerable (and even more so!) to the threat.

MATERNAL REACTIONS TOWARDS A PHYSICALLY HANDICAPPED CHILD

Initially range from anxiety, resentment, and a deep sense of inadequacy, guilt, and depression to over protectiveness and over indulgence. Denial of the disability and its permanent nature is the most common psychological reaction. This is often the most common cause of parent's inconsistency in treatment and rehabilitation. Guilt is another important emotion that the mother feels. This is often displaced and projected on to the medical staff in the form of argumentative and uncooperative and even aggressive behavior.

The mother also tends to avoid appropriate discipline and control on the child for the fear of aggravation of the child's illness.

Early maternal reactions to the handicapped child and their effects on behavior towards the child can be summarized as follows:

Psychological Response	Effect on Behavior towards the Child
a) Anxiety and depression	Over protection
b) Feelings of inadequacy, anger, guilt	Low self-esteem, frequent physical abuse, loss of confidence in child.
c) Bereavement	Anger, indifference
d) Shock	Disbelief
e) Embarrassment	Social with drawl

Mother's attitude is to some extent a reflection of the society they live in, their overall attitudes to handicap and to current service philosophy are also of relevance. Mothers of emotionally handicapped children are found to have more positive general attitudes about emotional handicap than mothers of non-handicapped children, (Watson and Midlarsky, 1979).The initial disappointment of not having a perfect baby may evoke a series of parental reaction. Feeling of guilt, shame, depression and simply giving up are typical parental responses to their loss.With a physical handicapped child, the stress on the family usually began at the child's birth or shortly thereafter, (Abramson, Scligman and Feasdale , 1978).

SOCIO-ECONOMIC STATUS AND DEPRESSION

The experience of living with a handicap is endlessly frustrating and at times families are indeed burdened. The experience is associated with such heightened levels of anxiety, depression and psychosocial dysfunction that these families must be considered as a population at risk. Andrews, 1982, Johnson, 1975. Such families are burdened economically. Families are bothered by positive symptoms such as hallucination, delusion and disturbed thinking, but equally troubled by the negative symptoms, anhedonia and lack of motivation. Researches have focused almost exclusively on parents of the mentally ill. Others relatives who are also affected by living with mental illness- siblings, children of the mentally ill and spouses- have been virtually neglected. Finally, it is clear that as the mentally ill person recovers, the experience of burden lightens (Johnson, 1987).

The physical environment is considerably potent and has the ability to color one's emotional health. A desirable, healthy and aesthetically appealing atmosphere is soothing and comforting. It is liable to promote emotional harmony and balance. An unhealthy environment, on the contrary, can become a source of many emotional upsets & disturbances. By their very filthy layout, stinking slums, dirty lanes, overcrowded and unhygienic housing accommodation, even unfavorable climate, etc., combined with other factors, can be conductive to a variety of emotional disturbances.

Economic want has been noticed to be a frequent source of emotional unrest. We often compare the ill tempered tone of a hostile individual to that of a "hungry person". A satiated person, on the other hand, seems to be less

liable to emotional provocations and disturbances. Children living in abject poverty have less chance to enjoy emotional equilibrium than those enjoying a freedom from economic want (Ahmad and Stephen, 1990).

It may, however, be remembered that an emotional disturbance is not usually aroused by any one of the foregoing causative factors. It is more often caused by a number of factors working together and producing a particular form of emotionally disturbing behavior. The classic study of Dunham(1959) on the demography of mental illness was enhanced by that of Hollingshead and Redlich (1958) who demonstrated that a definite association exists between class position and being a psychiatric patient, the lower the class, the greater the proportion of patients in the population.

They further demonstrated that there exists a significant association between class status and the proportion of patients who suffer from different types of psychiatric disorders. Hollingshead and Redlich found that a direct relationship appears between class position and the rate of treated cases in the population, the lower the class, the higher was the rate.They also stated that a definite super ego structure and dynamics are more prominent in the lower classes. On the other hand obsessive compulsive characters are more frequent in the higher classes.The upper class in many communities may be considered to be an extension of the middle class; the upper lower class is often termed the working class, and the lower – lower class as the poverty class or disadvantaged class.

