



## SOCIAL ADJUSTMENT IN FAMILIES WITH CHILDREN AND ADOLESCENTS WITH INTELLECTUAL DISABILITY AND FUNCTIONAL PSYCHOSIS

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### ABSTRACT

**Background:** The problem associated with rearing intellectually disabled and functional psychosis children and adolescent is multifold Problems like disturbance of –daily routine, family leisure education, family health, steady dram on time, physical and emotional energy as well as financial resources and over above social interaction of the parents. Parents' psychological adjustment can be defined as the adaptive task of managing upsetting feelings aroused by the illness of the child and preserving a reasonable emotional balance (Moos R. H. & Tsu V. D., 1977). Pless and Pinkerton (1975) have postulated that adjustment to chronic illness changes over time and that at any given moment psychological adjustment will reflect the cumulative product of earlier transactions.

**Aim & Objective:** The purpose of this study was to assess and compare social adjustment among parent of children with intellectual disability and functional psychosis.

**Participants and Methods:** This study was a cross-sectional hospital based study. The study samples were selected through purposive sampling technique. The sample size was 40 parents among which 20 parents of children and adolescent with intellectual disability and 20 parents of children and adolescent with functional psychosis taken from Erna Hoch Child and Adolescent Psychiatry Unit and Charak Outpatient Department, of the Central Institute of Psychiatry, Kanke, Ranchi. The Modified Social Adjustment Scale (SAS-M) scale was used for the data collection. Data were analyzed by Statistical Package for Social Sciences (SPSS- 21 version).

**Result & Conclusion:** Results indicated no significant group differences in ratings of “modified-social adjustment scale”.

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### INTRODUCTION

Adjustment is the behavioral process by which humans and other animals maintain equilibrium among their various needs or between their needs and the obstacles of their environments. A sequence of adjustment begins when a need is felt and ends when it is satisfied. Hungry people, for example, are stimulated by their physiological state to seek food. When they eat, they reduce the stimulating condition that impelled them to activity, and they are thereby adjusted to this particular need. In general, the adjustment process involves four parts: (1) A need or motive in the form of a strong persistent stimulus, (2) The thwarting or non-fulfilment of this need, (3) Varied activity, or exploratory behavior accompanied by problem solving, and (4) Some response that removes or at least reduces the initiating stimulus and completes the adjustment.

**Social adjustment:** Social adjustment can be defined as: the manner in which an individual fulfils his/her roles in social

relationships and the individual's well-being within these relationships (Lazarus & Folkman, 1984). In the family context, parents participate in parent-child relationships, the marital relationship, and the family-level relationship-the relationship shared by all family members. Each type of relationship has its specific functions (Olson, 1993). The parent-child relationship serves the purpose of childrearing and caretaking responsibilities (Colapinto, 1991). Important dimensions are: parental support, parental control, parent-child communication, and parental well-being (Teti & Candelaria, 2002). Parental support refers to parental warmth and responsiveness to the child's needs and demands (Baumrind, 1996). Parental control can be defined as the disciplinary actions that limit or direct the child's behavior (Baumrind, 1996). Parent-child communication refers to interaction patterns of listening and speaking between parent and child (Olson, 1993). Parental well-being can be described as parents' feelings of competence and satisfaction in the relationship with their child (Teti & Candelaria, 2002). The marital relationship serves the function of partner intimacy and support (Colapinto, 1991). Important dimensions are: marital happiness, marital communication, and marital

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stability (Karney & Bradbury, 1995). The family-level relationship serves to support, regulate, nurture, and socialize family members as a unit (Colapinto, 1991). Important dimensions are: cohesion, adaptability, and communication (Olson, 1993). Cohesion refers to the emotional bonding among family members. Adaptability reflects the ability of the family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stresses. Communication refers to interactions among family members that facilitate cohesion and adaptability.

Family adjustment refers to the process undergone when a profound stressor, such as an illness, disability, or injury occurs within the family system. The family in its most common form is a lifelong commitment between men and women who feed, shelter and nurture their children until they reach maturity. It is a primary socialization context and is, therefore, considered to be a very important factor influencing children's social adjustment.

**Intellectual disability:** Intellectual Disability, formerly known as "Mental Retardation," is a disorder with onset during the developmental period. It includes intellectual deficits and difficulty functioning in daily life in areas such as communication, self-care, home living, social/interpersonal skills, self-direction, academics, work, leisure, health, and safety.