Studies showed that lower class mothers made more disapproving statements to their children and made more attempts to get them to modify or stop whatever they were doing. Middle class mothers made more

informational statements. The researchers concluded that the middle class strategy seemed calculated to help children with problems they might have in the future, where as the lower class strategy made it difficult for children to learn concepts that they could generalize to other problem solving situations (Lewinsohn, 1973).

One crucial point is that before many parents can accept the handicapped child they have, they must first "bury" the image of the ideal perfect child they had fantasized. Other salient ideas are that the parents must work through their guilt about their part in having a disabled child and stop blaming their partner. (Kaslow, 1978; Kaslow and Cooper, 1978). Dohrenwend, Shrant, Skodol & Martins, (1987) found the highest rate of mental illness to be in the lowest socio-economic class & the majority of the studies reported the lowest rate to be in the highest class, review of studies indicates that the incidence rates for neuroses & personality disorders, as well as far Schizophrenia, are highest in the lowest social-status groups.

Pakistan is a developing country. It is striving to become an independent industrialized country. In their process of transition it is going through strains & stresses which are usually faced by most of the developing countries. There are various socio-economic & other changes that have been taking place, socially, family, & individual characteristics are undergoing transition. It appears that we in Pakistan are possibly in a state of social reorganization (Zaidi, 1970).

Poverty, illiteracy & health (mental health predominantly included) are closely inter linked. Sarwar G, (1990) people subjected to affliction & deprivation cannot enjoy finer taste of life, instead, they fall a prey to various diseases, both mental & physical. Poverty, infact, is the root cause of all maladies that afflict us today, poverty leads to illiteracy and illiteracy causes various aliments mental agonies being the most prominent. Low incomes carry with them high risk of mental health. Poverty means hopelessness especially for the women. The women grow up without a decent education, in a hostile & squalid environment, in ill health- such a woman is often trapped in a life of poverty. A poor women faces a mounting sense of despair, which drains initiative, ambition and energy and makes her a victim of various diseases both mental and physical in such a situation, where women is already facing so many problems the birth of a handicapped child is very frustrating for her. The same time if the mother is uneducated it will further enhance her problems. People from various socio-economic groups encounter different types and amounts of stressors. The uneducated or poor tend to encounter more or different stressors then the middle class. Many of their stressors are chronic such being stuck in the low-paying jobs, lacking jobsecurity and living in over crowded and crime ridden areas (Anderson,N.B, 1991). These chronic stressors can increase the stress produced by short-term stressors,

as can the fact that the poor usually have fewer resources- such as skills and effective strategies – to deal with their stressors (Franklin, 1994).

Dr. Farrukh Z Ahmed (1993) describe the different socio-economic classes found here in Pakistan:

1. **THE LOWER CLASS:** The group comprises about 80% of the population of Pakistan. These people are mostly illiterate & semi-skilled and bound by customs, values and fixed methods of living and working.This great lower class lives in perpetual economic insecurity. A flood, a shortage of rice or flour, extremes of weather creates immediate hardships such as death of children, diseases and hunger. Although many of this group make an effort to be hygienic they have little knowledge of sanitation, nutrition the causes of disease. They depend more on superstition. Lower class women have fewer restraints on them than those in the upper and middles classes. Economic necessity frees them to work. Many of them do not observe purdah but are still not free to choose their own way of life. In short this class is restrained and controlled by religion, with little opportunity for emotional release. They have their parents with them, and live in a joint family life because it helps to pool the family income.

2) **THE MIDDLE CLASS:**It comprises of businessmen, industrial managers, professionals & politicians at the top, with government employees,office workers, teachers and other allied workers and cooperative laborers in the lower half of the middle class. The middle class in most countries comprises not only upwardly mobile people. Who are trying to

improve their economic and social conditions, but they are attempting to create a new semi western pattern of life that is neither the pattern set by their forefathers nor one accepted by the upper class groups.

3) **THE UPPER CLASS:** It is just one or two percent of the population and includes newly rich people of industry and mines. Specially since the new generation has started giving importance to industrialization, frequently men of this class are well educated, but the women as in the other classes, lay behind, a few of them are engaged in social and welfare activities.

The low status of women seems to be one of the features of all the south Asian countries. Among the aged one finds a much bigger number of single (widowed) women at marriage, studies found that the average age of men at marriage was 15.6 years higher than that of women. As a result a larger number of women are dependent on their children than men. This situation of dependency in their old age has to be viewed with in the context of the low status of women. Indications are found in the extent of mal nourishment among girls in the 0-5 age group, low educational standards & predominance of women in the informal & unskilled job sector. Their low work participation & limited opportunities in the organized job sector, all of these factors make women dependent both in their active life & old age.

People at the lower end of the socio-economic ladder have worse health & higher mortality rates for almost every disease & medical condition than do those on the upper rungs (Adler, et al, 1994), one obvious reason in that poor people cannot afford good medical care & preventive

examinations. But another has to do with the kinds of stressors they live with. Lower socio economic status when combined with illiteracy leads to emotional and mental illness and pains. Usually less education is related with lower socio economic class, but in our culture it is not so, because it is not necessary that if a person is from a higher socio economic background, he/she must be educated. Education is not related with higher class however we will have to take education as a separate factor.

Mothers with less education & lower socio economic class are more vulnerable to depression. It is believed that women with lower socio economic status are related to depression. (Kaplan, Roberts, Camacho & Coyne, 1987).

Several studies indicate that episode of depression are likely to develop in response to lower socio- economic class, (Beach & Cassidy, 1991).

Studies of middle class sample suggest that findings for depressive mood do not necessarily generalize to clinical depression Gotlib, et al., (1991).

For lower socioeconomic status women, the consequences of depression are also potentially more severe than for affluent women, (Ahmad & Stephen, 1990).

The link between maternal depression & socio economic status has received considerable attention. (Barnett & Gotlib, 1988, Jacobson, 1984).

It may be noted that these researches were conducted in advanced countries, hence there is higher need to conduct research in Pakistan, which

is a developing country. For this research purpose lower class families are those who earn three thousand rupees a month, upper class families are those who earn fifty thousand plus a month.

The present study is being conducted in Pakistan to find out the vulnerability to depression in mothers of emotionally handicapped children. While framing the hypothesis cultural patterns and various other factors prevalent in Pakistan were also kept in mind. Keeping in view the theoretical and literature review the following hypotheses were formulated.

Hypothesis 1:

The mothers of emotionally handicapped children from lower socioeconomic status will be more depressed as compared to the mothers of emotionally handicapped children from upper socioeconomic status.

Hypothesis 2:

The mothers of physically handicapped children from lower socio economic status will be more depressed as compared to the mothers of physically handicapped children from upper socioeconomic status.

Hypothesis 3:

The mothers of healthy children from lower socio economic children will be more depressed as compared to the mothers of healthy children from upper socio economic status.

METHOD

PARTICIPANTS:

This study was conducted to assess the depression level of the mothers of emotionally and physically handicapped children in Pakistan. In order to analyze it scientifically, the mothers of emotionally handicapped children and physical handicapped from lower and upper classes were compared with the mothers of healthy children.

A total of three hundred subjects were selected for the study, out of which hundred were the mothers of emotionally handicapped children, hundred were mothers of physically handicapped children and hundred were mothers of healthy children.

The handicapped children were selected from the institutions, hospitals and schools of Karachi, where they are studying or being treated. The ages of these children ranged from 6-12 years.

PROCEDURE :

The Beck Depression Inventory (BDI) was individually administrated to the subjects in standard manner. As the test consists of 21 item. Prior to starting the test, subjects were brought into a quiet room and seated comfortably. Realizing the fact that psychological testing is not common in Pakistan and that subjects may have reservations about it, an effort was made to build rapport with them. They were explained the significance of the psychological

testing and their contribution to the research was appreciated. They were assured of confidentiality. After, that the following demographic information was collected from each Subject:

1. Age
2. Education
3. Occupation (if any)
4. Family income from all sources
5. Place of residence.

INTERVIEW MEASURES:

Beck Depression Inventory was used as interview measures. This is a 21 items self-report scale used to asses cognitive and physical symptoms of depression. It has been used extensively in psychological research with numerous populations and psychiatric disorders, including PTSD. The split half reliability of BDI is .93, it has been found to be correlated with clinician rating of depression. The BDI was self administered in its study with assists from interviewer as needed and was scored following Beck's original cutting points for a normal population.