According to American Association on Mental Retardation (AAMR), "Mental Retardation refers to significantly sub average general Intellectual functioning, resulting in or associated with concurrent impairments in adaptive behavior, and manifested during the developmental period. According to ICD-10(WHO, 1992) Mental retardation or intellectual disability is a condition of arrested or in complete development of mind, which is especially characterized by impairment of skills manifested during the development period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities.

**Psychosis:** It is not easy to define psychosis; therefore, sometimes we have to specify whether we are referring to the psychodynamic or psychiatric definition, or to the perspective of a given author. There are a wide series of definitions: "loss of affective contact with reality," "temporary or permanent withdrawal from objective reality," "a severe psychic disturbance that eventually leads to the deterioration of personality structures," "a pathological exacerbation of constitutional tendencies," "an extensive personality disorganization," "a severe mental disorder or pathological reactions, which vary and involve all forms of adaptation," "the final outcome of the confluence of several nociceptive factors on the psychic apparatus" or "fragmented personality."

**Aim of the Study:** This study was planned to explore and compare social adjustment among parent of children with intellectual disability and functional psychosis.

#### **Objective of the Study**

To explore and compare the social adjustment among parents of the children and adolescents with intellectual disability and functional psychosis.

#### **Hypotheses**

There will be no significant difference between social adjustment among parents of children and adolescents with intellectual disability.

#### **METHOD AND MATERIALS**

This study was conducted at the Erna Hoch Child and Adolescent Psychiatry Unit and Charaka outpatient department of the Central Institute of Psychiatry, Kanke, Ranchi. The present study was a hospital-based, cross-sectional study. The study samples were selected through purposive sampling technique. The sample size was 40 parents among whom 20 parents of children and adolescent diagnosed with intellectual disability and 20 parents of children and adolescent diagnosed with functional psychosis taken from Erna Hoch Child and Adolescent Psychiatry Unit and Charak Outpatient Department, of the Central Institute of Psychiatry, Kanke, Ranchi. In this study 32 children and adolescents with intellectual disability were screened on DST and VSMS and 29 children and adolescents with functional psychosis were screened on BPRS-C after considering inclusion and exclusion criteria 20 children and adolescents were selected in each group. Selected children's and adolescent's parents were assigned to two study groups.

#### **Inclusion and Exclusion Criteria**

In intellectual disability group, children and adolescents belonging to the age range of 6-17 years who diagnosed with Moderate to Profound Mental Retardation as per ICD-10-DCR were included. Children and adolescents age below 6 years and more than 17 years, diagnosed with severe physical disability, addiction (except nicotine and caffeine) and problems in addition to mental retardation were excluded from the study. And in functional psychosis group, children and adolescents belonging to the age range of 6-17 years who diagnosed with schizophrenia/bipolar disorder/acute and transient psychosis as per ICD-10-DCR were included. Children and adolescents age below 6 years and more than 17 years, diagnosed with co-morbid psychiatric diagnosis and mental retardation, severe physical disability, substance addiction (except nicotine and caffeine) and problems in addition to their primary diagnosis (psychosis).

Similarly, parents belonging to the age range of 30-55 years and educated up to at least Class-8 and above who gave written informed consent for the study were included. Parents aged <30 or >55 years, education level less than Class-8 and not giving written informed consent for the study were excluded from the study in both groups.

#### **Tools used for data collection**

1. Socio-demographic & clinical data sheet"
2. "Development Screening Test (DST)"(Bharat Raj. J., 1983)
3. "Vineland Social Maturity Scale (VSMS)" (Bharat Raj. J Indian adaptation by A. J. Malin, 1992)
4. "Brief Psychiatric Rating Scale for Children (BPRS-C)" (Overall JE. Pfefferbaum B, 1982)
5. The Modified Social Adjustment Scale (SAS-M):

#### **Descriptions of Tools**

**Socio-Demographic & Clinical Data Sheet:** This data sheet was used to obtain information about various socio-

demographic and clinical variables of the selected children and their parents like age, gender of children, education of children and parents, religion, ethnicity, domicile, psychopathology and behavioral problems, family history, etc.

**Development Screening Test (DST):** Developmental Screening Test developed by Bharath Raj (1977, 1983) was designed for the purpose of measuring the developmental sequences of children from birth to 15 years of age. It consists of 88 items which represent the behavioral characteristics of respective age levels. At each age level, items are drawn from behavioral areas, like motor development, speech, language, and personal-social development. Appraisal of a child can be done in semi-structured interview with a parent or a person well acquainted with the child. Scores obtained on these items with IQ calculator are used to assess the level of development in the child.

**Vineland Social Maturity Scale (VSMS):** This scale consist 89 items. The Vineland social maturity scale was originally devised by E. A .Doll in 1935 and Indian adaptation was developed by A. J. Malin in 1992, since then this test is being used in many parts of the country. This scale is not only providing social age and social quotient measures but also indicate the social deficits and social assets in a growing child. It is for age level from 0 to 15 years. It is good to locate mentally retarded.

**The Psychiatric Rating Scale for Children:** The Brief Psychiatric Rating Scale for Children commonly abbreviated BPRS-C scale), is a 21-items clinician-based rating scale designed for use in evaluating psychiatric problems of children and adolescents. It was developed to provide a descriptive profile of symptoms applicable to a broad range of child and adolescent psychiatric disorders and is increasingly used as an outcome measure in research, managed care, and public-sector child/adolescent clinical settings. Ratings are based on a 7point Likert scale, from "Not Present" (scores 0) to "Extremely Severe" (scores 6 points).

**The Modified Social Adjustment Scale (SAS-M):** This scale was developed in the line of Social Adjustment Scale (SAS) of Weissman and Paykel. In that scale, social adjustment is assessed on three ways: (i) functioning in each of six Role Areas (work or house work; social and leisure activities; relationships with extended family; relationship with spouse; functioning as a parent; and functioning in the family unit); (ii) four Descriptive Categories (Performance, Inter personal behaviour, Friction and Feelings); (iii) a single score for all items, the Overall Adjustment score. The basic structure of the modified self-report social adjustment scale (SAS-M) is almost similar to Social Adjustment Scale of Weissman and Paykel. In the SAS-M the six main Role Areas and the four Descriptive Categories were maintained. Two changes were made in SAS-M, as: (i) Wording: Where appropriate, the original wording of the questionnaire was changed to make it more familiar and easily understandable to people in the United Kingdom (because the in the SAS scale few things, e.g. phrases and wordings were based on American Style of English and the SAS-M was developed in Britain). (ii) Rating Scale: In the SAS the respondent was required to answer questions about her social functioning over the preceding two weeks, using different sets of ratings for each question. In the SAS-M, the subject is to be asked to use the same rating scale throughout the questionnaire: this consisted of five possible responses: not at all; occasionally; about half the time; most of the time; all the time (with slight variations where necessary). This scale has high reliability and validity and also it is easy to administer.

**Procedure**

Parents of the children and adolescents with diagnosis of Intellectual Disability and Functional Psychosis as per ICD-10 (DCR) criteria included in accordance with the inclusion and exclusion criteria taken for the study. At first, written informed consent were taken from each parent who was willing to participate in the study. After that socio-demographic profile was filled and later on Development Screening Test (DST) and Vineland Social Maturity Scale (VSMS) had been applied on children with intellectual disability and Brief Psychiatric Rating Scale for Children

**Table 1** Comparison of socio-demographic variables of patients and parents with Intellectual disability and Functional Psychosis

Variables		Groups N=40		$\chi^2$ /Fisher's Exact Test#	df	p
		Intellectual Disability N=20, n (%)	Functional Psychosis N=20, n (%)			
Sex of the patients	Male	11(45.8)	13(54.2)	.417	1	.519
	Female	9(56.2)	7(43.8)			
Religion	Hindu	17(48.6)	18(51.4)	.230#	-	1.000
	Other	3(60)	2(40)			
	Farmer	5 (35.7)	9 (64.3)			
	Labourer	6 (75)	2 (25)			
Father Occupation	Business	2 (28.6)	5 (71.4)	8.744#	-	.090
	Private Job	5 (83.3)	1 (16.7)			
	Gov. Job	0 (0)	2 (100)			
	Unemployed	2 (66.7)	1 (33.3)			
Mother Occupation	Employed	0 (0)	1 (100)	1.412#	-	1.000
	Unemployed	20 (51.3)	19 (48.7)			
Parental Status	Both parents	18 (48.6)	19 (51.4)	1.204#	-	1.000
	Single parent	1 (50)	1(50)			
	Separated	1 (100)	0 (0)			
Family Type	Nuclear	12 (44.4)	15 (55.6)	2.553#	-	.301
	Joint	8 (66.7)	4 (33.3)			
	Extended	0 (0)	1 (100)			
Socio-economic Status	Lower	15 (53.6)	13 (46.4)	.476	1	.490
	Middle	5 (41.7)	7 (58.3)			

(BPRS-C) was applied on children with Functional Psychosis. Subsequently, COP Einventory was administered on parents of children with intellectual disability and functional psychosis.