STATISTICAL ANALYSIS:

Z- test was computed to investigate whether or not there was significant difference between the vulnerability to depression in mothers of emotionally and physically handicapped children belonging to lower and upper socio economic status.

DEFINITIONS OF DIFFERENT VARIABLES EMOTIONALLY HANDICAPPED:

A person suffering from emotional handicap is naughty, mischievous, troublesome and difficult to manage in the class. His aggression, anger, rage etc. seem to be utterly out of his control. His temperament is fiery and inconsistent, and he is unpredictable. A less socially based definition is inability to cope with one's environment. It can be defined as the state of having severely distorted behavior, thought or feeling. All the handicaps, which originate in organic lesions, are excluded from the definition of an emotionally handicapped.

PHYSICALLY HANDICAPPED :

A child suffering from any physical defect, which impedes his educational, vocational, emotional or social adjustment is referred to as a physically handicapped child. A physical defect may be congenital. It may, on the other hand, be acquired through disease or accident.

The group of physically handicapped children includes those children who are crippled, blind or partially-sighted, deaf, hard of hearing, defective in speech, epileptic and vitally low that is cardiac, allergic, diabetic and malnourished. A physical handicap is a disability of anatomy, function, or appearance, these can be detected in infancy and later in life.

SOCIO ECONOMIC STATUS (SES) :

Socio economics status refers to the individuals relative position in the community. Some of the factors contributing to socio economic status are profession, income, place, and cost of residence and relative, position on social and economical scale in community; determined largely by income and occupational level.

For this research the target segment was divided into two groups:1- Lower Socio Economic Group: Whose annual gross family income ranges between rupees 36,000 and 40,000.2- Upper Socio Economic Group: whose annual family income ranges between rupees 550,000 and 600,000.

RESULTS

THE HYPOTHESIS NO 1 STATES THAT:

The mothers of emotionally handicapped children from lower socio-economic status will be more depressed as compared to the mothers of emotionally handicapped children from upper socio-economic status.The results of statistical analysis are shown in Table No 1 graph A .

The results indicate that Z = 4.896, n1 = 100, n2 = 100, which shows that there is a significant difference between the two groups. Which reveals the fact that mothers of emotionally handicapped children from lower socio economic status are more depressed as compare to the mothers of emotionally handicapped children from the upper socio – economic status.

THE HYPOTHESIS NO 2 STATES THAT:

The mothers of physically handicapped children from lower socio economic status will be more depressed as compared to the mothers of physically handicapped children from upper socio economic status.The results of statistical analysis are shown in Table No 2 and graph B. The results indicate that $Z = 1.66$, $n_1 = 100$, $n_2 = 100$, which shows that there is significant difference between the two groups. Which is pointing to the fact that the mothers of physically handicapped children from lower socio economic status are more depressed than the mothers of physically handicapped children from upper socio economic status.

THE HYPOTHESIS NO 3 STATES THAT:

The mothers of healthy children from lower socio economic children will be more depressed as compared to the mothers of healthy children from upper socio economic status.

The results of statistical analysis are shown in Table No 3 and graph C

The results indicate that $Z = 2.309$, $n1 = 100$, $n2 = 100$, which shows that there is a significant difference between two groups. Which is pointing to the fact that the mothers of healthy children from lower socio economic status are more depressed than the mothers of healthy children from upper socio economic status.

TABLE 1

DEPRESSION LEVEL OF MOTHERS OF EMOTIONALLY HANDICAPPED CHILDREN FROM LOWER AND UPPER SOCIO ECONOMIC STATUS

Groups	M	SD	Total No of Subjects
Mothers of emotionally handicapped children from lower socio economic status	32.74	5.783	100
Mothers of emotionally handicapped children from upper socio economic status	27.08	5.784	100

Z = 4.896

Significant at less then 0.05 level.