**Statistical Analysis**

The raw data was analyzed statistically with aid of the computer program-SPSS (Statistical Package for Social Sciences)-21. Descriptive statistics was used to describe various sample characteristics. Chi square test was used for describing and comparing categorical data. Mann Whitney U Test was used for describing and comparing continuous data. Spearman’s correlation and point bi serial correlation coefficient were computed to study the relationship for continuous and categorical variables, respectively.

**RESULTS**

Table 1 Shows comparison of socio-demographic variables of patients and parents of children and adolescents with Intellectual disability and Functional Psychosis. Most of the patents were male and Hindu by religion in both groups. It was found that majority of the fathers were farmer by profession in functional psychosis group. Results also shows that most of the mothers were unemployed (51.3% & 48.7%) in the both groups respectively. It was also found that majority of the families with children and adolescent with intellectual disability, and functional psychosis were belonging to lower socio-economic status and nuclear family. There was no significance difference with regards to sex, religion, father’s occupation, mother’s occupation, marital status, family type and socioeconomic status in both the groups.

**Table 2** Comparison of clinical variables of patents with Intellectual Disability and Functional Psychosis

Variables	Groups N=40		$\chi^2$ /Fisher’s Exact Test#	df	p
	Intellectual Disability N=20, n (%)	Functional Psychosis N=20, n (%)			
Past Present	0 (0)	12 (100)	21.949#	-	.000
History Absent	20 (71.4)	8 (28.6)			
Family Present	5 (33.3)	10(66.7)	2.667	1	.102
History Absent	15(60)	10 (40)			

\*\*\*p<.001

Table 2 shows clinical profile of the children and adolescent with Intellectual Disability andfunctional psychosis. There was a significance difference in the past history of mental illness of children and adolescents of intellectual disability and functional psychosis. No significance difference was found in the family history between intellectual disability and functional psychosis.

**Table 3** Comparison of patient’s age, education, age of onset, duration of illness, number of hospitalization and duration of pharmacological treatment in patients with Intellectual Disability and Functional Psychosis

Variable	Groups N=40		Mann Whitney U Test	p
	Intellectual disability (Mean Rank) N=20	Functional Psychosis (Mean Rank) N=20		
Age	13.12	27.88	52.500	.000
Education	11.30	29.70	16.000	.000
Age of onset	10.50	30.50	00.000	.000
Duration of illness	29.98	11.02	10.500	.000
Number of hospitalizations	12.60	28.40	42.000	.000
Duration of pharmacological treatment	18.82	22.18	166.500	.40

\*\*\*p<.001

Table 3 shows the socio demographic and clinical profile in patients with Intellectual disability and Functional Psychosis. There was significantly higher in age (\*\*\*p<.000), education (\*\*\*p<.000), age of onset (\*\*\*p<.000), and number of hospitalizations (\*\*\*p<.000) in Functional Psychosis as compared to Intellectual disability. Results also found duration of illness (\*\*\*p<.000) was significantly higher in Intellectual disability as compared to Functional Psychosis.

**Table 4** Characteristics of father age, mother age and number of family members in families with Intellectual disability and Functional Psychosis

Variable	Groups N=40		Mann Whitney U Test	p
	Intellectual disability (Mean Rank) N=20	Functional Psychosis (Mean Rank) N=20		
Fathers age	14.85	26.15	87.000	.002**
Fathers education (in years)	16.70	24.30	124.000	.035*
Mothers age	12.82	18.18	46.500	.000***
Mothers education (in years)	11.40	29.60	18.000	.00***
Number of family member	18.30	22.70	156.000	.229

Table 4 shows socio demographic profile of parents and families of children and adolescents with Intellectual disability and Functional Psychosis. There was significantly higher in father’s age (.002\*\*) and mother’s age (\*\*\*p<.000), fathers’ education (.035\*) and mothers’ education (.000\*\*\*). Functional Psychosis as compared to Intellectual disability. No significant difference was found in the number of family member in Intellectual disability as compared to Functional Psychosis.