GRAPH "A"

DEPRESSION LEVEL OF MOTHERS OF EMOTIONALLY HANDICAPPED CHILDREN FROM LOWER AND UPPER SOCIO ECONOMIC STATUS

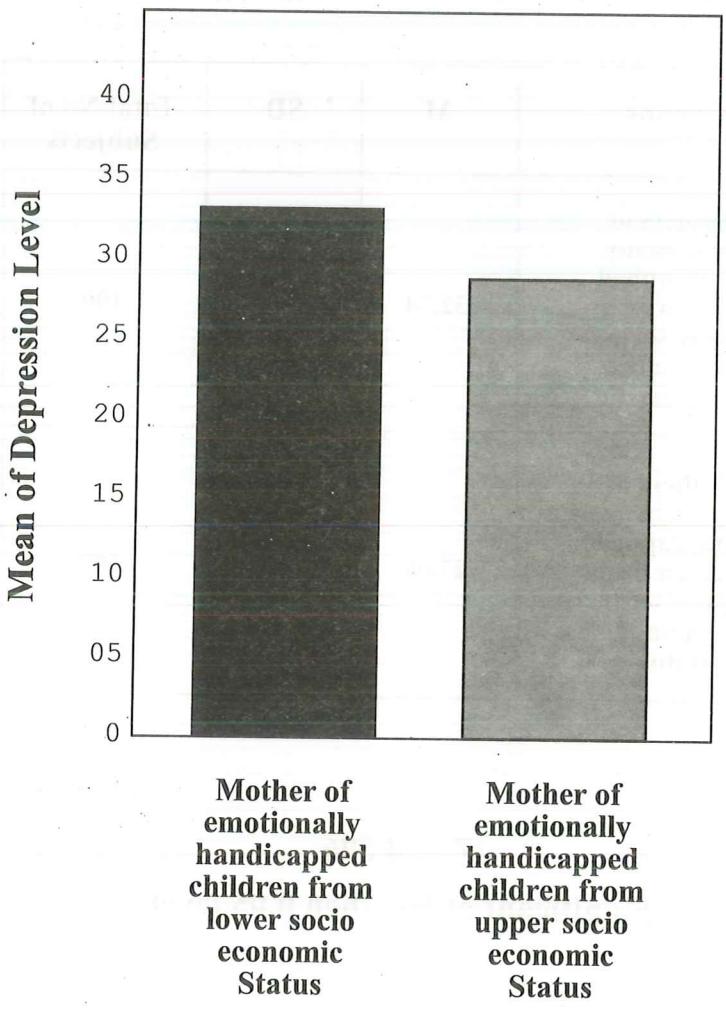


TABLE 2

DEPRESSION LEVEL OF MOTHERS OF PHYSICALLY HANDICAPPED CHILDREN FROM LOWER AND UPPER SOCIO ECONOMIC STATUS

Groups	M	SD	Total No of Subjects
Mothers of physically handicapped children from lower socio economic status	25.02	5.908	100
Mothers of physically handicapped children from upper socio economic status	23.04	5.958	100

Z = 1.669

Significant at less then 0.05 level.

GRAPH "B"