**Table 5** Social adjustment in Parents of children and adolescent with intellectual disabilityand functional psychosis

Variable (Modified Social Adjustment Scale)	Groups N=40		Mann Whitney U Test	p
	Intellectual disability (Mean Rank) N=20	Functional Psychosis (Mean Rank) N=20		
Outside work	9.25	8.86	31.500	.877
Housework	21.58	19.42	178.500	.553
Social and leisure	21.78	19.22	174.500	.486
Extended family	20.78	20.22	194.500	.880
Marital	19.65	21.35	183.000	.643
Parental	19.70	21.30	184.000	.660
Family unit	18.30	22.70	156.000	.180
Total score	18.62	22.38	162.500	.310

Table 5 shows the comparison of Modified Social Adjustment Scale in Parents of children and adolescent with Intellectual Disability and Functional Psychosis. Results indicate no significant difference in the sub domains of Outside work, Housework, Social and leisure, Extended family, Marital, Parental, Family unit and Total score of social adjustment scale of parents of children and adolescents with intellectual disability and functional psychosis.

**DISCUSSION**

The present study was a hospital based cross sectional single contact study and it was conducted at the Central Institute of Psychiatry, Ranchi. The purpose of this study was to assess

and compare the coping patterns among parent of children with intellectual disability and functional psychosis.

Parental adjustment is a very important factor for keeping consistency in care and assistance to the children with chronic or enduring conditions, e.g. intellectual disability and functional psychosis. In the present study, Parents of children and adolescents with intellectual disability reported higher mean in the sub domains of outside work (9.25), housework (21.58), social and leisure (21.78), extended family (20.78) and lower mean in the sub domain of Marital (19.65) Parental (19.70) Family unit (18.30). It might be due to, the raising the children and adolescents with intellectual disability were easier in comparison to functional psychosis because they get social and emotional support from external resources. However, had feelings of guilt or blame that somehow, they or other partner caused the child to be disabled, for logical or illogical reasons or feelings of embarrassment, shame, and they had poor marital, parental and family adjustment. However, parents of children and adolescents with functional psychosis reported (22.38) higher level of social adjustment in comparison to parents of children and adolescents with intellectual disability. However, significant difference was not seen in the sub domains of Outside work, Housework, Social and leisure, Extended family, Marital, Parental, Family unit and Total score of social adjustment scale of parents of children and adolescents with intellectual disability and functional psychosis.

In general, children with intellectual disability have adjustment difficulties in their life, which disturb inclusion in the society. An appropriate adjustment in a family life becomes essential for the successful adaptation in their life. Although studies indicate that the families of children with disability experience more than the average amount of stress (Dyson & Fewell, 1986; Dumas, Wolf, Fisman, & Culligan, 1991), not all suffer from the stress and no universal coping way exists for the stress. It is important to keep in mind that the majority of parents of children with disabilities do not have psychological problems. According to some studies, many families have coped with having children with disabilities successfully (Bristol, 1984) and the birth of their child brought the family closer together (Singer & Farkes, 1989). This is not to minimize the fact that the families of children with disabilities can experience devastating situations. However, it is dangerous to assume that all families of children with disabilities automatically go through the same situations.

Giallo and Gavidia-Payne (2006) observed that parent and family factors were stronger predictors of sibling adjustment difficulties than siblings' own experiences of stress and coping. Specifically, socio-economic status, past attendance at a sibling support group, parent stress, family time and routines, family problem solving and communication, and family hardiness-predicted sibling adjustment difficulties. Finally, siblings' perceived intensity of daily uplifts significantly predicted sibling prosocial behaviour. Thus, social adjustment of caregivers, more specifically parents can ensure better care to their children as well as stability of family in general.

## LIMITATION & CONCLUSION

It was a hospital based study with small sample size which was the main limitation of this study as hospital based study,

which dealt with referred patients which might not have been truly representative of the general population. Nevertheless, it has given us numerous insights into the problems of the patients who reach us but due to less sample size generalization of results could not possible. Future research with larger, less selective samples and longitudinal designs may provide a clearer picture of the multiple factors associated with family stress and dyadic adjustment.

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