DEPRESSION LEVEL OF MOTHERS OF PHYSICALLY HANDICAPPED CHILDREN FROM LOWER AND UPPER SOCIO ECONOMIC STATUS

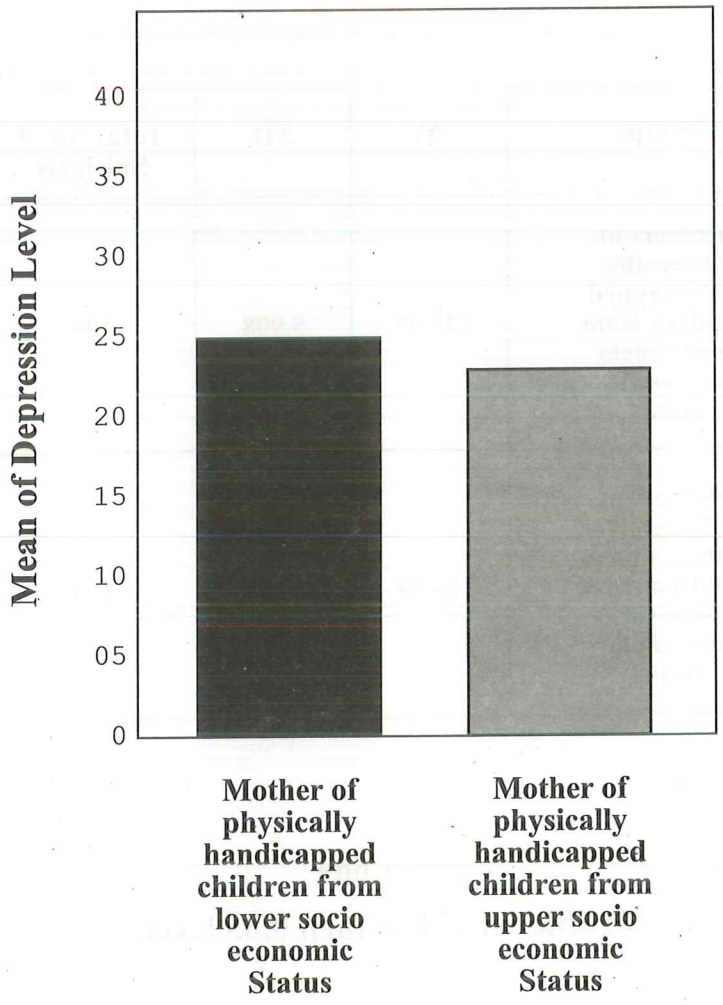


TABLE 3

DEPRESSION LEVEL OF MOTHERS OF HEALTHY CHILDREN FROM LOWER AND UPPER SOCIO ECONOMIC STATUS

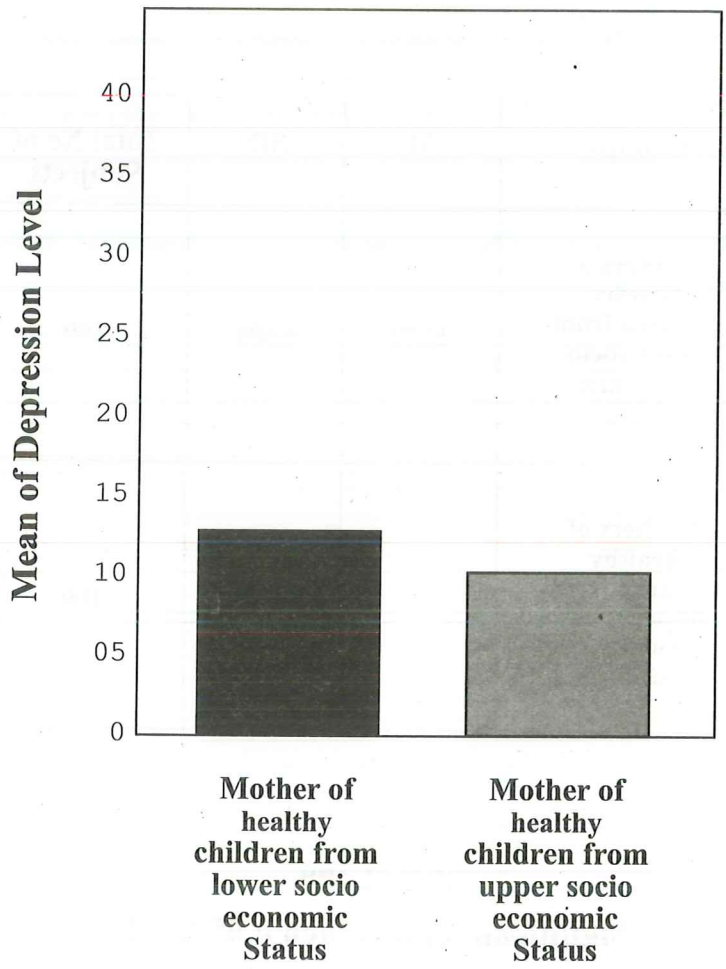
Groups	M	SD	Total No of Subjects
Mothers of healthy children from lower socio economic status	12.76	6.688	100
Mothers of healthy children from upper socio economic status	9.7	6.569	100

Z = 2.309

Significant at less then 0.05 level.

GRAPH "C"

DEPRESSION LEVEL OF MOTHERS OF HEALTHY CHILDREN FROM LOWER AND UPPER SOCIO ECONOMIC STATUS



DISCUSSION

THE HYPOTHESIS NO 1 STATES THAT:

The mothers of emotionally handicapped children from lower socio economic status will be more depressed as compared to the mothers of emotionally handicapped children from upper socio economic status.

This hypothesis is supported by the data and is statistically significant at P less than 0.05 level.

According to Table Number 1 and Graph A, it is quite clear that the mean scores for mothers of emotionally handicapped children from lower socio economic status are more than the mother of emotionally handicapped children from upper socio economic status. Hence, it is clear that the mothers of emotional handicapped children are more depressed as compared to the mothers of emotionally handicapped children from upper socio economic status.

The mother of emotionally handicapped children from lower socio economic status are more depressed as they do not find excess to the treatment due to financial constraints being one of the reason. The professional treatment for emotionally handicapped children sounds a far fledged idea to the mothers among the poverty line population of the developing countries like Pakistan.

In case of mothers of emotionally handicapped children from upper socio economic status severity of depression among them is less. As there are no economic constraints. The matter of concern for those mothers are people around them, who blame mother for the emotional handicapped of the children.

THE HYPOTHESIS NO 2 STATES THAT:

The mothers of physically handicapped children from lower socio economic status will be more depressed as compared to the mothers of physically handicapped children from upper socio economic status.

This hypothesis is supported by the data and is statistically significant at P less than 0.05 level.

According to Table Number 2 and Graph B, it is quite clear that mean scores for mothers of physically handicapped children from lower socio economic status are more than the mothers of physically handicapped children from upper socio economic status. Hence, it is clear that the mothers of physically handicapped children from lower socio economic status are more depressed than the mothers of physically handicapped children from upper socio economic status.

Poverty was accepted as inevitable and as the fate of the masses in most countries. It was looked upon as a God given condition, dividing mankind into rich and poor and assigning a fixed place to every one. With the passage of time, things, however, seem to have considerably changed. Now people understand that it is up to the individual to see what place he wants to occupy in this panorama of life. People now fully realize that adverse conditions are a hard reality and solution lies in the fact that we should understand them and so far as it is possible to remove them.

A poor individual or family has a high possibility of staying poor. Low income carry with them high risks of mental health physical illness as also, limited access to education, information or training. Poor parents cannot give their children the opportunity for better health and education needed to improve their lot. The cruel legacy of poverty is passed from parents to children. Also, poverty leads to social evils. As a result, violence, vagrancy, addiction, delinquency become rampant in the society. These social evils lead to depression ending up in various mental diseases.

In Pakistan mostly upper class families are influenced by western culture and hence are aware of the usefulness and benefits of psychological treatment. Moreover, they do not face the problems of financial burden. At times they also consider going for psychotherapy as a symbol of prestige. Mother from lower class are not highly educated and hence do not readily understand the value of just talking to them as a technique of treatment.

THE HYPOTHESIS NO 3 STATES THAT:

The mothers of healthy children from lower socio economic children will be more depressed as compared to the mothers of healthy children from upper socio economic status.

This hypothesis is supported by the data and is statistically significant at P less than 0.05 level.

According to Table Number 3 and Graph C, it is quite clear that the mean scores for mothers of healthy children from lower socio economic status are more than the mother of healthy children from upper socio economic

status. Hence, it is clear that mothers of healthy children from lower socio economic status are more depressed than the mothers of healthy children from upper socio economic status.

Being poor, a mother is usually over burdened with a host of domestic and professional problems which are constantly threatening the very survival of her family. In such situations the presence of a emotionally disturbed child brings a whole lot of problems for the mother, which usually leads to depression. Further more she is also not economically competent to get the treatment.

Mental illness is not an acute and sudden condition that strikes women who were previously functioning very well. Rather, the woman who is identified as mentally ill has been impaired long before. During this prerecognition period she moved downward socially because her impairment interfered with her performance of the roles required for membership in the higher class.

Females from lower class are more likely to develop mental illness for a number of possible reasons, perhaps lower class members are subjected to greater stresses than higher class members, and consequently they develop mental disturbances.

The upper class mothers frequently are found to have some understanding of the mental disorders. Lower class mothers on the other hand have a distorted conception of it.

The mothers adjustment intervention can be concluded in this manner:

- Information in order to understand and make sense of what is happing and how to plan and manage them through accurate sources.

- Sharing feeling with significant others, family friends and other parents of children with similar disabilities.

- Maintain and support by continuous follow up.

- Update and adequate written information regarding disabilities and problem of the baby.

Reassure the parents about their reactions, and that they are common and normal and need to be aired.

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